All Care (GB) Limited

All Care (GB) Limited –High Wycombe Branch

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: All Care (GB) Limited – High Wycombe Branch is a domiciliary care service. It provides personal care to people living in their own homes. It provides a service to younger adults, older people and people with dementia. It was providing care to approximately 200 people who lived in High Wycombe and surrounding areas at the time of our inspection. All referrals for the service came from the local authority.

People's experience of using this service:
People told us they did not receive a service they could rely on. This was because the timings of their visits by care workers (calls) were erratic, sometimes late and sometimes missed. People who required two care workers told us two were not always provided, which meant they could not be hoisted out of bed. This impacted on their independence. Following the inspection, the provider sent us records to show that for the four weeks prior to the inspection, all visits which required two care workers were carried out by two workers.

People told us care workers did not always stay the agreed amount of time supporting people. This was confirmed by looking at the service's computer records. In some cases, this was far shorter than the scheduled length of time. We have shared this information with the local authority. Some of the feedback we received was that care workers were rushed. Some people told us care workers did not always promote good hygiene when they supported them.

Due to the erratic nature of some calls, people did not always receive their medicines within safe intervals if they required more than one dose a day. On some occasions, doses were given too close together.

Staff knew about safeguarding people from abuse. Concerns were referred to the local authority and to us, when required.

Robust recruitment procedures were used at the service. There were systems to supervise and train staff, to help ensure they had the skills to meet people's needs.

People's needs were assessed before they received a service. Care plans had been written and were kept up to date. Risks were assessed and measures were put in place to help keep people safe. The service had not always assessed people's capacity to consent to their care, in line with legislation. Copies of Lasting Power of Attorney documents had not always been obtained, to prove others who acted on people's behalf had the authority to do so.

People had mixed experiences about being treated with respect by care workers. This was also the case with their privacy, dignity and independence.

People told us they did not feel listened to. They said their calls or emails to the office were not always returned.

The service worked in partnership with other agencies such as healthcare professionals and the local authority. The registered manager kept their own learning up to date and attended local forums to share good practices.

Monitoring was undertaken by the provider and registered manager. This included 'spot checks' of care worker practice out in the community, surveys and audits. A mock inspection had been carried out by the provider a couple of days before our visit. It had not identified the areas where we found improvement was needed. Some actions had been taken to improve the service. These had only been introduced very recently and had not had time to become embedded in practice.

There were examples of where people had not received the care they expected from the service. These could have been managed using the duty of candour principles, which aim to ensure providers always act with openness and transparency.

We have made recommendations about infection control and hygiene practices, implementation of the Mental Capacity Act (2005) code of practice and demonstration of the duty of candour principles.
Rating at last inspection: This was the service's first inspection since changes to registration in November 2018.

Why we inspected: The inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Enforcement: We found areas of practice where the provider was not meeting the regulations. These were in relation to management of people's medicines, handling of complaints and care workers not staying the full amount of scheduled time to carry out all the required care tasks.

Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: We will ask the provider to submit an action plan which outlines what they will do to improve the service and by when. We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Inspections will be carried out to enable us to have an overview of the service, we will use information we receive to inform future inspections.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

All Care (GB) Limited –High Wycombe Branch

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was carried out by two inspectors on the first day and one inspector on the second and third days. Two experts by experience made telephone calls to a sample of people who used the service, on 29 and 30 April 2019. 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 area of expertise was care of older people and dementia care.

Service and service type:
This service is a domiciliary care agency. It provides personal care to people living in their own houses. It provides a service to older adults and younger adults with disabilities.

The service is required to have a registered manager. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was announced. We gave the provider two days' notice of the office visit, to make sure someone would be available to assist us and to allow access to records and systems. Inspection site visit activity took place on 25 and 26 April 2019 and 8 May 2019.

What we did:
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.
We reviewed notifications and any other information we had received. A notification is information about important events which the service is required to send us by law.
We contacted community professionals, to seek their views about people's care.
We spoke with the registered manager and five staff members in a range of roles.
We contacted 44 staff by email and invited them to provide feedback about the service. A further seven staff were contacted after the inspection. We received five responses.
We spoke with 16 people who used the service and 13 relatives.
We checked some of the required records. These included eight people's care plans, medicines records, six staff recruitment files and staff training and development files. Other records included policies and procedures, auditing reports and complaints.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment:
• People told us they did not receive a reliable service. Comments about timing of care visits included "Never on time. (We're) sent every Tom, Dick and Harry, (there's) no consistency. (We've been) let down three to four times a month" and "Times are erratic. I haven't been given specific times. The lunch call can be any time between 11.30 a.m. and 1.00 p.m." Other people told us "Times are all over the place. (They are) quite often late. (It is) very rare for them to be on time. (The) last call can be between 4.00 p.m. and 7.00 p.m. (There are) lots of different carers. Mum has dementia so would be better if there was consistency," "(They) missed one day recently, (they) didn't call. I often get her up as she doesn't want to wait for them to arrive to get her washed and dressed." A further person commented "There have been times when they have not turned up at all or just one comes. I've told them not to bother if they only have one but he gets anxious. He doesn't always want to get up but if he does he needs two (care workers)."
• People told us staff did not always stay the agreed length of time. Comments included "They (carers) are very, very quick and are supposed to be here for 30 minutes but they are usually gone after ten. There are never any apologies but it is not the girls' fault" and "They sometimes give me a slapdash wash and take just 10 minutes when it is supposed to be 30." A relative commented "Their time keeping is not good. The visits are supposed to be 30 minute calls but you have no idea who has been in and what has happened, there is no book to record these things." They added "Once when we were with her they were supposed to stay 30 minutes but they had been and gone in seven minutes." Another relative said "It makes me cross that I will still have to pay for 45 minutes when someone has been in and gone in ten minutes and hasn't helped him with what needs to be done."
• Computer records at the service showed discrepancies in the amount of time care workers spent in people's homes compared to the scheduled length of time. For example, records of staff log in and out times showed 31 occasions out of 72 when care workers left 10 minutes or more before the scheduled end time. In some cases, the records showed care workers had been in people's homes for one, seven, eight and 11 minutes for visits scheduled for 30 minutes.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as care was not always provided in a safe way.

• Some of the shortened calls were attributed to care workers not using the logging in and out procedures correctly. We have shared this information with the local authority contracts' department. We were shown examples of letters sent to care workers by the registered manager, to remind them about the procedures for logging in and out.
• Where unplanned care worker absences occurred, we observed care co-ordinators attempted to cover the call with another member of staff.

• The service used robust recruitment practices. Checks included written references, proof of identification and a check for any criminal convictions.

Using medicines safely:
• Care plans identified where the service was supporting people with their medicines. Medicines administration procedures were in place to provide guidance for staff on safe practices. Staff were assessed to make sure they were competent to administer medicines.
• People who received support with their medicines told us they had some concerns. Their comments included "Timings don't work. There should be three hours between medications but they can come late for one visit and early for the next .This does cause concern," "He should have his meds at 8.00 a.m. but they're not always on time. (There's) no chart at home so (we) can't always check, everything is logged on their phones" and "Not given on time. He is on (medicine to treat symptoms of Parkinson's Disease). He did have an episode where an ambulance had to be called. I do wonder if it was due to his medication."
• Records were kept of when medicines had been given to people. Computer records showed some occasions where people who required medicines more than once a day were given them at intervals which were too close together. For example, a medicine to treat persistent pain was prescribed to be given four times each day. We saw records of it being given at an interval of less than three hours from the previous dose time. This could result in unintentional overdose.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as medicines were not always managed in a proper and safe way.

Preventing and controlling infection:
• There were infection prevention procedures in place to guide staff on good hygiene practices.
• Staff undertook training on infection control as part of their induction.
• Staff had access to personal protective items, such as disposable gloves, aprons, hand gel and shoe covers.

• Care plans and risk assessments were in place where people had infections. This information was highlighted in red to make sure it was clearly visible. Alerts were in place on the mobile devices care workers used, to make sure they knew of the infection risks before care was carried out.
• Some people told us they had concerns about hygiene practices and the condition in which care workers left their homes. For example, feedback included "(They) leave waste bins overflowing, don't dispose of used (incontinence pads) properly. It's basic hygiene" and "(Family member) is just wiped, not washed. Not good when they've been in pads all night. If there is just one carer, they can't wash her properly." Other comments included "The poorer ones often leave things in a mess when they go. They do things like leave the porridge in the microwave and the kitchen in a mess and just rush off." A relative told us "One carer came and simply stripped him down, then put on his clothes and did not even bother to shower or shave him. One lady came and did not know what she had to do, I told her that you have to shower him, and she said 'I don't do showers'."
• We recommend further training and monitoring takes place of infection control and hygiene practices.

Systems and processes to safeguard people from the risk of abuse:
• There were procedures for staff to follow to safeguard people from abuse. Staff received training on safeguarding as part of their induction. This training was updated annually. The registered manager and regional operations manager had attended the local authority's safeguarding training for managers.
• Staff demonstrated awareness of when to raise a safeguarding concern to the local authority. We saw posters displayed around the office and training room on who they could contact in the event of being made aware a person may be at risk from abuse.
• Appropriate referrals were made to the local authority safeguarding team, when required. This was

followed up by notification to us.

Assessing risk, safety monitoring and management:
• Risk assessments had been written to identify and reduce any risks to people's safety and welfare. These included areas of practice such as moving and handling, people's home environment and nutrition. Appropriate measures were put in place where risk assessments identified potential hazards.
• Risk assessments were reviewed and updated to reflect people's changing circumstances.
• Staff were trained in safe moving and handling practices, first aid and health and safety.

Learning lessons when things go wrong:
• Staff took appropriate action if people had accidents or were unwell. For example, ambulances were called, they informed relatives and made people's houses secure if they needed to be taken to hospital.
• The service received information about national and local safety alerts, so action could be taken, if required.
• The provider and registered manager complied with any requests made by the local authority or CQC regarding enquiries or investigations.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Good: People's outcomes were consistently good, and people's feedback confirmed this.

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. Applications to deprive a person who is supported in their own home need to be made to the Court of Protection. We checked whether the service was working within the principles of the MCA.

Ensuring consent to care and treatment in line with law and guidance:
• People were supported by staff who had received training in the MCA. The registered manager told us "Staff really enjoyed the MCA training."
• We were informed and could see from records some people were living with mental health issues and different types of dementia. We asked the registered manager if their capacity had been assessed, to agree to the support provided. After a check was made, it was confirmed that no assessments had been carried out for these people.
• One person's records showed they lived with a dementia and had been resistant to receiving support with personal care. The registered manager and care supervisor told us the family were insistent care workers supported the person, even when they had refused to be supported. We checked if a MCA assessment had been undertaken. There was no record of this being done. The service had not ensured it routinely and consistently followed the code of practice of the MCA.
• Some assessments were in place for other people, but they were for people who had mental capacity and did not require an assessment. We discussed this with the registered manager. They advised all the assessments we were shown were prior to staff understanding when assessment was needed.
• We discussed our findings with the registered manager who later advised us they had arranged for further training for staff on the MCA.
• We were told some relatives had Lasting Power of Attorney (LPA). The service had not obtained copies of these for the sample of people we checked. They said some relatives had been reluctant to provide this information, despite it being a legal document to be shared with appropriate agencies and services. This meant the service had not satisfied itself it always consulted the right persons who had legal authority to make decisions on behalf of others. We acknowledged they had obtained copies of LPAs for some other people who used the service and were shown an example of this.
• We recommend the provider seeks guidance from a reputable source on how they can support staff to

ensure the code of practice of the MCA is fully understood and followed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• A full care needs assessment was carried out before people started to use the service. The assessment gathered information about the person's physical and mental health, communication and social history, as examples.
• Where the assessment identified a need for equipment, this was in place prior to care starting. For instance, one person used two pieces of equipment to help them move position, depending on their level of independence on the day. There was guidance for staff on which piece of equipment should be used when.
• Assessments identified any individual needs which related to protected characteristic identified in the Equality Act 2010. For instance, preferred language, faith, religion, and cultural considerations.
• The service received all referrals from the local authority. The service worked closely with the local authority to respond to referrals in a timely manner. The service had a referrals co-ordinator who managed this process.

Staff support: induction, training, skills and experience:
• Staff received initial training the provider considered was mandatory. All staff attended a four day theory-based training course. New staff were expected to complete the Care Certificate. The Care Certificate is a set of nationally-recognised standards all care staff need to meet. The standards include communication, privacy and dignity, equality and diversity and working in a person centred way, as examples.
• New staff were allocated to a more senior member of staff who provided line management and worked alongside them until they were assessed as being able to work alone. A care liaison role had been created so that new staff had someone to contact as a point of reference.
• The service had access to an internal trainer who was able to offer bespoke training if additional training needs were identified. For instance, one member of staff required additional training in the safe administration of medicines.
• Staff had access to support from a line manager at all times. The provider operated an 'on call' managers rota. We saw from records staff would seek support from the on call manager as needed.
• Staff received support through face to face and telephone supervision sessions. Skills were checked as part of 'spot checks' of them whilst they worked in the community. We could see staff had regular opportunities to meet with their line manager as part of their professional development.
• There were mixed responses from staff about the support they received. One care worker told us "I don't feel very supported…I have had many different supervisors…when I put in a call to the office to advise of issues with clients etc, (I) am often told I will get a call back and do not receive a call back." Another said support "Varies. Sometimes slow to act on concerns I have on clients." Other staff spoke positively. One said "I am very supported in my line of work…they make the time to take any concerns or issues raised by myself and follow through," another said "Very good."

Supporting people to eat and drink enough to maintain a balanced diet:
• Not everyone who used the service needed support with their nutrition and hydration needs. Where this was part of their care package, information had been recorded as part of the care plan, to outline their requirements.
• Care workers were made aware if people had specific dietary needs. For instance, one person was at high risk of choking and required all food to be soft and fluids to be thickened. This was highlighted in the person's care plan. Guidance was available to staff on how fluids should be prepared.
• Where people remained in bed, staff were reminded to leave drinks and snacks within easy reach.
• People told us care workers heated microwave meals or made sandwiches and drinks for them.

Staff working with other agencies to provide consistent, effective, timely care:

• When people were admitted to hospital, a care supervisor would keep in contact with family members and healthcare professionals, to ensure their needs could be met on discharge.
• Changes to people's care packages were communicated to care workers so they would be aware of revised requirements.
• Handovers took place from the on call managers to office staff, so they were kept up to date with any issues which occurred out of hours.

Supporting people to live healthier lives, access healthcare services and support:
• The service worked with community health and social care professionals where needs changed or they had concerns about people's welfare. For example, one person had been referred to an occupational therapist for equipment to aid them to move in bed. Another person had been referred to the district nursing service as they had an open wound.
• Some people told us care workers would take appropriate action if they needed healthcare support. For example, a relative said "(I would) feel confident they would act accordingly and contact me." Another said "They did call an ambulance as he was quite unwell." Most people we spoke with did not have experience of this as they had either not had any healthcare issues or lived with a spouse or partner who would make arrangements.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity; Respecting and promoting people's privacy, dignity and independence:

• We received mixed responses to whether people felt they were treated with respect. Some people spoke positively. For example, "Absolutely, no problems on that count," "Yes, he's treated with respect and dignity. He likes things done his way and they oblige," "One is very nice, calls dad 'sir'" and "On the whole they are okay. We have both male and female care workers, always respectful."

• Other people expressed some negative experiences. For example, one person said "They talk to each other in their own language, which is not respectful." Another commented "They're not respectful. They get away with the bare minimum. The quality of care is not up to expectation" and "Sadly lacking." One person said "We don't get a choice of carer, they send anyone. No consideration to mum's culture."

• We received mixed responses when we asked about privacy, dignity and being supported to be independent. Some people were critical of the service. For example, "Mum…needs two people. Quite often just one turns up and when we query it they say they haven't got a second person. This impacts on mum as it means she is unable to get up. It would be good if they could let us know. It happens quite regularly." Another relative told us "He doesn't have to be bed bound. They said they didn't have a sling for the hoist. It was under the bed with (other personal care items). How couldn't they see it? Just can't be bothered." A further relative said "My (family member) called at 10.30 to ask where the carers were. When I contacted them I was told they had not got anyone available. He is bedbound unless the two carers turn up. There's no communication, they never contact you."

• Other people spoke positively of the service they received. A relative said their care worker had been a 'Godsend.' "She really has gone the extra mile. The shampoo I was using was sometimes stinging his scalp but she suggested (name of mild shampoo) and I get it now on her advice and it is so much better." Another person told us "There are some much better carers. (Name of care worker) is very good and she can't do enough for me." Other comments included "I am as happy as Larry with the good carers," "The three (care workers) we have are fantastic" and "There are lots of different carers but they all know what they are doing."

• Records showed the service worked with relatives in an integrated way. For example, it was clear in care plans where family members supported the person with part or all of the tasks involved in medicines management and if the service had any role in this.

• Care plans were written in a dignified way. For example, one person's care plan contained the following, "Please give me reassurance when I am anxious or have any concerns regarding my emotional well-being." It went on to say "I can become unco-operative and anxious, during these times carers are to stop for a few minutes to allow me to calm down and then try again. Please also speak to me calmly at all times."

Supporting people to express their views and be involved in making decisions about their care:
• People were sent annual questionnaires by the provider, to ask about their experiences of using the service. We saw people were sent a letter to inform them of the feedback and what action would be taken.
• Only a few people we contacted said they felt listened to and involved in their care. For example, through questionnaires and visits from care supervisors. However, we saw reviews were arranged to discuss any issues people were unhappy about as and when needed.
• Advocacy services were used where this was required. For example, an external support organisation was used to manage some people's finances.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Improving care quality in response to complaints or concerns:
• The service had procedures for making complaints and people knew how to do this.
• We asked people about their experiences of making complaints or raising concerns. This was an area of general dissatisfaction. Comments included "I rang and spoke to (name of supervisor), she said she was very sorry and 'We'll see if we can do better in the future' but to be honest nothing happens and things go on just as before." Another person told us "I'd like them to take more notice about what I tell them…I'd like them to come and see me and then I can explain my problem to them." A relative said "One day I phoned three times. Each person that answered the phone said they would ring back, the third one even said they would ring me back within five minutes but no one rang back at all, ever." Another relative said "I phone them about visit times and all the other things but no one returns the call. I had reason to phone on an important matter...the calls were unanswered and the answer phone switched on." A person who had experienced late visits regularly said "No one from the company has been in touch at all."

This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the service had not ensured proportionate action was taken in response to failures identified by people's complaints.

• Records were kept of complaints and concerns. The registered manager was aware there were common themes to these around missed and late calls. They told us they had changed staffing rotas to try and reduce these issues and they monitored ahead to re-plan any calls, where necessary.
• The registered manager told us the provider and regional operations manager were made aware of all complaints. These were also shared with the local authority and discussed as part of contract monitoring meetings between the service and local authority.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• Care plans were in place for each person. These identified people's needs in relation to a range of areas including protected characteristics under the Equality Act (2010), such as age, disability, ethnicity and gender. They had been kept up to date to make sure they contained people's current care needs.
• Information was recorded in care plans about things which were important to the person and their preferences about their care. This included their likes, dislikes, important contacts and things which made them anxious.
• The Accessible Information Standard (AIS) is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service had assessed people's communication needs as part of their initial and on-going care needs assessments. This included any aids people needed to communicate effectively. For example, whether people wore glasses or required hearing aids.

• People and their relatives would be able to access their records and report any issues on-line when the system went live. It was being trialled at the time of our inspection. We saw part of the technology allowed people to use voice-recognition software which typed their message as they spoke.
• The service contacted other agencies when people's needs changed. For example, GPs and other healthcare professionals. They also contacted the local authority to increase the care package.
• We discussed one person who had not been managing meal times well. The service put food and fluid monitoring charts in place. The length of the call was extended to ensure care workers sat with the person, to encourage them to eat.

End of life care and support:
• The service had provided end of life care in the past. This involved working with other agencies, such as district nurses and hospices, to support people effectively.
• End of life training was available to staff via the in-house trainer.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• The service had a registered manager in post.
• They notified us of certain incidents which had occurred during, or as a result of, the provision of care and support to people. We were able to see from these notifications that appropriate actions had been taken.
• The regional operations manager frequently worked from the office and they and the registered manager were accessible to staff and others.
• Monitoring of the service took place by the provider. This included unannounced 'spot checks' of care workers whilst they supported people in their homes. Other checks included bi-monthly audits, manager reports, annual surveys to people who used the service and monitoring of significant events such as safeguarding concerns, complaints and medicines issues. A mock inspection had been carried out by the provider shortly before our visit. A summary of the findings was shared with us. It did not include the areas for improvement we found.
• New checks had recently been put in place to try to respond to issues raised by people. For example, a 'time critical spreadsheet' had been put in place to track when calls were being made to people where timing was particularly important. This could be because people needed medicines at a set time to manage complex health conditions. It was too soon to see the impact of these changes at the service, as they had only been in place a couple of weeks. The overall feedback we received from people confirmed this. We were also informed customer service training would be taking place soon.
• We spoke with the provider and registered manager about the actions they were considering regarding the UK's extended planned departure from the EU. They had kept abreast of government advice and taken appropriate actions in response to this.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• The registered manager was aware of the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.
• We asked for any examples of where they had applied the duty of candour principles. One example was

forwarded to us after the inspection visit. During the inspection and from people's feedback, there were several examples of where people had not received the care they expected from the service. These could have been managed using the duty of candour principles, to ensure openness and transparency.
• We recommend the duty of candour principles are fully applied at the service, including a written apology, with details of actions taken, to prevent recurrence.
• The staff we spoke with were aware of their responsibilities. A 'carer recognition scheme' had been introduced to acknowledge good practice or 'going the extra mile'.
• Records had been well maintained and were up to date. Policies and procedures had been kept up to date with changes to good practice and legislation.
• Sensitive personal and confidential information was stored securely, to prevent unauthorised access. Computers were password protected.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• Staff knew how to raise any concerns they had about people's welfare. They were advised of how to raise whistleblowing concerns and received training on safeguarding people from abuse. Whistleblowing is raising concerns about wrong-doing in the workplace. Staff told us they would be confident in raising any concerns.
• Staff were supported through supervision systems and received training to meet people's needs.
• Information was shared with staff. For example, through meetings and via mobile telephone technology.
• Staff told us about areas they felt could be improved. These included communication, co-ordination of their schedules so they did not criss-cross the area backwards and forwards, more unannounced spot checks, more team meetings and passing on good feedback to care workers.
• People were asked for their views during care reviews and annual surveys.
• People knew how to contact the office but their feedback showed calls and emails were not always responded to in a timely manner.

Continuous learning and improving care:
• The registered manager kept their learning and development up to date and attended local and provider forums to share good practices.
• There was learning from investigations. For example, staff were re-trained after an incident which involved hoisting. A referral was also made to the relevant healthcare professional and new equipment was put in place, to prevent recurrence.

Working in partnership with others:
• The service worked with other organisations to help ensure people received effective and continuous care. For example, community professionals and the 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 Care was not always provided in a safe way as care workers did not stay the agreed amount of time to fully support people's needs. Medicines were not always managed in a proper and safe way as the timings of care worker visits were inconsistent and did not ensure people received their medicines at the prescribed frequencies.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service had not ensured proportionate action was taken in response to failures identified by people's complaints.