Natgab Services Limited

Natgab Care

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

Summary of findings

Overall summary

We undertook this announced inspection on 20 December 2017. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults. At the time of the inspection the service was supporting 21 people, many of whom had palliative care needs.

At our last inspection on 10 September 2015 the service was rated as 'Good' overall.

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

At the last inspection we made a recommendation that the service put in place a comprehensive system of audits and checks to ensure that it was well run and deficiencies were identified and promptly responded to. At this inspection we found there were not always effective systems or audits in place to check the quality of the service. We also found there were not always effective systems in place to prompt management actions in relation to reviewing care and prompting spot checks. We also found issues with recording so actions taken by staff were not always recorded on care records.

We found that medicines management was not always safe as the registered manager did not assess the competency of staff to support people with medicines and did not require staff to undertake refresher training in this area. There was not an effective system to check medicines records at the office reflected current medicines people were being supported with.

Risk assessments did not always provide detailed information to staff in supporting people as the service sometimes relied on documentation from health professionals to guide staff.

The provider could not always evidence safe recruitment practices prior to staff starting work with vulnerable people.

The registered manager organised comprehensive team meetings quarterly at which best practice was discussed. However, there was no requirement for care staff to attend or undertake refresher training courses or to have individual supervision. So the registered manager did not always check staff understanding in key areas. For example, we found not all staff understood fully their role in safeguarding adults.

People were supported to have maximum choice and control of their lives and staff understood the importance of consent, but they did not always understand best practice in decision making related to the Mental Capacity Act (2005).

Family members spoke highly of the care provided and staff supported people with complex medical conditions. Health and social care professionals told us the service worked effectively in partnership with them in meeting people's ever changing health needs.

The provider had a complaints process in place which dealt with complaints appropriately and family members told us they felt confident in drawing attention to concerns they had with the registered manager.

We could see there were infection control practices in place to safeguard people and the registered manager shared learning with staff from issues that arose from incidents or safeguarding concerns.

We found the provider was in breach of five fundamental standards. These related to safe care and treatment, recruitment, staffing, governance of the service and the requirement to notify CQC of significant events.

We have made three recommendations in relation to the Mental Capacity Act (2005) and best practice in care and recording of mental capacity, evidencing personalised care on care records and ensuring they are up to date to reflect current care needs, and developing a more robust system to minimise missed visits.

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 always safe. Staff recruitment was not always robust enough to ensure staff were safe to work with vulnerable people.

Risk assessments were in place but were not always detailed enough to provide guidance to staff.

Medicines management was not always safe as staff were not assessed as competent to support people with medicines. The service did not have a system to check they had up to date knowledge of people's current medicines.

Staff did not always understand their role in safeguarding vulnerable adults.

Infection control processes were in place and the registered manager shared learning with staff when incidents occurred.

Is the service effective?

Requires Improvement

The service was not always effective. Although staff attended quarterly team meetings at which best practice was discussed there was no requirement to attend refresher training in key areas.

Staff did not receive individual supervision in line with the provider policy.

Staff understood the importance of consent but were not always clear about best practice in relation to mental capacity decisions, and who could sign documents on people's behalf.

Relatives told us care staff were good at their job and they felt confident in the care provided by them.

The service liaised well with other health professionals to meet the health needs of people, many of whom had palliative care needs.

Is the service caring?

Good

The service was caring. Family members confirmed staff were kind to people.

Staff showed people dignity and respect and met their cultural and religious needs.

Is the service responsive?

Requires Improvement

The service was responsive. Family members told us care provided was personalised and met their relative's needs.

Care was provided at a time that suited people.

Family members knew how to make a complaint and told us the registered manager dealt with complaints effectively.

Is the service well-led?

Requires Improvement

The service was not always well led. There were not effective quality audits in place to check the quality of the care provided in a systematic way.

There were issues with contemporaneous recording. We found not all care plans were updated regularly and review minutes recorded on care records.

There were three occasions when the registered manager did not notify CQC of significant events as required, without prompting by a CQC inspector. .

The registered manager was well regarded by staff and people's families.

Natgab Care

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 20 December 2017, and was undertaken by 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 care service. Their involvement was phoning people who use the service and their relatives to gain their views of the service.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supported staff or providing care. We needed to be sure that they would be available for the inspection visit.

The provider had sent us the Provider Information Return (PIR), but it contained very limited information on it. The PIR 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.

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.

On the day of the inspection there were 21 people using the service. Inspection site visit activity started and ended on 20 December 2017. It involved a visit to the office to look at records held by the provider. During the inspection, we spoke with the registered manager, the care co-ordinator who is also one of the deputy managers and three members of staff.

We reviewed electronic care records of support plans and risk assessments for four people receiving care to see if they were up-to-date and reflective of the care which people received. We also looked at two full

recruitment records. Due to information of concern received by the CQC prior to the inspection about recruitment practices, we looked at Disclosure and Barring Service documents for seven staff. We also looked at five staff member's training records.

We looked at three care records held in people's homes which staff brought to the office for us to view, and one person's medicine administration record. We also looked at team meeting records, the complaints log and details of spot checks undertaken by the service.

Subsequent to the inspection the registered manager sent us additional information which included the policies of the provider, two additional people's medicine administration records and additional review records. We also obtained further information from the registered manager to support our inspection findings.

The expert by experience spoke with eleven relatives of people using the service as people receiving the service were too unwell to speak with us on the phone. We also spoke with two professionals to get their view of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people's relatives if they thought their family member felt safe with carers. Relatives told us "Yes indeed" and "Yeah, he definitely does."

There was a safeguarding policy in place and we could see that staff undertook safeguarding training as part of the induction process. We could also see that there had been learning by the provider from a safeguarding incident that took place earlier in the year. This had been shared with the whole staff team at a team meeting following the investigation by the local authority.

The provider could evidence they had notified the local authority of concerns and had systems to record outcomes of safeguarding alerts. We found although staff understood the importance of ensuring they cared for people safely and were able to tell us how they did this, one staff member could not tell us the different types of abuse that can occur. They also did not understand their role in notifying the provider if they witnessed any behaviours by other people that placed people at risk. Only one out of three staff understood what 'whistle blowing' was and how to alert external agencies if they had concerns.

We discussed this with the registered manager who told us that safeguarding was discussed at induction, staff watched a video and there was a question and answer session afterwards. Staff were given leaflets on safeguarding and safeguarding had been discussed at a team meeting in the last year. However there was no formal provision for refresher training on safeguarding and the registered manager did not have any system to check staff understanding in this area. This concern is referred to further in Effective.

The provider had a medicines policy in place which distinguished between assisting with and administering medicines. Best practice as set out by the National Institute of Health and Social Care Excellence (NICE) recommends either administering or self- administering of medicines in the community. At the outset of providing care the registered manager photocopied the medicines blister pack and details of the medicines people were being assisted to take or were being administered to. A medicine administration record was set up which care staff were expected to sign when they supported people with medicines. However, there was no system in place to routinely check the prescription for medicines remained the same, and there was not evidence on all review records that this had been discussed with the GP, the person receiving the service or the family member.

In addition, the provider's medicines policy stipulated care workers should only administer oral medication when they have been assessed as competent to carry out the task, having received appropriate training. Whilst staff are trained at induction to carry out medicines support the registered manager could not evidence competency assessments had taken place, although they stated they talked through with staff the use of medicines blister packs. The registered manager was a registered nurse so had the knowledge and skills to train staff in this area.

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

We could see on one care record that the registered manager had asked for and received updated information regarding one person's medicines. We could also see that where one off medicines, for example antibiotics, were prescribed that office staff liaised with the person or their family to evaluate if it was safe to assist or administer these medicines.

The service had risk assessments covering environmental issues at people's homes but there were not always risk assessments in place to provide guidance to staff in key areas. For example one person's care records identified 'mouth care should include cough assist cycles to remove secretions from the back of [person's] mouth' but there was no information on how to do this. This same person's records noted 'hoist from bed to wheelchair if appropriate', however there was no detailed risk assessment in place set out by the service to do this. For a second person we found that despite this person falling and fracturing a bone recently there was no falls risk assessment completed. This person also required all food to be liquidised but there was no risk assessment to manage choking. Nor was there information for staff on the equipment necessary to support this person.

We asked the registered manager how they ensured staff had the necessary information to provide care safely, they told us as the majority of care provided was to people who were extremely ill, occupational therapists and physiotherapists were involved. These professionals often trained individual staff working for the provider and then information was passed from one staff member to the next. We saw an email from one physiotherapist who had provided training for staff in how to use the hoist and particular slings. Some family members also showed staff how to provide care.

However, the provider still had a responsibility to set out clearly for their staff how to support people and manage risks safely and this was not always available to staff as this information had not been transferred to a risk assessment.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

References were in place prior to staff starting work at the service. However it was not clear from all Disclosure and Barring Service checks were in place prior to staff starting work at the service. For example, out of seven staff records we found three staff for whom the registered manager could not evidence had a DBS check in place at the time they started work. The registered manager told us they may have had a DBS in place but the data was not available to evidence this. This meant the provider could not satisfy themselves that the person was safe to work with vulnerable people when they started working at the service.

These concerns were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

By the time of the inspection there were up to date DBS disclosures in place for all seven staff.

A number of people required the use of a hoist for transfers and so two staff were required. Staff told us there was enough time between visits to get to people and staff members contacted each other to synchronise their visits. When we asked family members if both staff turned up at the same time family members told us. "The two staff come together 50% of the time, it's usually 5 or 10 minutes before the other one arrives. Whoever comes first starts preparing. My [relative] needs to be hoisted for two of the calls. The latest anyone has been is about half an hour. The carers will call or the agency will call." Another relative said "Yeah they do. Normally one will come earlier and prepare the stuff and wait for the other to come.

Normally late by 5 or 10 minutes. Normally the agency will call me. Maybe once a month." Also "Usually pretty good. The only time there are problems are when there are problems with transport. They arrive together or within 5 or 10 minutes of each of other. There is nothing wrong with the service." Family members were in general happy with the service and understood the difficulties of always synchronising two staff members to arrive at exactly the same time.

Only one out of eleven carers was not happy with the timing of care staff they said "No. They say they will come between 10.30 -11am and sometimes they don't come until after 12. They don't ring if they are late." We discussed this with the registered manager who told us they reminded staff repeatedly to keep people and their families updated if they were running late and we could see from staff meeting minutes this was the case.
Only one relative told us they had had problems with the length of time a member of care staff stayed. We discussed this with the registered manager who showed us team meeting minutes where they repeatedly reminded staff to accurately state their start and end times on care records.

We asked family members if care staff ever missed a visit. Six out of eleven relatives told there had been the odd occasion when there was a missed visit but they all told us the office had dealt with the care staff or resolved the situation. They said "There was one month when they missed several visits. I think it was either September or October, but it's ok now and has not occurred since." Another relative told us "I think four or five times. I have it documented. It was dealt with by Natgab. It was a particular carer in April 2017. It just happened in April. It has not happened since then." "Only once has there been a problem with communication. This Sunday it happened. They then sent someone in as soon as I called them."

We recommend the provider improve their system to minimise missed visits by care staff.

Family members told us people were protected by measures in place to prevent and control infection. We saw that the induction covered infection control procedures and there were gloves and aprons available for people to use. We asked relatives if care staff used gloves and aprons. Relatives told us "I have seen them wearing gloves and aprons." "Yeah they do. They have a pack in the house and they just take it out." And "Yeah mostly I see them wear gloves. I don't think the aprons are on all the time." The registered manager told us aprons were available and they would remind staff to use them when carrying out personal care.

There had not been any accidents or incidents logged by the service but we could see from team meeting minutes that the registered manager discussed learning from safeguarding alerts or incidents that took place to minimise the risk of them reoccurring.

Requires Improvement

Is the service effective?

Our findings

We asked relatives if they thought staff had the skills and experience to work with their family member. Family carers were in the main very positive about the skills of the care staff. They told us "I think they are very good" and "I could not fault them in shape or form. They were just amazing." Another relative said "They are. If they don't do it well my mum tells me." Also "We have had this agency just for two months. They are very good. He has by pat pump, suction machine, assisted cough, and hoist and nebulizer. He is on PEG [percutaneous endoscopic gastrostomy, feeding via the stomach] as well. The carers are limited as they have to know how to flush the peg. I have to be here to do the support. I get a break when the experienced ones come in. The main carer is the experienced one. I am happy with the carers."

Only two family members had a more mixed view of care staff. One told us "Some are good, some are not. He complains that they don't know how to wash him properly. There's a core of three who are very good." The second family carer said "No complaints. With the hoist, some carers struggle at the beginning. I don't know how much training they get. They need my help. They might not know how to use the sling. If they are inexperienced they ask for my help. Mainly we have regular carers. Sometimes at weekends we will have carers that are not as regular. This weekend we had two carers who did not know how to use the hoist. The last time that happened was a long time ago, maybe three or four months ago."

New staff undertook an induction which covered a range of key areas including medicine safety, safeguarding, pressure area care, food hygiene, infection control and record keeping. Practical issues such as moving and handling and emptying catheter bags were also covered. The provider also provided an induction pack which set out expectations of staff regarding their role and standards of behaviour expected, including dress code, safeguarding and the importance of dignity in care. The registered manager was a qualified nurse, practice teacher and community prescriber so was qualified to teach staff.

Of the staff records we reviewed staff had not been in post for over a year so no appraisal was required. We could see two appraisals took place with staff who had worked at the service for over one year.

The provider had a supervision policy in place which indicated individual supervision would take place and referred to a supervision contract, however it did not set out the regularity of supervision. The registered manager could show us some supervision took place with office staff, but not with care staff. The registered manager insisted quarterly team meetings were compulsory for staff. These were an opportunity to discuss best practice and issues related to providing good care, and so, in their view, doubled up as group supervision and refresher training. Attendance was high with the majority of staff attending on a quarterly basis.

The provider did not have a training policy in place, and there was no requirement of staff to undertake formal refresher training. Of five training records we reviewed we saw that four out of five staff had undertaken training in a number of key areas in the last three years including safeguarding, health and safety, infection control and safe handling of medicines. One staff member was employed to look after their family member with the permission of the commissioning body. We did not see any training certificates for

this staff member.

Of the three staff we interviewed one reported they had had training in safeguarding moving and handling and dementia in the last year but was vague as to when. The other two staff said they had not had refresher training in the last 12 months.

Following the inspection visit the registered manager sent us a training matrix which indicated that attendance at quarterly staff meetings constituted refresher training. For example, attendance at the staff meeting in July 2017 was considered refresher training in eight key areas including safeguarding, medicines support and moving and handling training. Attendance at the team meeting on 24 December was considered further refresher training in these eight key areas. The impact of this approach was that there was no systematic way to check staff understanding of knowledge, and there was no requirement for staff to account for their skills and knowledge. The lack of staff understanding of their role in safeguarding adults and whistleblowing, was outlined in Safe and was an example of the impact of how this approach was not effective.

The registered manager told us they spot checked staff skills working in people's homes and we saw 12 spot checks had taken place since January 2017, with one staff member being spot checked on three occasions to ensure their knowledge and competency had improved. However, not all staff were spot checked. The registered manager told us newly employed staff were spot checked within three months of starting, however, this had been recorded for only two out of seven staff records checked.

The registered manager told us she checked staff knew how to use the hoist after a team meeting in the last 12 months but this was not documented, and that everyone they supported was provided with the same hoist. However, one family carer indicated that, although it was not regular, there were occasions when care staff were not skilled in using the hoist safely.

These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Whilst we found staff understood the importance of consent when offering care, only one staff member had any understanding of the MCA. We found one care record where a family member was stated as having legal authority to make decisions without any legal right to do so. The care plan repeatedly stated the person had 'no capacity' when the person lived alone with only one short visit a day of 30 minutes from a carer. This showed a lack of understanding of how even people with a diagnosed dementia can still have capacity to make less significant decisions and how mental capacity assessment is decision specific not generic or global.

We discussed with the registered manager how staff were trained in the MCA and they told us this was covered as part of safeguarding.

We recommend that the provider ensure that all staff are familiar with the MCA and best practice associated with this for care and record keeping.

We asked family members if the carers asked permission before providing care to their relatives. They told us "Oh yes of course," and "Yeah they do. If she does not understand, they will call me and I can translate." A third person told us "Yes they ask him, sometimes he refuses and they don't do it."

Care records reviewed did not have a signature on the office copy but the registered manager told us records kept at people's homes were signed. Of two records from people's homes viewed, one was signed by the person receiving the service the other was not signed although the person had a disability which would preclude them signing.

The service worked in partnership with other health professionals effectively. We could see from records that a significant number of people were funded under continuing health care criteria and as such had complex health conditions. A significant number of people were receiving palliative care. We could see from records that the registered manager and office staff were in close communication with health care professionals, particularly when a person's needs were changing. One health professional told us the registered manager had worked very in partnership closely with her in relation to one person and found the registered manager effective in their role.

Care staff prepared light meals for some people but in the main heated up food left out by family members. This was confirmed by relatives and staff. "Family provides meal and the carers heat them up." "They make him a cup of tea. We would put a tray out with a cake or get him biscuits. If we had left a sandwich in fridge they would get it out and give it to him." Two family members told us that whilst they took main responsibility for percutaneous feeding the carers were confident in caring for a person using it. They told us "Family look after PEG feeding. The carers know how to clean around the PEG." Another said "The peg is done by me. But they [carers] know how to flush medicine through it."

Good

Is the service caring?

Our findings

We asked people's relatives if they thought the staff were kind and caring. They told us "Yeah, yeah definitely. They are sympathetic" and "Those that I have, the three that I have are very caring." A third relative told us "I think they are. Certain ones are very good. They are all very polite. They come in and say hello and call him by his name. Some of them ask is there anything else that they can do. Some of them are proactive."

Care plans were written in an objective way but did not contain information on care plans about people's backgrounds. The majority of people lived with family members who provided relevant information if people were unable to tell care staff themselves. However, best practice would be to record some information to assist staff in understanding and approaching people from a holistic perspective.

We asked staff how they showed people dignity and respect. One member of care staff told us "I always assume people can understand even if they can't talk." "I respect people as a woman or a man and make people comfortable." Another member of care staff told us "I close the door before providing care, and cover their body when providing care. We asked relatives if their family member was shown dignity and respect. They told us "Definitely" and "Oh I think so without a doubt." A health and social care professional told us they had been out on a visit to see a person receiving a service with the registered manager and they showed the person dignity and respect and were caring in their interaction with the person.

We asked relatives if people's cultural and religious requirements were met and they told us "They do yes." Staff told us they take their shoes off if asked or used shoe covers in some houses. They confirmed a number of people lived with family members who made staff aware of people's cultural and religious needs.

We asked people's relatives if they were involved in planning the care. They told us "Discussions have taken place" and "Yeah normally every six months they meet with us to make sure everything is fine and the manager comes in as well." A third person said "Yes, they involve us with everything. We are lucky with the people we have got coming." However we found there were few documents with people's signatures on them. The registered manager told us this was often because the person was so unwell they could not sign their agreement, but this was not recorded on care documents.

Requires Improvement

Is the service responsive?

Our findings

We found the service did provide personalised care, although the care records did not always accurately reflect this. We asked people's relatives if care staff understood about their health conditions and what help they needed to support them. They told us "Yes they are completely informed about his problems. It appears that way." And "Yes they know he has Parkinsons and that he is bed bound and needs to be cleaned up." A third person said "Yeah, they are informed before they come in."

We asked if the care staff were well matched to the person they were caring for. Relatives told us "From what has been observed, yes" anther said "Yes, yes absolutely." A third relative said "I think they probably were. She was such a caring lady. She was caring and homely, she would chat with my dad. She would phone me to say that she was concerned about my dad, I had complete faith in them. The office staff were fantastic." People were asked if they had a preference related to the gender of the care staff and if they did, this was catered for by the service.

We asked if the carers fitted in with people's time schedules or whether people had to fit in with the agency demands. Relatives told us "Well he is at home nearly all the time. It more or less fits in ok" and "Yes, they fit in with ours. She used to get four calls now we changed it to three to adapt to her needs. If we ask them to come at a certain time they will adapt to what we need." "Our care is made for us. Everything is designed around us."

Care plans were in place and covered the essential areas, for example, personal care and mobility. While these were well structured and contained some good information notable shortfalls were identified regarding detail. For example, there was little information on how aspects of people's care should be provided. For example one person's care plan stated, 'hoist from bed to wheelchair if appropriate'. However, there was no information on how to do this and no assessment on how to manage the risks.

Another person's care plan stated; 'wash client, mouth care, pressure area care, put cream on pressure area, dressing, undressing, position and make comfortable'. However, there was no information on how the client liked to be washed, the products that should be used, or what mouth care for that person entailed. Additionally, for this person it was noted that they were supported by the district nursing service with their pressure care and it was unclear how staff from Natgab should support this person with 'pressure area care.' We also found the assessment and care record for this person had been completed after the first visits to provide care. This person lived with their husband and other family members. This meant the provider had not set out their own assessment of the care provided before sending staff in to provide care which was of concern.

The registered manager told us continuing health care referrals were extremely detailed and as people often had complex moving and handling needs, staff were shown by occupational therapists and physiotherapists how to provide care to people. Where people were on PEG feeds they were shown by nursing staff how to use them and flush them through to provide safe care. Care staff routinely passed on this information to any new care staff joining the team of people providing care. A health and social care professional confirmed

that the registered manager had visited with the physiotherapist twice regarding the needs of one person to ensure this person's needs were met safely and with dignity.

From the evidence above this showed us that whilst people received personalised care from care staff the care records did not always evidence this. We also found care records were not always completed in a timely manner and did not always provide the necessary detail to guide staff in providing care, or were not always updated following changes to care provision. Other care records we checked were for people whose care had started recently so they were reflective of current care provided. The registered manager told us they were aware they needed to improve their systems but had recent staff changes in the office that had impacted on this.

We recommend the provider develops an effective system of recording to evidence personalised care provided and to ensure care records are updated to reflect current care needs.

People were told how to make a complaint at the start of the service. There was a policy in place and we could see the provider had an effective system to log and deal with complaints to ensure they were dealt with in a timely way.

We asked people's relatives if they knew how to complain if they were not happy with the service they told us "Absolutely [registered manager name], manager of care agency, I felt comfortable speaking to her. She took it all on board." Another person told us "Yes we made a complaint a year ago when the carers were coming in late. We told them about it. It's ok now." A third said "Yes I have her number. At the beginning I was always making complaints. It's better now. Not made a complaint recently."

The provider could show us that they had received compliments for providing the service to people in the past 12 months which people and their families had valued.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we made a recommendation that the service put in place a comprehensive system of audits and checks to ensure that it is well run and deficiencies are identified and promptly responded to.

At this inspection we found these were not always in place and so there were ways in which the service was not well led despite providing family members being happy with the care provided.

Quality systems were not in place to check care records were updated or reviews had taken place. We found for example, a lack of accurate, complete and contemporaneous recording in relation to some people's care. We found reviews that had taken place that were not always recorded on care records and not all care support plans were updated to accurately reflect correctly the care provided at the time. We also found following a complaint that the daily log evidenced that the care co-ordinator and registered manager visited the complainant but the log did not indicate what they came to discuss or the outcome of the discussion.

We also found the provider did not always have effective systems in place to assess, monitor and reduce the risks to people using the service. For example, there was not a robust system to prompt regular reviews of people's care and to check what medicines they were taking to ensure the MAR was up to date. The quality assurance policy stipulated six monthly reviews should take place but the registered manager told us they worked to annual reviews or more frequently if people's needs changed, but there was no log of reviews undertaken or those due. When we asked people's relatives if they had had a visit to carry out a review in the last 12 months we got mixed responses. Whilst we were told "People from the agency come. I don't what position they hold" and "The Natgab people did." We were also told "No" and "No we usually just talk over the phone."

Another example of the lack of effective quality systems related to spot checks. We could see 12 spot checks taken place since January 2017, chosen on basis of feedback from people but also an element of random selection. We could see one staff member had been noted at one spot check to need additional advice in relation to using incontinence pads. Although the registered manager was not able to evidence how they had provided this, we could see there were two additional spot checks that took place of this carer in the following four months. Of the other nine spot checks there was no evidence they were related to risk or people were systematically chosen.

We also found a lack of effective systems to monitor the skills and knowledge of staff on an on-going basis as there was no requirement to undertake refresher training courses or individual supervision. This meant the registered manager did not have a forum to check individual staff understanding of the requirements of their role.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found the registered manager did not have an effective system to prompt them to send notifications

to CQC of significant events in line with requirements, as we were not notified on three occasions of issues related to allegations of safeguarding concerns. Prior to the inspection we received information from other sources of allegations of safeguarding concerns and it was only by prompting from CQC that notifications for these significant events were sent to us. Subsequent to the inspection, in January 2018 we were made aware by the local authority of another allegation of concern that occurred in November 2017 which we had not been notified of. As a result of prompting by CQC we subsequently received a notification. The registered manager told us the system of notifying CQC of significant events had failed due to staff changes, but they had now set up an effective system to notify CQC in the future.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There were other ways in which the service was well managed. Relatives were positive about the care provided despite people's complex health needs. Staff told us the registered manager was supportive and available to them. We saw that detailed staff meetings took place quarterly where the registered manager shared information with staff regarding best practice, learning topics were discussed and the registered manager used the opportunity to remind staff of their obligations and role as a carer. Management meetings took place regularly so office staff could plan their work and update themselves on client needs.

Health and social care professionals were positive about the service and the responsiveness of the registered manager.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the CQC of three incidents where a service user suffered abuse or an allegation of abuse had occurred. Regulation 18(1)(2)(e)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always in place to provide guidance to staff in how to care for the person. The provider could not evidence the safe management of medicines. Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider could not evidence systems or processes were established and operated effectively to ensure they could assess, monitor, mitigate the risks and improve the quality and safety of the services. The provider could not show they maintained an accurate, complete and contemporaneous record in respect of each service user including a record of the care and treatment provided to the service user and of decisions taken in

relation to the care and treatment provided.
Regulation 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider could not evidence persons employed for the purposes of carrying on the regulated activities were of good character as they could not show DBS checks had been completed prior to them starting work at the service. Regulation 19(1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not provide appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1)(2)(a)