Nestor Primecare Services Limited

Allied Healthcare Leeds

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 inspected Allied Healthcare Leeds on 3, 8 and 24 August 2016. This was an announced inspection to ensure the registered manager would be present to provide us with the information we needed. The service was last inspected in July 2013 and they were meeting the regulations inspected at the time.

The service is registered to provide personal care to people living in their own homes. The service provided a variety of support to people such as those to people nearing the end of life, support for people with long term complex health issues, support to people when their family/ carer required respite from their caring duties and everyday personal care for people in their own homes. The people who required support for complex health issues were supported by nurses employed by the service to assess their needs and provide training to care workers. At the time of the inspection 222 people were receiving a service.

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

Systems in place for the management of medicines were not robust enough to ensure people received their medicines safely as prescribed.

There were systems and processes in place to protect people from the risk of harm. However the system did not always effectively recognise safeguarding, report safeguarding to the Care Quality Commission (CQC) and it did not always contain a full record of the investigation, outcome and actions to prevent a recurrence.

Assessment of risks to people the service supported and staff members were not always identified and sufficient control measures recorded to provide staff with adequate guidance to keep people safe.

Assessments were undertaken to identify people's care and support needs. However person centred information about how a person wanted their support was not always gathered or recorded in the person's care plan. Care plans did not always reflect the support a person required.

The registered manager and staff we spoke with had an understanding of the principles of the Mental Capacity Act (MCA) 2005. No mental capacity assessments were completed in the development of people's care plans where required. The documentation staff were asked to use did not support them to assess capacity in line with the MCA.

The registered provider had a procedure for staff to follow when a person raised a complaint. We saw this was not always followed. Some people told us they were not sure how to complain but felt confident contacting the office if they had concerns.

The systems in place to monitor and improve the service provided were not robust or effective enough to ensure safety and quality.

Effective recruitment and selection procedures were in place and we saw appropriate checks had been undertaken before staff began work.

There were enough staff employed to provide support and ensure people's needs were met. The registered manager and team in the office told us they worked hard to provide consistency and to prevent missed or late calls for people. People told us this was an area the service did well most of the time.

Staff who provided direct support to people told us they felt supported and had received regular supervision and appraisal. Records we saw confirmed this. However staff who worked in the office had not received the same level of support. The registered manager told us they would work to improve in this area.

Staff training was up to date and staff told us they had received training which had provided them with the knowledge and skills to provide care and support.

People and their family members told us staff treated people with dignity and respect. Staff gave examples of how they supported people in a caring and compassionate way. People we spoke with confirmed staff were caring.

People were provided with their choice of food and drinks which helped to ensure their nutritional needs were met. Staff at the service worked with other healthcare professionals to support the people. Where people had complex health issues plans to manage their needs in an emergency were in their care plans. Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found during this inspection. You can see what action we told the provider to take at the end of this 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.

Systems in place to manage people's medicines and safeguarding incidents were not effective enough to ensure safety for people.

Risks to people and staff members were not always recognised and control measures put in place to reduce the likelihood of harm.

There were sufficient staff employed to meet people's needs. Safe recruitment procedures were in place

Is the service effective?

Requires Improvement

The service was not always effective

The Mental Capacity Act 2005 was not used during assessment and care planning to ensure decisions were made in people's best interests who lacked capacity.

Staff told us and records confirmed they had enough training and support to enable them to perform their role well. However staff working in the office required more support.

People were supported to maintain good health and had access to healthcare professionals and services.

Is the service caring?

Good

This service was caring.

People told us they were well cared for. People were treated in a kind and compassionate way.

People were treated with respect and their independence, privacy and dignity were promoted.

The staff were knowledgeable about the support people required and about how they wanted their care to be provided through the relationships they had built with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans needed were not person centred. Care plans did not always contain all the information gathered during assessment.

People we spoke with were not always aware of how to make a complaint or raise a concern.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to ensure quality and safety were not robust or effective.

Staff were supported by the registered manager and could have open and transparent discussions with them and the team in the office.

People who used the service had opportunity to feedback their views via an annual survey.

Allied Healthcare Leeds

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 checked 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.

We inspected Allied Healthcare Leeds on 3, 8 and 24 August 2016. This was an announced inspection to ensure we could access the information we required.

The inspection team consisted of two adult social care inspectors and one 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. The expert by experience made telephone calls to people who used the service and family members to find out their views on the care and service they received. One of the adult social care inspectors contacted staff members by telephone to discuss their experiences and the other inspector visited the office base on the three dates outlined.

Before the inspection we reviewed all the information we held about the service, which included information we had received about safeguarding and information reported by the registered provider through statutory notifications. We contacted the local authority and Healthwatch to find out their views of the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The registered provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. All of the information gathered was used to plan the inspection visit.

During the inspection we spoke with 11 people who used the service or their family members / representatives. We spoke with the registered manager, care delivery director, head of regulation and compliance, two nurses, two care delivery managers, trainer, practice development nurse, a rota scheduler and 12 care staff. We looked at eight people's care records, including care planning documentation and medication records. We also looked at 11 staff files, including staff recruitment and training records, records

relating to the management of the service and a variety of policies and procedures developed and implemented by the registered provider.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems the registered provider had in place to ensure people received their medicines safely as prescribed.

People had a medication administration record (MAR). The MAR's we saw did not always contain the information staff needed to ensure they administered medicines as prescribed safely. For example, We saw on one occasion a person's prescribed medicine was not recorded. We saw some gaps on peoples MAR's which meant people potentially had not received their medicine.

People prescribed 'as and when required' (PRN) medicines did not have protocols in place with full instructions for administration. The registered provider's medication administration, management and record keeping procedure which was undated said 'PRN. A specific plan for administration must be recorded in the care plan and detail kept with the MAR chart that is clear how to give the medication as intended.'

We saw on one occasion guidance in the person's care plan regarding a medicine differed from guidance on the MAR.

Where people were prescribed creams and lotions we saw topical medication administration record (TMAR) were not in place. The branch trainer showed us a copy of the registered provider's TMAR which had been shown to staff members in training. However, the document was not used in any of the records relating to medicines we saw.

The registered manager told us MAR's were collected and returned to the office at least six monthly for audit so they could assess if people had received their medicines as prescribed and whether staff were completing documentation appropriately. Of the MAR's we looked at audits had not always been completed as frequently as the registered manager told us they should have been. For example one person had no MAR's on file in the office since November 2015. Staff members who completed MAR audits did not always pick up on the issues we identified such as gaps on MAR and lack of protocols for PRN medicines.

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

Staff members we spoke with told us they had received training and competency checks around safe administration of medications. Records we saw confirmed this.

We spoke with people who used the service who required help from staff to administer their medicines. People did not report any problems and advised care workers were reliable. One family member told us "My relative needs their tablets at certain times and they always get done on time."

We asked people who used the service if they felt safe. A person told us "I get my medication on time and I

do feel safe when they [care workers] are in my house." A family member said, "My relative does feel safe, the lasses are very good with them" and "I am very happy to have the carers here looking after my relative I have no problems about safety."

We asked staff about their understanding of protecting people who used the service from abuse. Staff were aware of the different types of abuse and what to do if they witnessed any poor practice. The registered manager was aware of local safeguarding protocols. Staff told us they had received training in respect of abuse and safeguarding of vulnerable adults. Records we saw confirmed this. One staff member said "We are aware of what to do if we have any concerns over people and their safety."

We looked at the registered provider's electronic reporting system which included information about the number of concerns raised in the service. We saw nine incidences of safeguarding were recorded on this system for the 12 months prior to our visit. We looked at the detail and saw some of the concerns logged as safeguarding were not and had been recorded incorrectly. Some that were clearly safeguarding had not been reported to CQC through statutory notifications. This meant the registered provider had not always notified the CQC of safeguarding incidents.

We looked at accidents and incidents on the electronic system and saw two incidences of safeguarding had been recorded as incidents incorrectly and therefore did not show on the registered provider's report which listed the number of safeguarding's. This meant the registered provider did not have a full account of safeguarding and therefore could not assess patterns and trends or ensure plans were in place to prevent a recurrence.

We saw when concerns had been raised a full account of the investigation and outcome was not always robustly recorded. Also actions to prevent a recurrence were not always put in place. For example where a staff member had been disciplined following a concern the outcome letter and sanction was not available and the registered manager had no investigation file to view. On another occasion a person required a change to their care plan following a concern and the registered provider did not know if this had happened because no care plan was kept in the office for the person.

The electronic system required incidences to be signed off by senior staff and they had signed off the records on occasion when they were incomplete, recorded incorrectly and for some which had not been reported to the CQC.

This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Visual checks were carried out on gas and electrical appliances in people's homes to make sure they were safe for use. During assessment other checks included checking the lighting and finding out if the person smoked and checking for clutter which could be a fire or falls risk. The registered manager told us equipment such as hoists would be checked to ensure they had been serviced and were fit for use. We saw evidence of this was not always recorded in peoples care plans.

We saw the assessment documents used did not always contain correct or full information. For example, one person was not able to evacuate independently if there was a fire and the section for the assessor to record the action staff must take was left blank. On another occasion the pathway was recorded to be in good condition but in the action section the assessor had recorded the paths were overgrown and could be slippy with loose paving slabs. This did not provide staff with all the information about the environmental risks they may find in a person's home to prevent harm to people and staff members.

There were risk assessments in place for people who used the service. The registered provider had just started to introduce a new care plan system following feedback that the old system was too lengthy and complicated. We saw the new system signposted assessors to supplementary assessments. However the new system had no sign posting to further assessment for example in pressure area care or falls. We spoke with the head of regulation and compliance who told us they would use our feedback to review documents in September 2016.

We saw three different versions of care plan and risk assessments which staff members were actively using. In each of them we saw gaps in the assessment of risk and control measures required to keep people safe. For example, on day one of the inspection we saw in one person's care plan it did not identify to staff the person was at risk of choking and how to support them to eat and drink in a safe way. We requested a review of the person care plan and on day two a new care plan had been formulated with more detail in this area.

For another person we saw they were at risk of malnutrition due to poor appetite and recent weight loss. The screening document asked the assessor to refer a score of three or more to the branch manager registered manager but this had not occurred.

Some people who used the service relied on staff to support them with their shopping. People we spoke with confirmed staff always provided them with receipts for their shopping and counted out their change. We saw in one person's care plan they had consented to staff using their bank card to access their monies via the bank machine. We noted in the registered provider's customer money procedure dated June 2014 it clearly stated managers must 'ensure that alternative solutions are sought to support customers being able to access their money so that care workers do not use the customers personal pin numbers'. The risks and control measures around finances were not recorded to protect staff and the person if this situation had been authorised to happen.

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

We saw the service used an initiative called 'early warning system' (EWS). This was a list of things care workers should look for to know there may be deterioration in a person's health and wellbeing and a change in support or medical advice maybe required. We saw staff recorded they had checked a person's EWS when recording their visit. We saw incidences where staff recognising an EWS had led to them contacting the office and seeking a re-assessment for a person they supported.

During the inspection we looked at the records of six newly recruited staff to check the registered provider's recruitment procedure was effective and safe. Evidence was available to confirm appropriate Disclosure and Barring Service checks (DBS) had been carried out to confirm the staff member's suitability to work with vulnerable adults and children before they started work. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults.

References had been obtained and where possible one of which was from the last employer. Any gaps in potential staff's employment history were discussed at interview to determine their suitability to work in the service. This meant the registered provider followed safe recruitment procedures.

The registered manager told us the service employed 172 staff. This included the registered manager, care workers, care quality supervisors, care delivery managers, rota schedulers and administrators. The registered manager told us there were enough staff employed to meet the needs of current people who required support because the team of care workers were flexible enough to work across the different service

areas. We were shown data by a care delivery manager which showed in the 12 months prior to the inspection 78 calls had been missed by the service. The registered manager told us on average the service delivered 3342 visits each week. Therefore the percentage of missed calls in 52 weeks equates to less than one per cent.

Where a missed call occurred this was logged on the electronic system and checks to ensure the person was safe were made. The care delivery manager told us no checks were made on late calls but a new system was due to be introduced which would allow this to happen in the future.

We spoke with a rota scheduler who explained travel time was automatically built into the system between calls and where more time was needed they also built this in. If the service received feedback from staff members and people/ family members when calls were not working, they worked together to look for a solution. Staff members we spoke with in the office described examples of people and their family members who had worked with the team in the office to adapt and negotiate their package of care.

We received feedback from staff members about the volume of changes to their rota and requests to support calls across the branch. One staff member said "We do need more staff" and "We are really busy but we never miss a call." We discussed this with the registered manager who told us they worked continually to recruit, induct and retain staff. They explained they worked with the registered provider to look for incentives to retain staff and they had changed their induction to be more supportive which had helped to improve retention of staff. The registered manager told us new contracts of work also impacted on the care workers week.

People we spoke with during the inspection said staff mostly turned up on time and stayed for as long as they were expecting them to. The 2016 survey conducted to seek people's feedback also stated the punctuality of carers and having the same carers in a team supporting each person was an area where the service was doing well. One person told us, "Barring a blizzard they come on time and the only time they were really late I was told they had a medical emergency at a previous address. I am very happy with them" and "I have a package of 24 hour care, I know who is coming because I get the rotas and it tells me when and what shifts they are doing."

Requires Improvement

Is the service effective?

Our findings

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.

We looked at people's care plans and saw the MCA was not used when assessments and care plans were developed. We saw documentation asked for people to sign consent to care and treatment form and only those people with capacity should have signed this document. Where it was felt a person did not have capacity the document asked the staff member to highlight why and prompted the staff member to ask a representative to sign on the person's behalf. It did not prompt staff to complete a formal assessment of capacity to make the judgment and it did prompt staff to complete a best interest decision to decide who should sign the document in the person best interest as the MCA requires.

We saw on occasions families had signed the consent forms with no MCA or best interest's decision and on one occasion a family had signed even though the person had capacity themselves. We saw no evidence of decision specific MCA assessments around more complex decisions such as a person's understanding of medicines they needed to take for health conditions.

When we spoke with staff they had a basic knowledge of the MCA. All staff understood they needed to gain consent when supporting a person with their care and also how to respect a person's right to refuse care.

The new care plan documentation we were shown by the registered provider on day three of our visit had a new consent form. The new form asked the assessor to complete some questions about the person's level of capacity. It asked staff to think about dementia as a condition which could affect capacity and not the range of other impairments of the brain which could affect a person's ability to make their own decisions such as a learning disability or brain injury. We told the head of regulation and compliance about this and how it did not support staff assessing people's abilities to understand the process outlined in the MCA. The head of regulation and compliance told us they would review this document.

This evidence above demonstrated a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014
Staff we spoke with who delivered support to people told us they felt well supported and they had received regular supervision which included an annual appraisal. Records we saw confirmed this. One staff member told us "Yes they are good with that; we have spot checks, supervisions and appraisals."

We spoke with staff who worked in the office and they told us their supervision and appraisal was not regular. Records we saw confirmed this and we saw one staff member had never received any supervision or appraisal since 2014. Staff told us the registered manager did meet with them informally but they would prefer a more formal system to support them. The registered manager agreed the registered provider's

policy around staff supervision had not been implemented for office staff and this was something they would look to put in place.

People told us they were confident staff had the skills and knowledge to support people with their specific needs. One person told us, "I think they are trained [name of staff member] and [name of staff member] who come are wonderful." A family member told us, "Oh yes the standard of training is good so much so that one of the girls who looks after my relative has now become a trainer and is showing others how to do the job."

The care delivery director showed us staff training information. We saw from the information all staff training was up to date and those people who did not have up to date training were absent from work for various reasons which included sickness. The care delivery director told us those staff would receive training upon their return to work.

We spoke with staff about training they had undertaken, and all confirmed the training they received was good. One staff member told us, "We do a good job and have all our training, it is one of the best agencies for training" and "I didn't feel confident using a piece of equipment and I asked for more training and they made sure I had this."

The registered manager told us about an induction they used called care coaching. They told us this was where following classroom based induction a trained member of experienced staff supported a staff on induction by showing them what they did (I do) and then they completed tasks together (we do) and finally the new staff completed tasks alone and were observed to be competent (you do). This induction linked to the care certificate which sets out learning outcomes, competences and standards of care that are expected.

The nursing staff we spoke with told us they had regular clinical supervision from the nursing supervisors and clinical lead. We saw records to confirm where staff provided clinical interventions, such as support for people to breathe through a ventilator, that staff had been trained and assessed as competent in each tasks. These ensured clinical tasks were completed safely.

The service provided support to people at meal times. Staff told us they encouraged and supported people to have meals of their choice. An' early warning system' staff used to highlight issues with people's health meant they always reported any concerns they had noticed with people's nutrition and hydration.

The registered manager and staff we spoke with during the inspection told us they worked with other healthcare professionals. Where people required support at the end of life staff told us they were in contact with the hospice staff for advice and community nursing teams to ensure people were comfortable. One family member told us "I don't think they could improve the support we are very happy. My relative was very poorly and with the help of Allied I am reassured my relative is being looked after. It gives me huge peace of mind and they have made a huge recovery with their help."

We saw in the care plans for people with complex health needs the nursing team had outlined emergency interventions for people at high risk of deterioration due to their conditions such as epilepsy and breathing difficulties. These documents provided staff with a step by step guide of how to intervene in those circumstances.

Good

Is the service caring?

Our findings

People we spoke with were complimentary about the care and service received. One person said, "The carers are excellent" and another person said "The staff are absolutely fine with me, I have no problems with them" and "They [care workers] are very good if I didn't have them I would go potty. They are wonderful and caring and if they were not I would tell you."

The registered manager told us there was a person centred approach to the support people received and this was evident in the way the staff spoke about people who used the service. Staff spoke with kindness and compassion and were highly committed and positive about the people they supported. A majority of staff knew and understood the individual needs of each person, what their likes and dislikes were and how best to communicate with them through the relationships they had built working with them. A staff member told us "One person I support has dementia; a letter came through for them which they did not understand so I supported them with my manager to go through it." Another staff member told us how they supported a person to communicate through eye pointing and finger pointing to make choices as they were unable to communicate verbally. The staff member told us "I always consult the person before an activity so they choose."

Family members told us about the positive relationships staff members had with people for example, "The staff are very caring, respectful and they are very patient with my relative, I would say they look after my relative like family" and "My relative has a good laugh and a chat with carers because they know them all very well and carers are very sociable." Also "It is very good they are really good with my relative making them laugh and it can be difficult at times because my relative has a cognitive problem and can shout and swear, but it is like water off a duck's back to the carers; they are brilliant with my relative. There is always laughter in the house."

People's diversity, values and human rights were respected. It was clear from our discussions with staff the values of respect and dignity underpinned the work they carried out with people. One family member told us how staff maintained their relative's dignity and privacy, they said, "They do respect their dignity by leaving the room when they are changing or showering and some of the female carers are not hands on because it is a cultural thing and they respect that." Another family member said, "They do respect my relatives privacy and dignity they [care workers] ask what they want and whether they can do things on their own and they are very good with my relative."

One staff member told us an example of how they respected one person's privacy when they had visitors to their home. A family member told us an example of the service providing Punjabi speaking staff to their relative to meet their needs.

We saw the results of the 2016 customer satisfaction survey completed in June 2016 and the results highlighted the service was doing well around 'carers treating customers with dignity and respect'.

People we spoke with told us how staff were supportive of their independence. One family member said,

"My relative is 97 and wants to be independent and it was a struggle getting them to agree to care. Staff do all sorts for my relative but they also let them do as much as they can for themselves." Staff confirmed they promoted people's independence and one staff member told us "I support a person to do things for themselves, like walking, making cheese and crackers, washing up and answering their door. I am there if they need me though."

We discussed with staff members the support they provided to people as part of the end of life service. They told us about the additional training they had received to enable them to feel confident in their role and to ensure people were pain free and comfortable during this period of their life. Staff members said "You have to be delicate, more caring and I have had training in this. Make people as comfortable as possible" and "People get the full quality care they deserve. We listen to them and talk to them and make them feel at ease."

Staff told us how the end of life service is not necessarily time limited, they told us they have a list of people to visit and they spend as much time as needed to ensure people were left comfortable and pain free before they moved onto the next visit. One staff member told us how the care they had delivered to one person which had been observed by family had motivated the person's relative to join the team once their relative had passed away.

Requires Improvement

Is the service responsive?

Our findings

People and their families we spoke with told us staff knew them well and were responsive to their needs. One family member said, "My relative has a group of the same staff who come and the staff think my relative is wonderful and my relative gets on with them so well, I can't knock them they are absolutely wonderful." And another family member told us "Staff are caring, we have got some fantastic outstanding people, they provide choice, independence and control to people."

Staff could tell us detailed information about people's likes and dislikes and how people wanted their support to be delivered for them. This meant staff had person centred knowledge about people. All staff were clear about treating people as individuals one said, "I have had training on person centred care, and I treat everyone as an individual. I have taken one person out to a place they used to work and they loved it reminiscing."

We looked at eight people's care plans and saw the person centred information staff knew about people was not always recorded in their care plan. We saw assessments did not always gather person centred information needed for a person's care plan and we saw on occasion information was not transferred from assessment into the care plan for people. For example; in one person's assessment from their care manager it stated the person was a heavy smoker and in their care plan this was not mentioned.

Detail within the care plan did not always provide staff with the information they needed to care for a person. For example; one person's care plan told staff to 'assess customer's own ability if providing any support'. This meant the staff did not know the person's current abilities and what skills they should be promoting the person to use to remain independent. In another person's care plan the access to the house section was blank but in the morning call description a detailed agreed plan was described which must be followed. Documents not conveying the same information may lead to a staff member providing support which had not been agreed to.

Staff told us they would like more detail about people's history and life story to help get to know them and they also told us they completed their first visits at times without a care plan in the person home. In these circumstances they told us the staff from the office would let them know people's needs.

People told us they were involved in developing their care plans and office staff regularly asked if their plan of care was working. However the care delivery director provided us with information from the registered provider's system which told us 106 peoples care plans out of 222 were out of date in line with the registered provider's policy. This meant the registered provider had not reviewed peoples support as per their policy and there was a risk the care plans in place did not contain relevant and up to date information.

We discussed the care plan system with the registered manager and care delivery director. On day three of the inspection they had secured the support of the practice development nurse. Their role would be to work with the branch to coach the staff members who complete assessments and review all of the peoples care plans over a three to six month period. They felt this would mean long term sustainability for service to

implement the new care plan system. They told us the work would include an audit cycle per person to ensure care plans were up to date and the quality was robust in the future.

This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) 2014

We saw from the registered providers electronic records system 64 complaints had been received by the service since July 2015. We saw the complaints were logged by type such as communication, continuity and late/ early calls.

We looked at three complaints records and saw the registered provider's complaints process had not been followed. The complaint's policy dated May 2013 outlined people complaining must receive an acknowledgement within two days of raising a complaint and a response within 28 days. For the complaints we looked at this had not happened.

We looked at the welcome document people received when they started using the service. The document contained the manager's details and told people to get in touch if they had any queries. The document did not state specifically how to make a complaint or the process. The results of the customer satisfaction survey completed in June 2016 also highlighted and area to improve was 'raising awareness of how to make a complaint'.

People we spoke with did not all know how to make a complaint but knew they had the office number and presumed they would contact the office. One person told us they had complained about the office changing their calls times and they told us this was resolved to their satisfaction.

The care delivery director told us no formal oversight regarding the patterns and trends of complaints was completed by the registered provider. This meant any preventative actions which could reduce complaints had not been identified.

This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Requires Improvement

Is the service well-led?

Our findings

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems which help providers to assess the safety and quality of their services. We saw checks were carried out on the care plans during review, medication charts, daily notes and care workers performance when they delivered support for people. The registered provider had set frequencies these checks should be carried out and the service had not met the frequency the registered manager told us they should have. For example medication charts had not always been checked every six months and 106 care plans out of 222 had not been reviewed when we visited.

We saw analysis of the safeguarding, incidents/ accidents, late/ missed calls and complaints had not happened, this meant the registered provider was not evaluating and improving their practice following occurrences.

We saw the electronic recording system for complaints, accidents and incidents was not administrated correctly this meant issues were logged incorrectly, corrective actions were not implemented. We saw varying levels of management had signed off records where the registered provider's policies had not been followed and where correct reporting had not occurred to the Care Quality Commission (CQC).

We discussed with the registered manager and care delivery director why the systems in place to ensure quality and safety were not working effectively. They told us about staffing problems in the office where they had multiple vacancies and sickness. The registered manager told us this had led to the focus on ensuring front line staff had support and people received visits they required. However it had resulted in the quality assurance systems not being administered effectively because the volume of tasks required to be completed was too much for the number of staff members they had to complete them. The registered manager told us they were routinely working to cover the vacancies in the team and hence their role was not being completed.

On day three of the inspection the care delivery director had organised additional resources to support the branch and had devised plans for recruitment with the registered manager for longer term stability.

We asked what systems the registered provider had in place to monitor the performance of the branch. The head of regulation and compliance told us the registered provider was looking to implement systems following the removal of the internal audit team from the structure.

A new self-audit tool had been implemented whereby the branch manager completed a tool monthly to assess the performance of their service. We saw the first one had been completed in May 2016 by the registered manager and the service had been rated at 92.4%. However the audit did not pick up the issues we had during our inspection. The care delivery director told us about a new approach whereby a peer audit will take place every six months. This had not started yet.

The systems in place were not effective in ensuring quality and safety for people. This was a breach of

Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014

There was a registered manager in post at the time of our inspection. People who used the service and family members told us the team in the office worked hard and were complimentary about the registered manager and the office team. One family member told us, "The service is excellent I would have no qualms recommending it to anyone else, they look after my relatives needs and are really good with my relative" and "They have got it on point with my relative, we are happy with the structure and the service which I would say is fantastic and better than other companies we have had in the past." One person told us how the office staff relationship had improved for them since one office staff member had left the organisation who they did not feel did their role well.

We found there was a culture of openness and support for staff members. Staff told us they were confident of the whistleblowing procedures and would have no hesitation in following these should they have any concerns about the quality of the provision. A staff member we spoke with said, "I could speak to anyone" and another said "They [office staff] are really good they look after you, I needed a week off and they were really good about it. If I had any problems I would ring and I know it would be sorted."

Staff told us they were kept up to date with matters which affected them. We saw records to confirm staff meetings had taken place. We saw three had taken place since August 2015 alongside memos, letters, and updates sent to staff directly. Staff told us, "I find staff meetings valuable, I have suggested things in the past" and "We attend these every few months and we get to know what is happening in the service." Staff told us they get to see the minutes if they cannot attend the actual meeting.
We asked the registered manager about the arrangements for obtaining feedback from people who used the service. They told us surveys were sent out annually and we saw the results of the June 2016 survey to confirm this. The survey highlighted areas where the service was performing well such as treating people with dignity and respect and areas for improvement such as helpfulness of office staff. The results had only just been collated when we inspected and the registered manager was to develop an action plan to improve where possible.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not contain full and person centred details about how a person wanted and required their support. Care plans were not always reviewed appropriately. Regulation 9 (1) (a), (b), (c)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The systems and arrangements to ensure the Mental capacity Act 2005 is used during assessment and care planning were not robust. Regulation 11(1) (3)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidences were not always recognised, reported or investigated robustly. Regulation 13 (1), (2), (3).

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints When complaints were received the registered

provider's policy was not followed to handle them robustly. People did not have robust information about the complaints process.

Regulation 16 (1) (2)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to ensure quality and safety were not effective or robust. Regulation 17 (1), (2) (a), (b), (f).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems in place to manage peoples prescribed medicines were not robust. Assessment of risk and identification of control measures were not always adequate to provide staff with the information they needed to support people safely. Regulation 12 (1) (20 (a) (b) (g).

The enforcement action we took:

Warning notice