Guinness Care and Support Limited

Guinness Care At Home Devon

Inspection report

Ground Floor Suite 1, Key House, 4 Woodward Road
Howden Industrial Estate
Tiverton
Devon
EX16 5GZ

Tel: 01884242525
Website: www.guinnesspartnership.com/careandsupport

Date of inspection visit:
16 November 2016
23 November 2016

Date of publication:
06 January 2017

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This announced inspection took place at the service's office in Tiverton on 16 and 23 November 2016. The provider was given short notice because the location provides a domiciliary care service and we needed to be sure that staff would be available.

Guinness Care at Home (Devon) provides personal care and support to people living in their own homes. The areas the service covers includes Exeter, Mid Devon, South Devon and North Devon. At the time of our inspection there were 132 people receiving a personal care service.

When we visited there was a registered manager in post. 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.
At the time of the inspection the agency employed a registered manager, team leaders, seniors, care staff and an administrator. The agency staff were supported by quality assurance and policy staff based at the head office.

People received care and support from care staff they felt safe with. Their comments included: "I do feel safe they are lovely" and "They are very good I trust them." Health and social care professionals were contacted to help support people in their own homes. People were safe because there was an effective recruitment system and employment checks were carried out on care staff before they worked with people to assess their suitability. There were enough skilled and experienced care staff to meet people's needs. The service was reliable, people said "I get a rota and they stay the full time," and "They are reliable always turn up and are very helpful and they have to put up with some awful hours." There was a positive culture to learning from complaints.

However, improvements were needed regarding the management of risk for some people and how these were reviewed to ensure these risks or changes were recognised and managed appropriately. People were supported with their medicines but staff had not alerted management to gaps in records. Staff had not recorded steps to safeguard a person's best interests. Improvement was needed to ensure there was a consistent approach to detail, reviewing and auditing of care records.

Staff had been trained to meet people's needs, although there were some areas that had been identified for further development to ensure staff understood their responsibilities. For example, understanding the Mental Capacity Act (2008). Staff received supervision to develop their skills and support them in their role.

People were supported to maintain their independence and staff protected people's confidentiality and need for privacy. Staff relationships with people were caring and supportive. For example, people told us "They are delightful with me; we have a nice relationship, they are very kind and courteous" and "They are very discreet." Staff were committed to offering care that was kind and compassionate. People were

involved in planning the care and support they received but there was not a consistent approach to reviewing and evaluating the standard of care.

There was a clear organisational structure, where staff knew their roles and responsibilities. The registered manager demonstrated a strong commitment to providing a good service and had begun to put plans in place to address areas for improvement but the development plan had not identified all of the areas highlighted during this inspection. However, steps were taken to address this following our feedback.

Different methods were used to gain feedback from people to improve the service. The organisation was reviewing their methods to assess the quality and safety of the service people received.

We found breaches of the Health and Social Care Act (2008) Regulations 2014. You can see what action we told the provider to take at the back 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

Most aspects of service were safe.

Risks to people's safety and well-being were not always managed safely or consistently.

Some aspects of medicine administration were not fully safe.

People received care from staff they felt safe with. Recruitment checks were carried out to ensure people received care from suitable staff. Staff understood their responsibilities to keep people safe.

People received a reliable service from staff they felt safe with.

Is the service effective?

Requires Improvement

Most aspects of the service were effective.

People's legal rights were not fully protected because staff did not always understand or follow the principles of the Mental Capacity Act.

People were cared for by staff who received regular and effective support and supervision and training to maintain good practice.

People were supported to have access to health and social care professionals.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were caring and compassionate.

People usually received support from a core group of staff, which them helped form positive and trusting relationships.

Staff provided the care and support people needed and treated people with dignity and respect.

People's views were sought and they were involved in making decisions about their care and support.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People received care that was personalised and met their individual needs. However, improvements were needed to care records and staff shared concerns about having the time to read them.

People could be confident that any comments or complaints about the service would be listened to and acted upon.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider's quality assurance systems were not fully effective and failed to ensure people were fully protected from potential risks to their safety and well-being.

People received care from staff who were supported by an open and approachable management team.

Different methods were used to gain feedback from people to improve the service.

Guinness Care At Home Devon

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 announced inspection took place on 16 and 23 November 2016. On these dates we visited the office but on two other days we also phoned people using the service and staff working at the service. The provider was given short notice because the location provides a domiciliary care service and we needed to be sure that staff would be available.

The inspection team consisted of two adult social care inspectors 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 service.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR 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 also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

We sent out 50 questionnaires prior to the inspection and received twelve responses. We spoke with ten people receiving a service and their relatives and 14 staff, which included the registered manager. We also visited two people in their homes. We also met with staff from the head office who monitored and supported staff.

We reviewed seven people's care files, six staff files, staff training records and a selection of policies,

procedures and records relating to the management of the service. Following our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people. We received feedback from one social care professional.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and well-being were not consistently managed and monitored. This meant there was not always a clear record of how decisions had been made. For example, two care records did not show how risks relating to people's nutrition and fluid intake had been made to keep them safe and well.

One person's daily records completed by care staff showed concerns were logged regularly in a one month period about the lack of food and milk in the house. Handwritten notes stated intermittently that the person must be encouraged to drink but the care plan had not been updated. This meant there was potential for this information to be lost if the daily notes were returned to the office or new staff attended the person and did not review previous notes. A social care professional said the staff were good at keeping them informed of the risks to the person's well-being. Staff logged concerns in daily records but it was not routinely recorded if they were reporting concerns connected to nutrition to health professionals.

In a second person's care file, a food chart to monitor their food intake had been stopped but there was not a log of the reason why. The person told us they had lost weight after a fall but felt this was not such an issue now. However, the reason for the decision to stop completing the food charts was not clearly recorded on the charts or in any record of a review of their care needs.

There were other examples in two other people's care plans where information in the person's initial assessment such as risk of falling were recorded but a falls risk assessment had not been completed. Risks to people's health and well-being, such as risk of falls, were not consistently recorded on the electronic information system that care staff accessed when they visited or on the person's individual summary care plan. Potential risks to care workers were not consistently recorded under the warning section of the electronic care system. For example, the presence of a relative living in the building whose behaviour could impact on providing care.

The quality of the information in care plans and electronic notes was variable. Sometimes it was detailed and provided clear guidance. However, on several occasions, risks were not assessed and guidance was not in place to manage the assessed risk.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During feedback on the first day, we asked the registered manager to consider if there were similar people who might be at risk and to review their care arrangements. By the second day, the registered manager could show us what had been put in place to address our concerns. They shared an action plan with us. It had been completed to help staff identify potential risks for a client group in one geographical area as there had been a number of staff changes. There were no completion dates but the registered manager said they were overseeing the work to ensure it was completed promptly.

On the second day of the inspection, a member of the organisation's management team said that a 'risk

analysis' plan was now being worked on. This was in relation to people's vulnerability. For example, if a person was at risk of poor nutrition. People were categorised from 'red' to 'green'. They told us this work was had been prioritised to ensure staff had a clear overview of the amount of risk in each geographical patch. This showed they were taking our concerns seriously and acting upon them. The registered manager was also waiting for approval from head office regarding supplying staff with training in a malnutrition assessment tool to help them assess risks to people's health.

In contrast to the above examples, we looked at the management of risk for a fifth person. Records and discussions with staff showed a strong commitment to support the person in their own home. The staff from the agency had worked closely with other agencies to minimise the risks to the individual who smoked. Staff liaised with the fire service, commissioners and health professionals to alert them to the person's deteriorating health and the impact this could have on their safety. Staff were proactive in ensuring new equipment was put in place to reduce the risk of fire. During our inspection, staff updated relatives and other agencies about the changes to people's health and well-being. This included a request for an assessment for equipment to reduce a person's risk of falls and increasing visits to address a person's deteriorating mobility at night.

Records showed care staff were provided with safeguarding training, and staff we spoke with confirmed this. One member of staff commented "The training we had on safeguarding was very good."

People received varying levels of staff support when taking their medicines. For example, from prompting through to administration. People said: "They help me with the blister pack and eye drops and put cream on my feet and I think they write down what they have done" and "They give me my medicine when I need it and they record it in the book." Information from staff showed how they were proactive in helping resolving problems with prescription errors. For example, care staff collected prescribed drugs missed off an prescription. We checked medicine records and found one set to be completed appropriately by staff. Another had three gaps in a 24 day period; codes had not been used by staff to explain the reason for the gaps. The registered manager confirmed staff should have reported these gaps to office staff to follow up on the potential risk to the person. The records were in a person's home so had not yet been audited by the registered manager.

Staff received medicine training and an assessment was completed by senior staff to ensure they were competent to carry out this task. Staff confirmed they were confident supporting people with their medicines. Community team leaders and members of the management team spot checked medicine records whilst working in the community to ensure staff were administering them correctly. The registered manager said there was sometimes poor communication from hospitals when people were discharged regarding their medicines. They shared details of a complaint which had been made linked to medicine administration and how Guinness Care at Home were reviewing their systems to learn from the incident.

There were effective recruitment and selection processes in place. The registered manager ensured new staff were suitable to work with vulnerable people. Recruitment files provided an audit trail of the steps taken to ensure new staff members' suitability, which included references and appropriate checks. Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were sufficient staff to meet people's needs. People confirmed that staffing arrangements met their needs and the service provided was reliable. People were generally happy with staff timekeeping and confirmed they always stayed the allotted time. People commented: "They come twice a week to help my

wife shower ... and they are always on time", "I get a rota and they stay the full time," "They are reliable always turn up and are very helpful and they have to put up with some awful hours."

An electronic system had been introduced which care workers used to log in and out when they left a person's house. A person told us "They stay the time they are very nice I can have a chat with them I appreciate their company." We saw care workers using this system when we visited people in their own homes. The registered manager said she had requested replacements for phones that were not working so not all staff were currently using this system and used an alternative method to log in. The registered manager collated information about visits, which included if there had been a 'missed' visit. We spot checked September 2016 and saw there had been none during this month.

People felt safe and supported by staff in their homes. Their comments included: "I do feel safe. They are lovely" and "They are very good. I trust them." People were usually informed which staff were visiting them either through a phone call or by information on a rota. People said "I get a rota to tell me who is coming and at what time" and "I get the same people coming." People were introduced to new staff joining the service when they 'shadowed' experienced care workers to learn how people liked to be cared for. They said "If they have a new one, I usually see them when they are shadowing." The registered manager confirmed this was always the case for new staff. She explained teams within the service aimed to ensure new staff met as many people in the area so that people had met new staff members before they began to provide personal care.

Occasionally, due to staff sickness, another staff member would visit to prevent a missed visit but they might not have met the person before. For example, one person said "I mostly get the same people but sometimes if there is a new one they just turn up." The registered manager recognised this was not ideal. They said this usually happened when it was an early morning call that was being covered in the event of staff sickness. Otherwise people were informed that there had been a change of care worker. For example, a person said "I've had X and X for eight years but if they are off they usually introduce a new one or I've seen them shadowing." Where possible, people received a phone call to let them know when staff were running late. For example, "They are a bit late sometimes because of traffic but they let me know" and "If they are late they ring to let me know."

Requires Improvement

Is the service effective?

Our findings

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. People's individual wishes were acted upon, such as how they wanted their personal care delivered. People told us staff asked their permission before they supported them, which we observed during our visits with staff.

However, care staff were unable to demonstrate an understanding of the Mental Capacity Act (2005) (MCA) and how it applied to their practice. They were unclear about the concept of the MCA. One member of staff said "I find it hard to describe it's what their minds can do." Care staff were not able to explain the concept of a power of attorney, such as having the legal power to make decisions on another person's behalf. The 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.

Records showed care staff had received training on the MCA. However, the registered manager and the management team said they had identified that the training had not met the needs of staff because it was too brief and combined with other subjects. The management team had attended a MCA workshop that provided practical examples to care staff. They planned to roll this training out to all care staff to improve their understanding in protecting the legal rights of the people they supported.

Most people signed their own care plan to consent to the content but in one file there was an inconsistency in who signed the care records. For example, sometimes the person using the service and sometimes their relative, which was not explained. And in another, the daughter of the person had signed but there was no explanation as to why.

Care records did not demonstrate consideration of the MCA. They did not show how a judgment had been made on whether individuals had the capacity to make specific decisions relating to their care. Relatives had not been asked to show that they held legal powers to make decisions on behalf of people who were judged to lack mental capacity around specific decision-making. The registered manager confirmed this information was not routinely requested.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us about a safeguarding matter that had resulted in a 'Best Interest' meeting being held on behalf of a person who did not have capacity to make important decisions about their finances. The agency had been praised by the social care professional for the actions they had taken. However, the agency had failed to keep a record of the meeting or the agreed actions.

People were happy with the way staff supported them and asked for their consent. For example, "If it's

something routine they get on with it if it's something out of the ordinary they will ask my consent", "They ask me what I need and whether it's okay to do something for me", "When they give me a shower they will ask if it's okay to do my hair" and "They never do anything without asking."

The service provided support with meals if this had been assessed as being required. For example, we saw staff liaising with a person about their lunch and what food they had in the house. Records showed staff contacted team leaders if people's meal arrangements changed, for example if day care was cancelled, so that an additional visit could be organised to help prepare a meal. People told us they were happy with the support they received from staff regarding meals and drinks, although a number had support from a family member or meals delivered to them. They said "Before they leave they make me a cup of tea and they leave me some water and cordial for the rest of the day", "I get plenty to eat it's up to me what I want", "I do most of my meals and drinks myself but they always leave me a weak cocoa at night" and "I have Parkinson's and I find it difficult carrying anything so they always do me a drink before they go and take up a jug of water for me."

People said staff knew how to do their job. Several people commented on the training of care workers that visited them. For example, "I think they are trained they go on courses and get certificates" and "Oh yes, X and X have got stage 3 certificates."

Staff had completed an induction when they started work at the service, which included training and a period of shadowing more experienced staff. The length of the induction varied according to people's experience, competency and confidence. For example, "I took two weeks and got certificates for everything I did" and "It gave me everything I needed to know." The service's development plan stated there was a commitment to ensuring staff had completed the Care Certificate. This is a nationally recognised set of standards that health and social care workers are expected to adhere to in their work experience. The induction formed part of a probationary period, so the organisation could assess staff competency and suitability to work for the service. Topics included moving and handling, medicines administration, safeguarding, infection-control, personal safety, food hygiene, dementia awareness and first aid.

We received varying responses from staff on the quality of training on topics such as dementia awareness. For example, a staff member who started work in the last year said that the induction had not covered anything specifically to do with dementia. Whilst other staff reported having had some training in understanding dementia, most staff struggled to explain how the training had influenced their practice. This indicated the quality of training in this subject reduced its effectiveness. For example, one staff member said they had been given a workbook on dementia to read in their own time. In contrast, another staff member had been on a half day course which had been successful and helped them adapt their practice. They said "I really enjoyed it. It gave you a real insight in how it seems to them. I found things I didn't know before. You talk to them about the time they're stuck in." Staff wanted to provide a good service to people living with dementia, they said "I try to talk as much as I can to the person", "If a person shouts, I try to understand", If someone is agitated, I try to calm them down. I wait" and "It's very important for clients to have space. If they don't want to do something, it's not good to push them."

Staff confirmed they were provided with regular update training. They recognised that in order to support people appropriately, it was important for them to keep their skills up to date. They referred to annual refresher courses, for example in medicine administration, infection control and said they were advised by head office when this was due. Staff said they were able to request special training in topics such as Parkinson's, Alzheimer's/dementia, diabetes; although they said sometimes there was delay because of a lack of availability of spaces on courses. The registered manager said they were working on solutions to address these delays.

Staff said they could speak with colleagues to gain advice if they felt there was a gap in their training or knowledge. The registered manager said they ensured four careworkers were trained by district nurses if a person required catheter or stoma care. These trained care workers were then paired up with other colleagues to demonstrate what they had learnt and share good practice, which the registered manager said worked well.

The registered manager recognised some aspects of training needed to be developed further, including supporting staff with end of life care. One member of staff said Guinness organised training from a local hospice but only two staff members from the North Devon team were provided with places. Other staff said they learnt by observation from experienced seniors when working in pairs. The registered manager said staff were carefully matched to provide end of life care if this was part of the referral. They recognised some staff excelled in this area of care. Four members of staff were able to describe specific techniques they would use when caring for someone at the end of their life.

Senior staff reported they aimed to give supervision to their staff once every six to eight weeks. Staff reported that it was happening at this interval. Team meetings also took place to provide support to staff; these varied in how they were run depending on the location and experience of the team. Staff were less clear about the purpose of the annual appraisal. One person said "I've heard about it, but that's it…" The annual appraisal is a time to assess staff skills and performance to help them develop further and maintain good practice. The registered manager confirmed it took place annually.

People were supported to see appropriate health and social care professionals when they needed to meet their healthcare needs. We saw evidence of health and social care professionals' involvement in people's individual care on an on-going and timely basis, such as GPs, occupational therapists and district nurses. For example, in one person's care records staff demonstrated good practice in liaising with the GP about the person's weight loss and with the occupational therapy team regarding their declining mobility. We saw staff contacting health professionals to advise them of changes to people's health.

Records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. For example, in caring for one person staff advised other agencies when equipment was damaged and needed replacing to help reduce the risk of pressure sores. They were proactive in the finding ways to mend the equipment to reduce risk further. Feedback from an external agency recognised the care staff members' commitment to the individual.

Good

Is the service caring?

Our findings

People and relatives said staff were caring. They said "They are companionship for me because I'm on my own all day", "They are excellent" , "Very good", "They are willing, cheerful and it is nice to have someone coming in to help", "They are very good the carers make it special", "They are like my friends and "They are marvellous they do whatever perfectly."

Staff treated people with dignity and respect when helping them with daily living tasks. Staff were respectful in the way they spoke with people and listened to people's requests and views. For example, a person said "When they shower me they always say what they are doing" and "They will ask if it's okay to wash my back." A person's care plan recognised the importance of ensuring the person felt they were in control of their care by reminding staff not to rush the person. This care plan also told staff not to make the person feel they were 'being bossed around.'

Staff had been reminded how they entered people's homes to maintain people's privacy and dignity. We saw staff following this advice. Staff maintained people's confidentiality. People said "No, they don't speak about other clients" and "Don't talk about others they see." We visited a person with a staff member; the staff member saw another person who they supported in the block of flats. They advised the person that they would be delayed by a few minutes but they were careful not to disclose the reason.

Staff relationships with people were caring and supportive. Staff spoke confidently and compassionately about people's specific needs and how they liked to be supported. Our conversations with staff and the registered manager demonstrated they were committed to proving a personalised service. For example, staff said ""I love the work. It makes me feel I can really make a difference to people" and "It's a good feeling giving people who needed the help they need, that's very nice the satisfaction of being useful" and "I absolutely love this job. It's so good to help people who are really grateful for it."

Staff told us how they maintained people's privacy and dignity when assisting with personal care. For example, we heard staff checking with people if they were ready for help and where they wanted assistance. For example, people told us "They are delightful with me; we have a nice relationship, they are very kind and courteous" and "They are very discreet." People were asked regarding their preference of gender for help with their personal care and this was recorded in their care records. For example, "I have women and men that come which I don't mind but I prefer women when I have a shower." Relatives provided positive written feedback regarding how staff had gained people's trust to help them with personal care. For example, 'The girls you're sending are wonderful...ever so patient, kind and understanding.'

Staff explained how they involved people in their care and respected their independence. For example, encouraging people to do as much as possible in relation to their personal care. People said "I try to be independent I like to cut my fingernails myself and dress myself whenever I can" and "I try to be as independent as I can but they are there to help me." One staff member said they experienced real job satisfaction after gaining the trust of a younger person with a learning disability. This had meant the person became more accepting of help with their personal care, which maintained their dignity, and also became

more engaged in managing the running of their home.

People told us staff supported their mental well-being and provided company. For example, people said "I like to talk to them and ask about their family", "They are very good with me", "They are very friendly and make me laugh which does me a power of good", "I am very tearful since I lost my husband and they try to cheer me up" and "They are pretty good, we have a laugh and a joke."

The registered manager shared an example of how a staff group provided emotional support for a person without close friends and family. They ensured they always received Christmas and birthday cards from each of them to show the person that people cared about them. When the person died, the team leader took on the responsibility of arranging their funeral.

Requires Improvement

Is the service responsive?

Our findings

People told us they received personalised care and support specific to their needs and preferences. Care plans contained personalised information in a summary sheet, such as the importance of a pet in the life of a person living with dementia and its name. Care files included personal information and identified the relevant people involved in people's care, such as their GP. In response to a written survey from CQC all the 12 respondents said the information they received from the service was clear and easy to understand.

Changes were being introduced to some aspects of the care plan; staff had mixed views on the effectiveness of some of the changes. Paperwork indicated there should be reviews at set timescales but this was not always followed. The management team explained this was because some of the paperwork needed to be adapted to suit the agency rather than the organisation's residential homes. There was a risk assessment form but the format did not give a clear and quick overview of all the potential risks and the level of risk. The management team said this form had been reviewed and the format changed to reflect care being provided in people's homes. They told us after the inspection that 'the new forms were already in the process of being introduced into new care plans and at the point of review.'

The agency used a secure electronic care planning system and staff accessed people's care details through the mobile phone system used by the agency. Two care staff said there was enough information. One said "there's a little bit of history on there about how they like us to do each visit." Another person said "I always check my phone because it has the basics so I know roughly what they'd like." A third staff member provided several examples when key information to the individual had been missing. For example, on one occasion a team member phoned them to update them just before they arrived about the person's medical condition, which they felt was pertinent to the person's mobility.

Most staff said they did not have time to fully read the care plan before starting work with a new person but they would try and fit this in whenever they could. For example, "We're supposed to take the folder and read as much as possible. But I can't do this in 30 min… it just can't be done," "It's very difficult… You don't want to be in there (client's house) reading it when you are also trying to meet them" and "It's multi-tasking; sometimes you're talking to them at the same time as trying to read the notes." All staff either passed on or received verbal communication from their team manager or colleagues about people's care needs. For example, we heard team leaders updating staff throughout our two day inspection. People using the service gave written feedback and verbal feedback to CQC that staff knew how to support them.

We discussed with the management team the importance of ensuring care records, whether electronic or paper contained key information. They had recognised that some staff needed further support with care planning and training was planned.

The service used a computerised care planning system that helped them to meet people's individual needs. For example, their care planning system ensured a person living with dementia only received care from a set group of staff who knew the person well. The registered manager said they had worked with the person's family to establish this arrangement and it was working well. Some people had been unhappy about the

lack of consistent staff visiting them, for example a relative said "We did have a few problems with different staff but it has settled down now and the same three girls now come to look after her."

Care staff showed a commitment to providing a responsive and individualised approach to care. The registered manager described how there was a small group of people in one area whose health had deteriorated over time and had been provided with a service for a number of years. They explained how the local staff team worked closely together to arrange cover for each other during annual leave and sickness to ensure these people had continuity in the staff who supported them.

People were satisfied with the care from Guinness Care at Home. People told us "I have nothing to complain about", "All my needs are catered for", "They don't call round or ring but the girls come in 3 times a day and they know all is well and they report back", "I have no reason to complain but if I did I wouldn't have a problem in ringing them", "I am a retired nurse myself and I could be critical if I wanted but I have no problems with them" and "I have no complaints about any of them."

We reviewed the service's response to four complaints, which was positive and open. The approach by staff was to not to be defensive but to apologise and reflect on any lessons that could be learnt. Where necessary they had taken action to improve the service. In some instances, the registered manager had met with the person receiving the service and an advocate to reassure them their concern was being listened to and where possible resolved. The registered manager confirmed staff at the head office were in the process of investigating a fifth concern raised by a person who had also contacted the CQC.

Requires Improvement

Is the service well-led?

Our findings

People received a service, which included aspects that were not well-led. The provider's quality assurance systems were not fully effective and failed to ensure people were fully protected from potential risks to their safety and well-being. However, we were reassured by the end of our inspection that some areas for improvement were already being addressed and others concerns raised by CQC had been taken seriously and would be addressed.

The service had a registered manager in post. The manager was registered with the CQC in September 2016. They had been working as acting manager to cover maternity leave prior to this appointment. People using the service were not clear who the registered manager was and sometimes referred to the team leaders as the manager. For example, 'I don't know the Manager's name", "I don't know who the Manager is", "Can't remember the Manager's name" and "I think X and X are in charge they are very friendly and approachable."

However, feedback from people was positive about their relationships with the staff that provided their day to day care. For example, "I have no problem with them they are very good" and "They are very good I have no concerns." In response, to a written survey from CQC all 12 respondents said they knew who to contact in the care agency if they needed to and knew how to make a complaint. All of the 12 respondents said they would recommend the agency to another person. People's written feedback to the service showed they appreciated the flexibility of the service to respond to their changing circumstances. For example, helping them to attend hospital appointments. A relative had commented in their feedback "You do your best and more."

The provider had systems in place to monitor the service and make improvements where necessary. They had already identified some of the problems highlighted in this report and were taking actions to address them. The registered manager showed us a development plan for the service which highlighted the need for an audit of staff files to be carried out. The records we looked at during this inspection showed this had been achieved and the files were well managed.

However, the development plan did not include some areas for improvement. Our inspection highlighted improvements were needed in the quality of some risk assessment and recording. Records relating to some people's care showed some risks to their health and well-being had not been considered and some electronic records lacked detail. Work was in progress based on feedback from another agency owned by Guinness care at Home to improve staff members' understanding on how to complete an effective care plan.

Audits were not routinely completed in a timely manner. For example, daily records for July 2016 were reviewed in October 2016. There were issues of concern in the daily records and these had not been picked up in the audit, which meant the review was not meaningful. Staff had been reminded in staff meetings to return daily records to the office for individuals receiving a service so they could be audited on a monthly basis. This was not always happening in a timely manner. This meant that the quality monitoring system had failed to recognise and address problems and risks effectively or pro-actively.

The registered manager explained they were making significant improvements in the management arrangements for one locality where there was a high number of people receiving a service. They had an action plan in place to provide support to staff and to ensure people's reviews were up to date. They discussed with us the actions they had put in place to address these issues, which were confirmed by their line manager.

Throughout the inspection, the registered manager demonstrated a strong commitment to improving the service. Since being in post, the registered manager had made improvements to information provided to staff. There had also been an appointment of an administration person to support the management team to enable them to complete more supervisory tasks. The registered manager said there was an on-going recruitment process for new staff. This was to help reduce the need for team leaders to cover care shifts to enable them more time to complete their supervisory tasks, although records showed observations of staff practice were routinely carried out by seniors or team leaders.

The registered manager responded positively where issues needed to be addressed. For example, people gave us mixed feedback about whether they had been asked about their views about the service. Some were unclear if they had been visited by a team leader to review their care. For example, people said "The senior carer has been out to review the care plan" and "Don't talk to the office much and they don't really come out to see me." Following our feedback from people using the service the registered manager showed us an action plan. This included contacting staff and customers to gain feedback on concerns or issues to ensure people were involved and consulted about the service.

The organisation had taken steps improve how they gathered people's feedback on the quality of the care provided to them by the agency. Some people told us they had completed a survey while others were unsure if they had received a survey. The registered manager provided us with information sent out to people using the service about an external company contacting people by phone in December 2016 to gather their feedback. The organisation said they were trying a different approach after a low response to a paper survey sent the year before.

The organisation had summarised the response to a customer satisfaction survey in 2016 and provided information on what had been done well and areas for improvement, which included communication if staff were going to be late. People told us they were contacted by the agency if staff were held up. Internal audits included an annual quality assurance report, which was dated April 2016, praised the standard of work achieved by the agency coming top in a league of other services owned by the organisation.

The agency had experienced staff changes and shortages during 2016 that had put pressure on the management team to carry out all required tasks. One member of staff said things were improving. They said "staffing levels have been up and down, but they are starting to get there I think." Staff were able to request additional support if something upsetting had occurred. The example given was finding a client who had died and being the first on the scene. Staff reported that their line managers were accessible and supportive. They said "We are looked after as the team, they are therefore as at any time we need them", "I can call at any time if I want to get something off my chest." The majority of people felt very well supported by their line manager. For example, "My team manager and senior care are always there to talk to. I've rung out of hours and they've helped me sort things out", "I'm part of a lovely team… We have a really supportive manager" and "(name of team manager) will always help… All the staff love her." The organisation recognised the quality of the work of care staff through the carer of the month award.

Staff told us there had been recent changes to the on-call system. They were positive because the support came from a senior or team leader who had local knowledge. Staff said "It's working much now" and "I think

it's better and safer this way."

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 11 HSCA RA Regulations 2014 Need for consent People's legal rights were not fully protected because staff did not always understand or follow the principles of the Mental Capacity Act.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety and well-being were not always managed safely or consistently.