APT Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 8, 9, 10 and 11 November 2016 and was announced. When we last inspected the service in November 2015 we rated it as 'requires improvement' in each of the areas we inspected. We took enforcement action to protect people using the service, but found during a focused inspection in February 2016 that improvements had been made to address the risks we had identified.

APT Care Limited is a domiciliary care service providing personal care and support to people in their own homes. They provide care to people requiring both long-term and short-term support, usually following hospital discharge. At the time of our inspection, the service was providing care and support to 79 people.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

While there had been improvements to the quality of the service in some areas we found that others still required improvement.

People told us they felt safe but raised concerns about staff not always arriving on time. While some people received consistent care from the same staff, others reported having many different staff attending to their needs. People's dignity and privacy was upheld and we were told that the staff team were kind and caring, but some people felt rushed and couldn't develop positive relationships with their care staff because of frequent changes.

Risks to people were assessed and control measures implemented to support people's safety. The management of people's medicines had improved but there were still some inconsistencies in practice.

While there had been significant improvement to the quality of care plans, people still did not always feel involved in care planning or making decisions about their care. People consistently told us that they did not feel that their concerns or views were listened to by the management of service and did not have faith in complaints being resolved. While some complaints were being investigated and resolved correctly, others were subject to delay.

There were enough staff available to meet people's needs. However the process for recruiting new staff was not always robust and references were not always acquired from previous employers. Staff received a comprehensive induction and completed a range of training which enabled them to carry out their roles effectively. They were able to contribute to the development of the service through team meetings.

There were improved quality monitoring systems in place which were effective at identifying trends and identifying areas for improvement. People were sent questionnaires and surveys to ask for their feedback on

the quality of care delivered.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely or correctly accounted for.

Staff were not always recruited with appropriate employment references.

The times that people received care were not always consistent.

Is the service effective?

Good

The service was effective.

Staff received a range of training that enabled them to carry out their duties effectively.

People were supported with the preparation of food and drink where required.

The service followed the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always feel that they received consistent care from staff who understood their needs.

People did not always feel treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were detailed and person-centred but did not always evidence involvement from people or their relatives.

Complaints were not handled effectively and people did not have confidence that the management would deal with their

complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People did not feel that they received an adequate response to their concerns or queries from management.

Staff were positive about the support they received from management and the culture of the service.

There were robust systems in place for monitoring the quality of the service and identifying improvements that needed to be made.

APT Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 8, 9, 10 and 11 November 2016 and was announced. The provider was notified 48 hours before the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be in the office on the day of our visit. We visited the provider's office on the 8 and 9 November and made phone calls to people using the service and staff on the 10 November and 11 November 2016.

This inspection was brought forward as a result on concerning information that we had received. Therefore we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

The inspection team was made up of one inspector and an expert-by-experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with 12 care workers, the deputy manager, the provider and the registered manager. We reviewed the care records and risk assessments of nine people who used the service, checked medicines administration records, daily records and reviewed how complaints were managed. We also looked at eight staff records and the training records for all the staff employed by the service. We reviewed information on how the quality of the service was monitored and managed. We contacted eight people and ten of their relatives by telephone to ask for their views on the care they received. We spoke with the contract and monitoring team for the local authority who commissioned the service.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection in November 2015 we identified issues with the quality of risk assessments, recording of incidents and the safe management of medicines. During this inspection we found that while improvements had been made in these areas there were still some elements of the service being delivered which were not always safe and still required further improvement.

When people were discharged from hospital or referred to the service the assessment information provided was used to ascertain the level of support that people required with their medicines. Since our last inspection we noted in that the majority of care plans we looked at, there were lists of the medicines that people took and some further information about the level of support they required. A risk assessment had been created to identify any risks associated with staff supporting people to take their medicines. This was a significant improvement since our previous inspection when there was often no information about medicines available in people's care plans. This was an improvement upon our last comprehensive inspection where information relating to people's medicines was not included in care plans.

Prior to the inspection we received five safeguarding alerts relating to the management of medicines. We checked to see whether the provider was taking appropriate action to address these and found that they were carrying out competency observations with staff and addressing individual mistakes through supervision and memos. Staff had received updated training in medicines management if a further need had been identified.

However we identified occasions where errors in medicine administration were preventable and left people at unnecessary risk. For example on one occasion it had been alleged that care staff had administered a medicine incorrectly on three separate occasions and failed to administer other medicines. When we reviewed the records relating to this person's medicines we found that the MAR (medicines administration record) charts had been signed to indicate that this was indeed the case. However, there were gaps in the charts, signatures crossed out and the MAR charts were not always reflective of daily notes. The investigation was still on-going at the time of our inspection but we had previously requested a report on this to be provided by the 26 October 2016 which was not forthcoming. Because the medicine alleged to have been given was alendronic acid, an overdose could have resulted in damage to the person's throat. While the allegation had not yet been substantiated the delay in investigating the matter meant that prompt action had not been taken to address the issues with recording or take action to protect the person from further risk of harm. The registered manager and provider told us they would focus more on initial assessments in future to ascertain the level of support people needed with their medicines and ensure that this was being provided correctly.

The quality of recording of medicines had improved overall but there were still mistakes being made in accounting for people's medicines. One person's MAR chart was consistently signed by staff for their morning medicines but all of their lunchtime, teatime and evening medicines were routinely signed for as 'refused'. However when we spoke with the office staff it was explained that this was because the person's family administered medicines at these times. However the person's care plan did not reflect this and clearly

stipulated that staff were to administer all of their medicines. This was further complicated by there was not a consistent approach to accounting for this, and some staff signed 'refused' for some medicines and some signed 'not required', neither of which were accurate. The provider told us they would discuss this with staff in the next team meeting and adapt MAR charts so that staff could sign to indicate when medicines had been administered by a family member.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Safe Care and Treatment.

The provider had a recruitment policy in place, and we found that while this was being followed in the recruitment of staff there was some improvement required to ascertain whether staff had suitable experience, knowledge and skills to perform their duties safely. We looked through eight staff files and six of them contained references which were from personal friends or colleagues and were therefore not permissible employment references. All six staff in question had listed some employment history in their application forms which meant that references should have been sought from these employers. To compensate for a lack of employment references, three personal references were sought instead. However for one member of staff we found that the three personal references given were identical in wording. We noted that in four staff files there were was no accounting for gaps in employment.

Not regularly accounting for the previous employment history of staff meant that the service were recruiting staff who may not have had suitable character or experience. We did note however that DBS (Disclosure and Barring Service) checks were being carried out as required. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. Staff were also asked to complete medical questionnaires and provide proof of their identity as required.

People told us felt safe during visits from their care staff. One person said, "Yes they do keep me safe, I can't fault them for that." Another person said, "I feel safe when they come most of the time, yes." While most people responded positively to this question, one person said, "I do feel safe, but sometimes I do just feel like I'm bothering them too much. The occasional deep sigh can be quite hurtful."

When we asked people if there were enough staff available, every person we spoke with said they had never been left without care, but the majority stated that timings were erratic and that staff were pressured and rushed. One person said, "My regular care staff are lovely but even they sometimes really don't have time to do anything but just the essentials before they rush off to the next client. I do just feel like I'm a number to them rather than a person." A relative said, "Recently it's getting better but carers have turned up an hour or two late or sometimes early. It means [relative] ends up eating at funny times, sometimes they'll have breakfast and then lunch immediately afterwards because there's a small gap."

The service employed a total of 71 members of care staff who were deployed to work flexibly in the community. Because of the large amount of packages requiring support from two carers some staff often worked in pairs. When we asked staff whether there were enough of them to meet people's needs they told us the numbers deployed were sufficient. One member of staff said, "We try and keep to the same rotas so we know where we're going and who we're delivering care to. I've never been left on my own if we need another carer." Because of the large turnover of people coming into the service it was important for staffing levels to be sufficient to meet people's needs. The provider told us that for a period over the summer they had been stretched in their deployment of staff and that the office staff had needed to provide care themselves.

We looked at the electronic system used for allocating staff and found that the service were working to

within a half hour tolerance of people's proposed visits. For people who were receiving short-term care packages, they were given a broader window of time in which staff would arrive to allow for more efficient management of staff deployment. We found this to be necessary to avoid being unable to fulfil visits at specific times. However the majority of people who received longer-term care packages from the agency also told us that times were erratic and often inconsistent. One relative we spoke with explained the impact upon their loved one, saying "The care itself is pretty good but a bit lacking with timings somethings. They stay the right amount of time but sometimes they're late and we're just sitting there waiting. [Relative] in limbo then waiting because [they] can't move and [they] are just waiting in bed, unable to go about their day. I can't go out anywhere because I can't leave [them]."

The service now had a robust policy in place for reporting accidents and incidents and we saw a number of incident forms which had been completed and included in people's care plans with remedial actions. These were now being collated within the provider's quality monitoring system and trends were being identified.

People's risk assessments now contained a higher level of detail and were more reflective of people's individual needs. Risks in areas such as mobility, dementia and medicines had now been created and formed part of the initial assessment that needed to be undertaken at the first point of contact with each person. Each risk assessment included control measures and actions to be taken to mitigate and manage each of these risks effectively.

Good

Is the service effective?

Our findings

During our last comprehensive inspection we identified that the training provided to staff was not always sufficient to meet the needs of people receiving care from the service. Before this inspection we received additional concerns that staff did not always receive adequate training to understand people's needs.

Most of the people we spoke with felt that staff were adequately trained to provide care to their relative. One person said, "Yes they do seem to have good training." Another person told us, "The carers are well trained." A third person said, "Now and again you get a bit of a novice member of staff but one of them always seems to know what they're doing."

The training was still provided by the owner of the service, but two of the other senior members of the team had also completed 'train the trainer' courses and were able to support the owner with the provision of training. All of the staff we spoke with were positive about the level and standard of training they received. One member of staff said, "I've had safeguarding and infection control training and a few others, but it's also the kind of job where you learn as you go. The training I've had has been good though." Another member of staff told us, "I had all my training and recently I've done infection control and safeguarding, food safety and I've got one coming up on confidentiality. The [provider] gives the training which makes it much easier. [They] can show us practically what we need to do." A third member of staff confirmed, "I've done my infection control and moving and handling. The providers are hands-on and that means we can be shown what they're doing. They'll come round and check individually what we've learned and whether we've understood."

The staff completed courses the provider considered essential such as moving and handling, safeguarding, food hygiene and medicines management. Staff were also provided opportunities to complete training in more specialised areas such as dignity, tissue viability and duty of care. The provider had introduced the care certificate as part of the induction process for staff. The monitoring of the training needs of staff had improved, and we were shown a matrix that detailed when all staff had last completed training and were due to attend further courses. When we spoke with the registered manager and the provider we were told that the service planned to make use of more external resources for training going forward.

During our previous comprehensive inspection we also found that staff were not always being provided with regular supervision or appraisal of their performance. During this inspection we found that the frequency of supervision had improved significantly and that in all of the eight staff files we looked at the staff were being supervised at least three times a year. The staff we spoke with confirmed they were receiving regular supervisions. One member of staff said, "We have them every six to eight weeks now, as well as the spot checks." This was further supported by shadowing supervisions, where senior members of the team would observe practice and provide feedback. Annual appraisals were taking place to give staff feedback on their performance over the course of the previous year.

During our last comprehensive inspection we identified that the service were not always able to evidence consent or how people provided consent to have care and support provided by the service. During this

inspection we noted that care plans now contained substantially more information in relation to how people provided consent, and the majority had been signed to demonstrate that the person was aware of their care plan and happy for staff to deliver care in plan with what was written. Consent had also been sought in specific areas such as the administration of medicines.

There had also been improvements made to develop the understanding of staff in relation to the Mental Capacity Act (2005). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. People's care plans now included more information in relation to their communication and level of understanding including dementia assessments if the person was living with this condition. Staff had completed training to understand the MCA and were able to describe how they understood people's level of capacity.

Information relating to people's healthcare conditions was now more detailed and we saw evidence of the service improving the quality of care and support they were providing in relation to these. For example we saw in two care plans that the service were working closely with the local physiotherapy and occupational therapy teams to highlight the progress of people who were working towards becoming more mobile or needed additional equipment or guidance.

People who needed support with eating, drinking and preparing meals told us that their care staff were able to deliver this effectively. One person said, "I have to say that even the new staff are very good at making sure I am offered a drink when they are with me and I never really get thirsty at all." Another person told us, "I will occasionally just ask the staff to make me a quick sandwich for the afternoon or cut me a slice of cake which they will usually do if they have time just before they leave."

Requires Improvement

Is the service caring?

Our findings

During our last comprehensive inspection we identified issues with the quality and consistency of care being provided. During this inspection we found that there was still improvement required and that some people were unhappy with the way in which they were being provided care.

During the inspection we spoke with eight people who used the service and 10 of their relatives. While some were positive about the care staff and the regular carers that visited them, we were frequently told that there were too many changes to staff, inconsistency of visit times, issues with language and communication and some people did not feel treated with dignity or respect. This was further compounded by people not always feeling that they had their views heard or listened to.

When we asked whether staff were caring, one person said, "In my experience, the care staff come in to do the jobs they need to do as quickly as possible, scribble a few lines in the notes and then disappear. Some days it is difficult even just to raise a conversation with them." Another person told us, "My regular care staff are lovely but even they sometimes really don't have time to do anything but just the essentials before they rush off to the next client. I do just feel like I'm a number to them rather than a person." However others were more positive about the staff who visited them and told us, "They are wonderful staff. Really lovely." A relative said, "It's been really good since [provider] started, their staff really do seem to care."

People explained the impact of the frequent changes in staff. One person said, "I would dearly love to know who is going to be coming to me. I don't receive any rota for the week and even the member of staff who comes first thing in the morning won't necessarily know who I am likely to see for the rest of the day. It can be very frustrating." Another person said, "It is alright when I see my regular care staff because they will tell me when they will be coming next. Particularly at weekends it can be anybody, sometimes even someone that I haven't met before, although they will usually come with somebody who at least I do know." A third person told us, "I think they only really get to know my needs if they have the opportunity to look after me regularly. It is really difficult, and tiring for me, to explain over and over again what I need help with." A relative said, "They're always changing and you never really know who you're going to get."

Prior to the inspection we had received concerns that staff were not always a good command of English. We noted in the team meeting minutes in September 2016 that the issue of staff talking in their own language to each another had been raised, and that this was an on-going concern. When we asked people about how the care staff communicated with them we received mixed responses. One person said, "They are most happy when they are talking to themselves in their own language, but I haven't got a clue what they're talking about and to be honest they could be talking about me for all I know. It's not a very nice feeling to have." Another person told us, "Most of the care staff are fine, but there are just a few of them who have very strong accents and I do struggle sometimes to understand what it is they are saying to me. If I ask them to repeat themselves too many times, they can get a little frustrated with me, so I will usually then just give up."

We asked the staff we spoke with whether they were able to communicate effectively across the team. One

member of staff said, "There are communication issues, sometimes no communication at all. Some of the staff can't read or write English. People seem to work in different ways. The experienced staff are great and you learn a lot from them but some of them really don't seem to understand very much." However the majority of the staff team felt that they were able to communicate effectively. When we looked through the written records held by the service such as people's care notes, we did find that the quality of English varied and that some records were almost illegible. However when we spoke with the staff we found that those we spoke with were able to speak adequate English and were able to understand and answer our questions. Staff were asked to complete an assessment of their English language ability as part of their recruitment.

When we asked people whether they were able to make choices in relation to their care and support we were told that they did not always feel supported with this. One person said, "I think the only choice I was asked to make was whether I preferred male or female staff. Other than that everything else has been decided by the agency." Another person told us, "I don't remember making any choices about anything to do with the care that the agency has been providing to me over the last year or so."

Some of the people we spoke with felt they were treated with dignity and respect. One person said, "They are nice people. Very respectful." A relative told us, "They're good staff, the regular staff will always treat [relative] like a friend almost." However some people did always not feel treated with dignity and respect. One person said, "My staff will keep telling me that they want to wash my hair. They get really annoyed when I say that I'm not ready for it to be washed and that I'll tell them when I am. Then what usually happens, is on the day when I do need it washing, they will tell me that they haven't got enough time. It is so frustrating, I get the feeling they just do it deliberately because they want to do things when they want to do them rather than when it's right for me."

Another person told us, "They have a habit of trying to confuse me and make it sound as if I'm in the wrong. The staff asked me the other day to get a spray aerosol because after I went to the toilet it was rather smelly, they said. I don't like aerosols myself, but I got [my relative] to get me one and then the next day they asked me why I had got it and where it had come from as it was pointless because it doesn't really do anything. I just don't understand these staff." A third person said, Another person said, "My care staff tell me that I'm wrong to ask them to turn me in a specific way because it's their way or no way. Then it makes me feel as if I'm not valued at all. Sometimes if the two care staff have had a bad day I can hardly get a word out of them when they come to put me to bed. It's almost like they are giving me the silent treatment and it's not very nice."

When we spoke with the staff team about the ways in which they treated people with dignity and respect they were able to tell us about ways in which they observed this when providing care. One member of staff said, "We'll close doors, cover them during personal care and tell them what we're doing." People's care plans included outcomes in relation to dignity and respect. When we raised the issue with the provider they bought to our attention their last quality survey in which 96% of respondents had replied positively to the question "do carers treat you with dignity and respect?" However, they acknowledged the concerns we raised and told us they would ensure that this reiterated to the staff team in supervisions and meetings.

During the inspection we saw some positive examples of where staff had demonstrated a caring and thoughtful approach. For example one person had been admitted to hospital and a member of the care staff had agreed to feed their dog for two weeks in their absence. The service had received a number of compliments which included comments such as "It was because of your care and support that [relative] was able to stay at home and this was a comfort to us all." "Your staff were friendly, kind, considerate but most of all caring."

Inadequate

Is the service responsive?

Our findings

The provider's response to complaints came up often in our conversations with people and we found that this was still an area in which the management of people's concerns and grievances was inefficient. One person said, "If I had any confidence in the abilities of a manager, then perhaps I would contact one of them about a problem. However the difficulty is that in the past I have always been left thinking it was me in the wrong when I have raised issues to which they have no positive responses." Another person said, "I have raised numerous concerns about the fact that care staff come at any time that seems to suit them, I don't know how long they're supposed to stay with me for, and I would like some regular care staff who I could see most of the time. Unfortunately having raised these issues with the office and the managers, nothing has changed and I still don't know how long care staff are supposed to be here with me for." A relative said, "The response to my complaints has been insulting and downright false, they've tried to imply that my [relative] did something they didn't and didn't actually carry out any kind of proper investigation."

On two occasions since our last comprehensive inspection in November 2015 we were contacted by relatives who had complained to the agency but had not received a response. One relative did not receive a response to a complaint made on the 21 June 2016 until the 3 August 2016. Another relative had raised a complaint on the 5 September 2016 and had not received a response until 14 October 2016 following a direct request from CQC. Another relative contacted us in August 2016 to say they had complained to management about poor care for their relative and were told the provider was "not interested." The uncaring and disinterested attitude of management to people's concerns was relayed to us consistently by people during our conversations. One of the relatives we spoke with told us that after raising several issues with management they had eventually agreed to a meeting to discuss their concerns, which the manager in question then failed to attend without notice.

When we looked through the complaints received by the service we found further shortcomings in the way that complaints were being investigated. For example a relative had complained when their family member was not prompted to take their medicine during a care visit. The person's care notes care notes clearly stated that the member of staff could not find the medicine and therefore it was not administered. The person's initial assessment and their care plan clearly stipulated that the person was to be prompted to take their medicines, and therefore it was the responsibility of the care staff to account for this. However the response to the complaint implied that the care staff was not at fault due to the person having previously refused their medicines and made reference to other behavioural issues. These bore no relation to the fact that the member of staff had not followed the care plan correctly or called for advice on the matter. This meant that the response had not addressed the concern with the member of staff in question. While there was evidence of the provider investigating complaints and taking appropriate action in some cases, the amount of people who expressed concern in this area meant that there had not been sustained improvements made since our last inspection.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Receiving and Acting on Complaints.

During our previous comprehensive inspection in November 2015 we identified issues with care plans not containing adequate or up to date information and not being sufficiently person-centred. We also found that complaints were not always being managed appropriately.

During this inspection we found that while there had been significant improvements to the quality of care plans there were still some improvements needed to make sure that they were available to staff providing support to people in their own homes. Some people did not know they had a care plan in place and there was limited evidence of their involvement. One person said, "I wasn't involved in my care plan." Another person said, "I know I came home from hospital and a couple of days later someone came round from the agency to talk about what help I needed. I know there's a care plan in the folder, but I don't think I've ever looked at it." A third person told us, "I know there's a plan of my care in the folder where the care staff fill in the records, but I don't think I've looked at it before."

Because the service often began providing care using initial assessments from the hospital or social services, there were sometimes delays in providing staff with a plan to work to. Three of the care plans we requested to see during the inspection were not made available to us because the person had not received care for long enough to have had a care plan created by the service or held in the office. We asked the staff we spoke with how they knew what kind of care they were providing to people before their visit. One member of staff said, "We'll get a message via [messaging system] which explains what we're going in to do." Most of the staff we spoke with said this was initially how they were provided with information, however they said a care plan was usually available within a day or two for them to work to.

The provider told us they would always strive to complete the assessment and have a care plan available on the first day they began providing support. To address this going forward they were making use of a new electronic system for care planning and investing in remote printing equipment. This meant that when assessors visited the service they could immediately detail somebody's needs in a care plan and print this off so that it was available during subsequent visits.

When an assessor or a senior member of the care staff were able to carry out an assessment and create a care plan, we found these held good information regarding people's needs. One member of staff tasked with creating care plans told us, "We assess all their needs, often around moving and handling first because that's what they usually need most support with. But we also ask them what they want out of the service and how we can help." The service had introduced a new format for care planning which included more information about the person's stated aims and objectives and their needs in areas such as personal care, communication and healthcare.

The service were now keeping improved records relating to changes in people's condition, and were reviewing care plans more frequently. For example we noted that one person had previously required PEG (percutaneous endoscopic gastronomy) feeding but no longer needed support with this, and their care plan had been updated accordingly. PEG feeding is a way to provide people with food directly into their stomach when they are unable to take food by mouth. However one relative did express some concerns with us about their family member's care plan not being updated when their needs changed, and care staff continuing to provide unsuitable care as a result. They said, "It was a few weeks until I saw an updated care plan for [relative]. They came out and did an assessment but [relative]'s needs changed quite dramatically and they became more mobile. It took a while for the plan to actually reflect that, and so the care staff were still using a hoist to move my [relative] even though it was no longer required and [they] were mobile."

While we saw evidence of people's changing needs being recorded at the office, changes were sometimes communicated informally rather than being immediately updated and made available as a care plan to staff

working in the community. A member of staff confirmed, "If there's anything we need to know before we go and visit someone they'll let us know on the [messaging application] group."

Requires Improvement

Is the service well-led?

Our findings

During our last comprehensive inspection in November 2015 we found that people did always feel listened to by the management of the service. There were insufficient systems in place for quality assurance and monitoring the delivery of care.

People using the service and their relatives still gave mixed responses when we asked about the quality of management and whether they felt listened to. One person said, "Even just trying to get hold of the manager on the telephone is extremely difficult and I haven't got much further than that." Another person told us, "I can't say as I have ever thought about asking to see a manager. I've been with the agency for nearly 12 months now, but I certainly haven't seen anyone who said they were a manager." A third person said, "I couldn't even tell you the manager's name, or what they look like and I certainly don't recall seeing anybody who has introduced themselves as a manager." A relative said, "Up until now I've called two or three times to try and speak to the manager but they don't always get back to me." One person was enthusiastic about the managers of the service however and told us, "When we've had a problem we've spoken to the owners and they've resolved it."

We were consistently told of the difficulties speaking to a manager or receiving a response from the office staff. One person said, "I don't think there's really anybody I can talk to if I have any difficulties because I'm fed up trying to talk to somebody in the office when nobody knows me and nobody can even be bothered to call back." Another person said, "If they promise to call you back they don't always and I usually end up calling them again to find the usual excuse of 'we were just about to phone you back'."

When we spoke with the provider they acknowledged that there had been some difficulty with responding to people during a period over the summer and that this had been picked up by their own internal quality monitoring. They told us a new member of staff was being recruited for the office to attempt to resolve this issue and that they were now more available to speak with people who called and wanted to address issues with management.

The management team consisted of the registered manager and the provider who were both involved in the day-to-day running of the service. A deputy manager had been appointed since our last inspection in additional to three senior care staff. Each of them occasionally provided care to people in addition to their primary roles in the office. The staff we spoke with were all positive about the management of the service. One member of staff said, "The office staff are lovely and they will act on our feedback." All of the staff felt supported and listened to by management and were positive about the culture and values of the provider. One member of staff said, "It's a really good job. I definitely feel supported." Team meetings were held to provide them with the opportunity to contribute to the development of the service, and we looked at the minutes for the two meetings which had taken place since our last inspection. These included discussions around conduct, medicines, care planning and communication.

During this inspection we found that significant improvements had been made to the way that quality monitoring was conducted, and that this had helped to improve the overall standard of governance within

the service. We were shown the auditing tools used to monitor the amount of accidents, medicines errors, safeguarding referrals and compliance with training. Call times were now being more closely monitored alongside written records to analyse whether care was being delivered in line with the electronic call system. The provider was able to tell us about further improvements that would be made including the development of their bespoke computer software used for deployment and care planning. They also were in the process of recruiting a new quality manager who would be tasked with finding ways to improve the service.

The provider had recently sent satisfaction surveys to people using the service which requested their feedback. We saw that feedback was largely positive, with 96% of respondents answering 'satisfied' or 'extremely satisfied' to questions such as "does the care and support we offer help you to have a better quality of life?" Positive comments included "The [staff] are always warm and friendly and do a great job." The provider had produced a report to analyse people's responses.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always safely managed or accounted for correctly.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Necessary action was not always taken in response to failures identified by complaints or investigations. People did not feel they would get a satisfactory outcome from their complaints.