Jacaranda Healthcare 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?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults of any age, particularly people with a physical disability.

Not everyone using Jacaranda Healthcare Limited receives a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care, which is help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a registered manager. This 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.

At the first inspection of this service, in June 2016, the service was rated 'Requires Improvement'. A subsequent shorter inspection in March 2017 established the provider had addressed all concerns arising from the previous inspection, but the rating was not changed because to do so required consistent good practice over time. The service's rating from this current inspection remains 'Requires Improvement', the second time it has received that rating based on a comprehensive inspection.

At this inspection, we found people were not always safely supported with their medicines. There were instances where records demonstrated people had not received their medicines as prescribed. There were also inaccuracies and omissions on records of medicines support.

Recruitment procedures for recently recruited staff were not consistently robust at ensuring all reasonable checks, such as written reference and criminal record checks, were carried out before they worked in people's homes.

We found staff did not always receive appropriate support and training to deliver effective care. This was primarily because new staff were not always fully trained before working with people, although there was better training of established staff. We also identified that staff working with someone who had diabetic needs did not have the skills and experience for this.

The service's governance processes and audits were not consistently effective as they had not identified the concerns and service shortfalls we found. Office records were not always easily accessible and accurate, and oversight summaries such as for missed visits were not always up-to-date.

The service had enough staff to meet people's needs, but feedback indicated visits were not always punctual. However, people's feedback about the service was otherwise mainly positive, especially for staff

who visited them regularly.

The service and care staff treated people with kindness, respect and compassion, and gave emotional support when needed. People's privacy and dignity was respected and promoted.

The service worked in co-operation with other organisations such as healthcare services to deliver effective care and support.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. People's views on the service were regularly sought and acted on.

People's individual needs were met through the way the service was organised and delivered. This was particularly evident for helping some people regain skills and independence.

The service took steps to assess and manage safety risks to people, and to protect people from abuse. It supported people to eat and drink enough and maintain a balanced diet.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

The service promoted a positive and inclusive culture in support of achieving good outcomes for people. Staff reported being well-supported overall.

Some systems at the service enabled sustainability and supported continuous learning and improvement. In particular, the service was in the process of introducing new software systems by which to plan and monitor the timing and quality of care visits better.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe. Records showed people did not always receive their medicines as prescribed, and records of medicines support were not always accurate.

Recruitment procedures were not consistently robust at ensuring all reasonable checks of prospective staff were carried out before they worked in people's homes.

The service had enough staff to support people to stay safe and meet their needs, but feedback indicated visits were not always punctual.

The service's systems, processes and practices helped to safeguard people from abuse.

The service took steps to assess and manage safety risks to people. It protected people by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective as staff did not always receive appropriate support and training to deliver effective care. This was primarily because new staff were not always fully trained before working with people, and due to relevant staff not having training on the diabetic needs of one person.

The service worked in co-operation with other organisations including healthcare services to deliver effective care and support.

The service supported people to eat and drink enough and maintain a balanced diet.

The service was working within the principles of the Mental Capacity Act 2005 in respect of consent to care.

Is the service caring?

Good

The service was caring. It ensured people were treated with kindness, respect and compassion, and given emotional support

when needed.

The service ensured people's privacy and dignity was respected and promoted.

As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support.

Is the service responsive?

Good

The service was responsive. People's individual needs were met through the way the service was organised and delivered. This was particularly evident for helping some people regain skills and independence.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Governance processes and audits were not consistently effective as they had not identified the concerns and service shortfalls that we found. Office records were not always easily accessible and accurate, and oversight summaries such as for missed visits were not always up-to-date.

However, the service promoted a positive and inclusive culture in support of achieving good outcomes for people. People's views on the service were regularly sought and acted on. The service also worked in partnership with other agencies to support care provision and development.

Some systems at the service enabled sustainability and supported continuous learning and improvement. In particular, the service was in the process of introducing new software systems by which to plan and monitor the timing and quality of care visits better.

Jacaranda Healthcare 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 8 and 19 December 2017. The provider was given 48 hours' notice because the service is small and the registered manager can be out of the office supporting staff or providing care. We needed to be sure that they would be available.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also contacted local authorities who have a commissioning role with the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was carried out by two adult social care inspectors and an Expert by Experience, which is a person who has personal experience of using or caring for someone who uses this type of care service. Their involvement was limited to phoning people using the service and their relatives to ask them their views of the service.

There were 41 people using the service at the time of our inspection visit. During the inspection, we spoke with eight people, two relatives, nine care staff, an office staff member, the registered manager and the

company director. We also received feedback from three community health and social care professionals.

We reviewed the care records for four people living at the service to see if they were up-to-date and reflective of the care which people received. We also looked at records for six members of staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including complaint and safeguarding records, to see how the service was run. We also requested further specific information about the management of the service from the registered manager in-between and following our visits.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us of no safety concerns with the service. One person told us of staff supporting them to move safely and patiently, adding, "I am more confident as they are there." Another person said, "They remind me to take medicines as sometimes I forget."

However, we found the service was not consistently ensuring the proper and safe management of people's medicines. The service kept a record listing each person's prescribed medicines, backed by photos of pharmacist labels of people's medicines containers. Staff then signed a separate monthly medicines administration record (MAR) in the person's home to indicate they had supported the person to take medicines at that visit. The MAR did not specify what the medicines were. The process relied on there being a clear separate record of what medicines staff were signing for. We found this was not the case, as there was no direct link between the MAR and the medicines list.

The above process was further complicated for one person who had recently returned from hospital with changed medicines. A copy of the hospital discharge notes stated the medicines now prescribed. The service's medicines list stated to refer to the pharmacy label, but a copy of this listed only two of the five daily medicines on the discharge note. The management team checked this with the person's family following our first visit, which established one medicine that was not being given. Records did not therefore accurately state what medicines staff had supported the person to take. The management team subsequently informed us, "We have now regularised the medication and learned lessons from this discharge."

We found other evidence of insufficiently robust systems for documenting any changed medicines. The care visit records for the above person in November 2017 showed staff sometimes supported them to take an antibiotic. But this support was not documented at each visit. A stand-alone record was also kept of supporting the person to take the antibiotic, but it had not been used at each visit. It showed the person was supported to take the antibiotics across nine days; however, the supply was for seven days. This indicated the person was not always supported to take the medicine as prescribed.

We were shown a medicines chart used to support someone with eye drops. However, although these were for twice-daily application across a 16 day period, there were five omissions for the eye drops. There were four omissions for nightly eye ointment records in the same period. Care delivery records showed evidence of the support being provided where omissions on the chart had occurred. Therefore, the medicines chart records were not consistently accurate. The management team told us they had spoken with relevant staff about this.

People's care plans contained a record of what medicines they were taking and reasons why. However, this was often out of date compared to medicines lists and photos of blister packs. In one person's case, the care plan clarified where medicines needed to be taken before, during or after food. However, where this person was to take a once-weekly medicine at the start of their morning care visit, three recent records stated they had medicines after breakfast. It was therefore unclear whether or not they had received the specific

medicine as prescribed.

Staff told us of receiving medicines training before working in people's homes. However, only ten of the 26 staff listed on the staff training matrix were recorded as having had a medicine competency assessment. Where five staff were recorded as supporting one person with medicines in November 2017, only one of them had a documented competency assessment on the training matrix. The failure to check the competency of staff supporting people with medicines was contrary to the provider's medicines policy, and so did not help to ensure care was provided to people in a safe way.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was finalising new and computerised care planning and record-keeping systems in people's homes. We recognised this would improve records of what medicines support each person received, and allow for better and quicker checks that people received their medicines as prescribed.

We found staff recruitment procedures were not consistently robust at ensuring all reasonable checks of prospective staff were carried out before they worked in people's homes. The management team told us of interviewing prospective staff over the phone, to screen unsuitable candidates, before inviting them into the office to complete application forms. They informed us checks of criminal record (DBS) disclosures, two written references and employment gaps would be in place before staff then shadowed experienced staff and were then trained. They explained shadowing was important so that prospective staff could see the reality of what the job entailed.

However, whilst we found good documented exploration of employment gaps and reasons for leaving previous jobs amongst the staff files we checked, there were instances when references and DBS checks were acquired after staff started shadowing experienced staff in people's homes. The service had not therefore taken all reasonable steps to ensure these new staff were safe to be in people's homes.

One staff member shadowed in people's homes on 9 September 2017. Records showed they were working soon after. However, a DBS disclosure for them was not obtained until signed as seen by office staff on 23 October 2017. This was 44 days after they first went into someone's home.

The DBS disclosure for a new staff member was dated April 2015, and so was not sufficiently up-to-date. Guidance states a maximum DBS portability of three months from point of application. Additionally, there was information on that DBS disclosure that the service had risk assessed before making the decision to employ the person. Whilst the risk assessment process was appropriate, the risk of new information being on an up-to-date DBS disclosure had not been mitigated. Following our visits, the management team told us this staff member was no longer working in people's homes pending an up-to-date DBS being acquired.

The management team informed us of one staff member recently restarting employment. Their file showed an application form from 2015 and records from that year, then nothing until November 2017. There was therefore nothing to show what employment they had from 2015 until the present. Their application form declared they were working for two care providers in 2015. However, whilst there was a written reference for one of those employers, there was nothing to show the other employer had been contacted for a reference. Records did not show reasonable steps had been taken to acquire satisfactory evidence of conduct with previous care employers, or to acquire an up-to-date employment history for the person.

The above evidence demonstrates a breach of Regulation 19 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

The service had enough staff to support people to stay safe and meet their needs, but feedback indicated visits were not always punctual. Two people were quite happy, for example, "Yes, they are punctual." Two people were very unhappy, for example, "Timekeeping is atrocious. Call should be at 8am. It's always later." They added, "They do help me in the shower, but if they are very late I manage on my own." Four other people sometimes experienced visits that were around 30 minutes too early or late. One such person told us, "I phone up when someone does not turn up at the weekend. I always get someone. It's very annoying when they come late as it messes up my day."

Two relatives fed back about visits at the weekends being an hour late. One told us of staff turning up for the morning visit an hour late on the "last four Sundays. No-one phones from the office to say they are running late. I don't bother ringing any more on a Sunday as I know they will always be late."

In contrast, staff reported no concerns with getting to people's homes on time. As one staff member put it, "I've never been late. They give us travel time." Another staff member said, "Once I was running late and I called the office and they paid for a taxi for me to get to the client."

During our first visit, the management team showed us all planned visits were covered for the next four days. The service used a weekly template for rostering visits to each person, so that they automatically received the same staff each week unless changes had to be made. The co-ordinator told us of allocating staff within small geographical areas, to minimise travel time, and of informing them which bus to take if needed. This all helped to ensure people received a consistent, punctual and reliable service.

The management team sent us, on request, electronic visit data for the two weeks just before the inspection started. As it was a new system which the management team stressed was still on trial and had not yet gone live, we mainly looked at those records where staff had successfully signed in and out. This demonstrated that where anyone required two staff to attend at the same time, both staff usually attended together. Commonly, they then travelled together to the next person needing two staff to attend. This helped to meet the needs of people requiring two staff to attend. One person told us, "They come together as I need to use the hoist."

The service assessed and managed risks to people, to balance their safety with their freedom. There were risk assessments in place for people covering such things as the environment, the person's health, their mobility, nutrition, medicines and property access. These specified the severity of each risk and any actions proposed to reduce the risk. There were separate risk assessments in more detail for such things as moving and handling where the risk was significant. We saw records reminding staff not to wheel people any distance in a hoist, as that is an unsafe practice. An email from a community professional praised the safe approach of two current staff in supporting the moving and handling of one person.

One person's swallowing abilities had recently deteriorated. Their care plan had been updated to reflect health professional guidance on how to support them with eating, for example, to make sure they sat upright and on how to thicken drinks for them. A staff member working with them demonstrated good awareness to us of the choking risks and how they were to safely support the person as per the care plan. The management team told us they visited the person two days after they came out of hospital to review their care needs, and hence the risk assessment was being updated. They also showed us a referral to the funding authority written a week after the person came out of hospital, requesting additional time as the person was now slower and at greater risk.

The service protected people by the prevention and control of infection. People's care plans provided specific guidance on this, such as for staff to use personal protective equipment like gloves and aprons, using different cloths for supporting people to wash different areas of the body, and on how to dispose of waste items properly. The management team could give us examples of who had specific hygiene requests. Staff told us of infection control training, and no-one told us of any infection control concerns.

The service's systems, processes and practices helped to safeguard people from abuse. Office and care staff knew what could constitute abuse, and how they should report this. One staff member told us, "We might have clients who are financially or physically abused. I'd report this to the manager." The management team openly told us of recent safeguarding cases their service had been involved in. Records showed the service's co-operation with investigation processes, and did not indicate shortfalls in how the service had operated.

Where staff supported people with collecting money from the bank or for shopping, we saw financial transaction sheets were used to document what had been spent and what money was returned to the person. Where capable, people using the service signed these sheets. There were also copies of the receipts for what was spent.

The provider notified us of a safeguarding alert they had raised with a local authority because one person's access to money and food was causing care staff concern. The management team told us of writing to the social worker following the safeguarding meeting, to confirm what had been agreed. They showed us additional records they had now set up to provide an audit trail of what their service was doing to assist the person. Their approach demonstrated robust efforts to support the person's welfare.

The service provided examples of learning lessons and making improvements when things went wrong. The management team stressed that one of the reasons for the incoming system of electronically monitoring times of arrival and departure at people's homes was to check how punctual visits were. It would also help to monitor how much time people needed in comparison to what was scheduled. Similarly, the online care recording system would help to promptly check on people getting the right care. Both systems would flag for when expected care had not occurred. They would be monitoring the new systems closely when fully functional.

Earlier this year, there was a safeguarding case where someone's security had been put at risk by a number of organisations including this service. Records and feedback from the management team showed good co-operation in the investigation, and that lessons had been learnt. The service had addressed their role in the risk for the person. We saw access arrangements were prominent within everyone's care plan and risk assessments. Additionally, the management team showed us the key-safe staff used during training, to help ensure they knew how to use that piece of equipment safely. One person said, "I have a key-safe, they know the code. They always put them back properly." Another person also told us the service helped them set up more secure access arrangements.

Requires Improvement

Is the service effective?

Our findings

People's views on the effectiveness of the service were mainly positive. Most people said they would recommend the service. One person said, "I was with a different agency before and they were terrible. With Jacaranda I have had a very good experience. If things have gone wrong they have sorted them out really quickly." A community professional told us of involvement with one person using the service who informed them of getting an effective overall service.

However, we also received feedback about service weaknesses which included the ability of some staff to understand what was requested of them. One person said that staff "have difficulty understanding sometimes." Another said, "Some of them don't know what I mean." We noted office meetings identified the need to ensure new recruits had sufficient English language skills. However, of the five files of staff starting work in 2017 we checked, only one had records of testing the applicant's literacy and numeracy. The registered manager told us every applicant should have that tested.

The management team told us of aiming to assign staff with weaker language skills to visits that needed two staff, so that the other staff member present could communicate well with the person. They also told us of supporting some staff to undertake English classes with a local training provider. This helped to show the service was trying to address the communication weaknesses that some staff had.

The service's office had training equipment such as a bed, mobile hoist, medicines packs and continence products. The management team told us of also hiring a charity's facilities to provide other equipment training such as for using sliding sheets and bed-rails. Facilities to support staff training was therefore in place. However, the service was not consistently ensuring new staff had the competence and skills to provide safe care to people.

One staff member was employed from 11 September 2017. Their application form showed no formal care experience. There was a record of them shadowing experienced staff in people's homes, but there was no other induction record on their file. A certificate showed they received one day of classroom-based induction training on 3 November 2017. This included written tests to demonstrate knowledge. As the staff member had no previous care employment, it was not safe for the service to send them to provide care to people before formal training had been provided. The management team told us the staff member received informal induction training before providing care in people's homes, but agreed that documentation of what had been covered was needed.

In comparison, records showed a staff member employed in January 2017 received a four-day induction process before providing care in people's homes. At that time, the service was employing a trainer. The management team agreed to consider hiring another person for that role.

We noted the provider's training policy included for staff new to the care role to complete a 12-week induction training process in line with a national training organisation's standards. However, records showed this was not occurring in practice for new staff. Only three established staff were listed as having

completed that training on the service's staff training matrix, of the 26 listed.

The care plan and risk assessment for one person showed staff were to support them with their diabetic needs. However, when we spoke with one staff member who worked with this person, they were not aware of the person's diabetes. The management team confirmed they had not yet provided specific training on diabetes to staff working with this person. The failure to provide specific training presented potential safety risks for the care of this person.

We concluded that the service was not consistently making sure staff received appropriate support and training to deliver effective care and support. The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted staff praised the training they received and felt it covered their care roles. The service's training matrix showed established staff were provided with refresher training annually, covering such things as safeguarding, health and safety, and medication.

Staff records showed they received developmental supervision meetings approximately every three months. The records indicted good consideration of how they were progressing with the work, and what training needs they had. Records and feedback also showed established staff received annual appraisals. This helped demonstrate ways in which the service supported staff to provide effective care.

The service worked in co-operation with other organisations to deliver effective care and support. Community professionals informed us the service worked well with them. The management team told us they liaised with community health and social care professionals whenever people needed this, such as for trying to source more funding for care visits when staff told them there was not enough time. We saw records to that effect, some of which were successful. There was liaison for health professional support, such as to ask district nurses to visit. The management team told us of meeting one person and their social worker to help get the GP to change the prescribed build-up drink as the person did not like the flavour.

The service supported people to access healthcare services and receive ongoing healthcare support. People's care plans identified their health needs and where appropriate, how staff were to provide care and support. For example, attention was paid to people's skin care needs and what creams to apply.

The service supported people to eat and drink enough and maintain a balanced diet. One person told us of teaching their regular staff member how they wanted their meals cooked to reflect their cultural preferences. Another told us of staff offering choices of microwavable meals. Care plans were specific about what people's needs and preferences for food and drink were. Many emphasised that people did not want the same breakfasts each day. The management team told us of staff supporting one person to eat more by recognising that they were put off by plates with too much food on. They also told us one person may state they did not want breakfast but staff knew that they would eat if gently encouraged with the right food.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We found the service was working within the principles of the MCA. Records showed staff had been trained

on principles of the MCA relevant to their roles. The management team showed knowledge of how the MCA impacted on their work. They understood people using the service were entitled to make 'unwise' decisions if they had capacity in respect of the decision, although they said they also raised concerns with social workers if they considered those decisions put people at significant risk. Care files showed people had signed consent for their care where able and capable of doing so. There were records of whether anyone had formal arrangements in place under the MCA such as power of attorneys.

Good

Is the service caring?

Our findings

Most people told us staff were caring. One person said, "They come in every day and ask how I am and are sympathetic. They understand every day can be different." Another person told us, "They do care and are very kind and they ask if you need anything else." However, three people had some reservations, citing the approach of replacement and weekend staff. One person said, "It depends which girl comes. One always looks at her watch." However, they added that their favourite staff member "would put my rollers in for me."

We found the service was taking appropriate steps to ensure people were treated with kindness, respect and compassion, and given emotional support when needed. The management team told us the service and individual staff bought people small amounts of food and drink from their own money when they found this lacking in people's homes. We were shown photos of how the service had made a cake and celebrated someone's birthday. The management team told us it was important for that person as "they had no-one." There were similar photos for a number of other people. We also saw an email from a community professional praising the professional and dignified approach of two current care staff in working with someone using the service.

There were records praising the service from relatives of people who used to use the service. For example, one relative had written that the two regular staff members were, "absolute diamonds." Another said the service "always put Dad first." A third said their family member "never had a bed sore – amazing!"

The service ensured people's privacy and dignity was respected and promoted. All care staff we spoke with told us of training on this before they started working in people's homes. Their comments on how to treat people respectfully included checking how they wished to be addressed when first visiting them, and, "I ask them how they are doing before I start the care." Care plans reminded staff of ways to help uphold people's dignity during personal care. People's preferences for staff gender were checked on.

We noted people's care plans included individual information on how to approach and greet people on arrival at their homes. This was important for some people as hearing and visual needs meant staff were accessing some people's homes through key-safes. The person may not be aware of staff being present until in the same room as them, which could frighten them, so staff were encouraged to call out on entering the person's home, and be conscious of how they approached people.

The management team spoke respectfully of people using the service and their advocates. They showed understanding of people's views even when these were critical of their service. They told us of supporting people to take pride in their appearance. For example, they had helped one person to shave their beard off after one had grown during a hospital stay. They had helped another person to pay attention to their hair and get it cut, after it had not been attended to.

The service checked on people's nationality, culture and religion during needs assessments meetings, and whether this impacted on the care they needed. For example, the management team told us of paying

attention to how people required their food to be cooked. Some care staff told us of supporting people with religious customs, such as, "I had a client who uses a bowl for prayers. I would assist him by passing the bowl to him when he needed it."

As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support. One staff member told us, "We ask the clients what they would like us to do for them and we do it." Another staff member said of the management team, "They call the clients to find out how they are doing." The management team knew people as individuals. They therefore knew who could easily express their views, and who needed the support of friends, relatives, advocates or attorneys. People's care plans showed they signed their involvement in agreeing with them where possible.

The management team told us of listening to one person's views when taking over from another care provider. The person wanted earlier visits and to be supported out of bed more. This had been accommodated, to the extent that the management team knew which colour sling loops the person used as they could direct the care staff on this themselves.

Good

Is the service responsive?

Our findings

People's individual needs were met through the way the service was organised and delivered. The management team told us of working with community healthcare professionals such as physiotherapists and occupational therapists to support one person to regain mobility skills. As a result, the person no longer needing to be hoisted, and so the care package was cut from two to one staff visiting four times a day. We saw records to confirm this. Staff also supported the person to take pride in their appearance such as attending to their hair and getting it cut. The person was now visiting a day centre and going out with a neighbour, when previously they would not leave their house. A staff member corroborated this information, telling us the social worker had praised the service's work. The service had been a key support in significantly improving the person's quality of life across the previous two years.

In another person's case, the management team told us the person had been safely supported to walk short distances again. This had enabled the person to use a toilet in a different part of their house rather than relying on a commode in their bedroom. The management team put this down to staff encouraging the person, and attending to pain in their feet through daily soaking and creaming plus acquiring chiropody support. Staff had also understood the person's aggressive behaviour at the start of the care package, which had enabled the person to develop trust and cease behaving that way.

The management team told us of liaising with an occupational therapist to get better equipment for one person, as the person was frightened of being transferred out of their bed. The person was now using a commode rather than continence products, which reduced risks of infections and skin conditions. The management team showed us feedback from an occupational therapist in respect of supporting another person to gain better equipment to assist with their mobility.

There were individualised care plans in place for each person that reflected their needs and preferences. The plans clarified what support staff were to provide at each visit. They included some information on people's life histories and what was important to them, which could be relevant to the care being provided and getting to know the person well. Care plans informed staff of where pertinent items such as medicines would be found.

The provider's new software system that was being introduced at the time of the inspection showed staff were now prompted to complete records of each care task agreed for each visit. For example, for skin care, continence support, position transfers, medicines support, and what the person had to eat and drink. Care plans were in the process of being updated into this system.

The service provided some support of the communication needs of people with a disability or sensory impairment. The management team knew people's different communication abilities. Where someone wore a hearing aid, this was prominent in their care plan. Another person's care records included references to hearing aid support.

The service listened and responded to people's concerns and complaints, and used this to improve the

quality of care. Four people told us they had not needed to raise any concerns or complaints. The other four said they had, and that action was taken to address matters such as through changing care staff in response to staff approach and language abilities.

The service's complaints procedure was advertised to people in the service guide provided to them. It sought to make it easy for people to raise concerns or complaints, and for the service to investigate and learn from any matters raised.

There were six complaints recorded in the service's complaints folder for the first half of the year, but none since. These arose from a local authority on behalf of people, or as a consequence of the local authority's quality checks at people's homes. A community healthcare professional confirmed there had been a decrease in complaints in recent months.

Complaint records showed the service sent prompt acknowledgement letters to complainants. Investigation records were kept, which informed complaint responses. These acknowledged where service shortfalls occurred. The management team told us of actions taken in such circumstances, to minimise the risk of reoccurrence. This included improved staff rostering systems and using the outcomes to inform staff disciplinary processes.

The service responded when people raised concerns in other ways. Records showed one person did not rate the service highly on a feedback form earlier in the year. There were subsequent records of the management team checking what else they could do for the person. Two things were agreed on, one of which was for later evening visits. We checked recent care records and found the person was now receiving those visits at a time that suited them better.

Requires Improvement

Is the service well-led?

Our findings

Whilst we found there to be some qualities of a well-led service, our overall inspection findings including the regulatory breaches demonstrated the service was not always well-led. Quality and risk audits were not consistently effective as they had not identified the concerns and service shortfalls that we found.

Office records were not always easily accessible and accurate. Some people's care files, although well-organised, did not always have up-to-date versions of documents such as risk assessments. Complaint and safeguarding files were missing some relevant documents and their oversight summaries were not up-to-date. The management team told us office meetings were regularly held, however, they could not supply minutes of any since August 2017 as records had not been kept. Similarly, no care staff meeting records existed, meaning they could not be circulated for the awareness of those staff who had not attended. The management team told us people's care visit records were checked when returned to the office, but no records of doing this were made, just actions taken if needed. This demonstrated weaknesses in keeping records properly organised and with having a clear oversight of trends around potential service shortfalls such as can arise from complaints and safeguarding cases.

We established there were occasional cases of missed visits that were not on the service's missed visit record. Care visit records for a person needing two staff showed only one staff attended a visit in September 2017. The management team told us a second staff member was allocated but attended too late. In November 2017, the records for another person indicated they had three visits a day; however, the morning visit was missing on one day. The management team told us the person's son phoned to raise a concern about this, and they found the allocated staff member had forgotten to attend. However, neither of these instances were documented on the missed visit record provided to us. The record was not therefore accurate, which undermined the effectiveness of the service's governance systems.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team sent us a list of care staff on request as part of the inspection. However, care scheduling records identified two other staff who were working at the time the list was sent, meaning the list was not accurate and complete. The personnel file for one of those staff was not available in the office when requested on our second day of visiting, and a disclosure and barring scheme (DBS) disclosure for them could not be shown to us that day. The management team told us that, as the staff member had worked in the past but recently returned to re-start work, their file had been archived. The other staff member's file identified recruitment shortfalls.

Some aspects of the provider's governance framework were being followed to help ensure quality performance, risks and regulatory requirements were understood and managed. The management team told us of undertaking spot-checks of each staff member at least six-monthly. These are unannounced visits to people's homes to check the staff arrive on time and do the job well. Records in staff files showed that these occurred, more frequently if needed, and care staff also confirmed they took place.

People's care files included some positive feedback forms on specific staff members who worked regularly with them. Most people told us of receiving occasional phone calls or visits to check on service quality, for which we saw corresponding records. Comments included, "They asked if you are happy, is there anything different they can do for you?"

The provider engaged with and involved stakeholders in the development of the service. The management team told us everyone using the service was sent a survey during the summer. A detailed analysis of results was shared with us. It showed service strengths such as polite and courteous care and office staff, and that people felt safe with the service. Weakest areas included new staff not knowing people's routines, punctuality, and keeping people informed if staff were going to be late. The management team told us of taking actions to address the weaker areas, and discussing with individuals whose feedback was less positive. We noted one such person provided much more positive feedback to us, which indicated their service had developed as a result of their initial feedback.

The service promoted a positive and inclusive culture in support of achieving good outcomes for people. Office staff told us of good communication and improving systems for care visit rostering. Care staff spoke of good support from the office and managers. Their comments included, "The agency is always in touch and gives us jobs close to home", "They always answer your call and listen to us" and "They are a lovely supportive agency." Some staff had minor suggestions for improvements but there were no common themes.

Some systems at the service enabled sustainability and supported continuous learning and improvement. The service was in the process of introducing new software systems by which to plan and monitor the timing and quality of visits better. The registered manager explained staff now had to use their phones to scan a code in the person's home on arriving and leaving. This allowed live alerts to be made to the management team if staff had not arrived, which were followed up. Staff were also starting to use their phones to record completion of each necessary task specific to that person and that visit. The management team said this would enable live checks to be made that everything had taken place as planned. It also made care records more legible and easier to audit. Arrangements were being made to enable people using the service and their relatives to access the care records of the person if they wished. We noted the provider was registered on the national Data Protection Register, for the handling and regulation of people's personal data.

The management team told us they had held numerous training sessions to help staff to understand how to use the new technology systems in people's homes. For example, the system allowed care records to be made by staff speaking into their phone, which saved time. The management team informed us the new care recording system was currently in transition; we saw records to that effect. They planned to have the systems fully integrated and operational by the New Year.

The service's registered manager had been in that role since the service started three years ago. They told us of ongoing training for level 5 in care management. The director was also highly involved, and told us of taking a level 3 qualification for greater knowledge of care. They both told us they personally provided care visit cover if needed, and they visited people to understand where staff said more support was needed. They knew the individual needs of people using the service.

The service worked in partnership with other agencies to support care provision and development. The management team told us of attending a local authority's monthly workshops for homecare providers. They told us what they learnt from the most recent meeting which related to medicines support in homecare. They told us the host local authority had visited their service and made suggestions for improvements which they had acted on. Our contact with the local authority confirmed this information. There was also feedback

of improved communication between the service and another local authority.

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 The registered persons failed to ensure that care was provided in a safe way to service users, including through the proper and safe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the regulations. This included failures to: - assess, monitor and improve the quality and safety of the services provided; - assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; - maintain securely an accurate record in respect of each service user. Regulation 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons failed to ensure persons employed for the purposes of carrying on the regulated activity were of good character, and failed to ensure the following were available before employing anyone to provide care: •□a criminal record certificate; •□satisfactory evidence of conduct in previous

	care-related employment; • a full employment history, together with a satisfactory written explanation of any gaps in employment. Regulation 19(1)(a)(3)(a) S3 parts 3, 4, 7.
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons failed to ensure staff received such appropriate support and training as is necessary to enable them to carry out their care duties. Regulation 18(2)(a).