Care Quality Commission

Carlton Home Care Ltd

Carlton Home Care

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Good**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place between 4 and 12 November 2015 and was announced. At the last inspection on 6 January 2014 the service was found to be meeting the requirements we assessed.

Carlton Home Care provides care services to adults throughout the Bradford area. Their main office is based in Shipley. The service provides people with personal care and support to enable them to live in their own homes. Most people who used the service were older people or people living with a learning disability.

A registered manager was in place. However, they were on maternity leave at the time of this inspection so an interim manager was covering the manager's position. 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.

Summary of findings

Accidents and incidents were being monitored and analysed. However, information was not always being translated into care records to ensure care staff had up to date information to ensure appropriate action was taken to mitigate risk.

Our review of records, discussions with staff and people who used the service led us to conclude there were not sufficient care staff available to ensure people received consistent and person centred care.

The records, policies and procedures for managing medicines needed improvement to ensure staff practices and the process for administering medicines was safe.

The provider had appropriate arrangements in place to help reduce the likelihood of abuse going unnoticed and help protect people from the risk of abuse.

Staff received thorough training, on-going support and development to ensure they had the skills and knowledge to provide effective care.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and had a good knowledge of the people they supported and their capacity to make decisions.

Staff supported people to ensure their healthcare needs were met and where support with meals was required helped people to have a healthy balanced diet.

Many people told us they received a good standard of care and provided positive feedback about the staff who supported them. However, people said the quality of carers and standard of care they received was not consistent. Most people said their experience was influenced by staffing issues which led to inconsistencies in the time of their calls and the carers who supported them.

Most people told us staff treated them and their home with respect and dignity. However, as the quality of care staff was variable improvements were needed to ensure consistency in the attitude and approach of care staff.

Care records contained person centred information which demonstrated they had been developed in consultation with people. People told us they felt involved in making decisions about how their care was provided on a day to day basis but were not consistently involved in the formal care planning process.

Records showed and people told us call times were often inconsistent. This meant people did not always receive care and support which was responsive to their needs. People told us this was due to “staff shortages” and the fact the provider did not include travel time on the call run rota, which often caused staff to run late.

Formal complaints were investigated and responded to in line with the provider’s complaints policy. However, where people raised informal concerns it was not always clear what action had been taken to respond to the issues raised. Systems were in place to seek people’s feedback. We saw examples where the provider had taken effective action make improvements based on people’s feedback, however this was not always the case. People told us the management team should be more “visible” and consistently clear about what action they had taken to respond to feedback.

We found the provider’s audit system was not sufficiently robust. We identified concerns with a number of aspects of service delivery including; the management of medicines, staffing, incomplete and ineffective care records. These had not been addressed prior to our visit were not included on the provider’s action plan.

The system for archiving documents was not robust. Some care records contained information which was no longer relevant and other documentation could not be located. Effective systems were not in place to ensure daily notes were checked. This meant important information and changes to people’s needs were not always identified and acted upon.

Staff and people who used the service provided positive feedback about the acting manager. However, due to staffing shortages said they often had to provide hands on care which we saw had a negative impact upon the quality of care records and consistency of management checks.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Care records were not always complete and updated following incidents or changes to people's needs. We were not always able to evidence appropriate action had been taken to respond to, monitor and mitigate risks to people's health and wellbeing.

There were insufficient care staff to ensure people received consistent and person centred care.

The systems in place for managing medicines were not robust and did not ensure staff supported people with medicines in a safe and appropriate way.

Effective systems were in place to help protect people from the risk of abuse.

Is the service effective?

Good

The service was effective

Staff received appropriate training and support to ensure they had the skills and knowledge to deliver effective care.

Staff demonstrated understanding of their responsibilities under the Mental Capacity Act 2005 (MCA) and had a good knowledge of people's capacity to make decisions.

Staff worked in partnership with other agencies to ensure people's healthcare needs were met.

Where support with meals was required care staff helped people to have a healthy balanced diet.

Is the service caring?

Requires improvement

The service was not always caring.

Staff had detailed knowledge of the people they supported. People told us the quality of carers and standard of care was inconsistent. Most people said their experience was influenced by staffing issues which led to inconsistencies in the quality of carers and time of their calls.

Most people told us staff treated them and their home with respect and dignity. However, improvements were needed to ensure consistency in the attitude and approach of all care staff.

People told us they felt involved in making decisions about how their care was provided on a day to day basis but improvements were needed to ensure they were consistently involved in the formal care planning process.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

Records showed and people told us call times were often inconsistent. This meant people did not always receive care and support which was responsive to their needs.

Care records were person centred and detailed, however, they were not always up to date which risked that responsive care was not consistently delivered.

Formal complaints were investigated and responded to in line with the complaints policy. However, where people raised informal concerns or provided feedback about the quality of the service it was not always clear what action had been taken to respond to the issues raised.

Is the service well-led?

Requires improvement 

The service was not always well-led.

The governance systems and processes in place did not consistently ensure the delivery of high quality care.

Staff and people who used the service provided positive feedback about the acting manager, however they often had to provide hands on care which had a negative impact upon the quality of care records and consistency of management checks.

Systems were in place to seek the feedback of people who used the service. However, the provider was not consistent in how it dealt with and responded to people's feedback.

Carlton Home 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.

The inspection to the office took place on 4 November 2015 and we telephoned people who used the service on 11and 12 November 2015. The provider was given 48 hours' notice of our visit because the location provides a domiciliary care service so we needed to be sure that someone would be available at the office.

Two inspectors visited the office and an expert by experience telephoned people who used the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert had experience of supporting and caring for older people and people living with a learning disability.

Prior to the inspection we spoke with the local authority safeguarding team, commissioners and reviewed the information we held about the service. Before our inspections we usually ask the provider to complete 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. On this occasion we did not ask the provider to complete a PIR.

We telephoned three people who used the service and seven relatives of people who used the service. We spoke with six members of care staff, the acting manager and the area quality assurance manager. We looked at four people's care records and other documentation relating to the management of the service such as policies and procedures.

Inadequate

Is the service safe?

Our findings

We saw that accidents and incidents were being recorded and monitored. The information documented on accident forms demonstrated incidents were reviewed by a manager to ensure action had been taken to reduce the risk of future occurrences .We saw examples where the service had made referrals to health professionals following an incident to help keep people safe and reduce risk. However, we found improvements were needed to ensure information to reduce risk was fully communicated to care staff. For example, one person had fallen in July 2015. There were details of the accident and what measures should be taken to reduce the risk of future falls on the incident form. However, this person's mobility risk assessment had not been reviewed since December 2013. This meant it had not been updated following this incident. There was also no other information within this person's care records to show they had recently fallen. We spoke with a member of care staff who supported this person. They were aware of the risk of falls and had a good knowledge of what action they needed to take in order to reduce this risk, however they were not aware that this person had recently fallen. This risked care staff not always having up to date information to ensure appropriate action was taken to mitigate risk.

Our review of care records showed potential risks to people had been assessed in a range of areas including their environment and people's specific care needs. However, the service had not always taken appropriate action to ensure potential risks to people's health and wellbeing were appropriately assessed, monitored and mitigated. For example, one person had been assessed as having a medium to high risk of developing a pressure sore. Their care records stated if any sore areas were identified this should be reported to their relative and district nurse to ensure action was taken to minimise the risk of their skin breaking down. We saw an entry in this person's daily notes made two weeks prior to our visit which stated the skin looked 'sore and red' in one area of their body. We spoke with the acting manager and a member of care staff who supported this person, neither were aware of this. The daily notes with this entry in had been returned to the office but not yet reviewed by a manager and there was no record in the call logs to show care staff had passed this information on to senior staff. This meant this concern had not been picked up and addressed. We spoke with this person's family and they had no concerns about their relative's skin integrity. However, without appropriate records in place the service were unable to evidence they had taken appropriate action to respond to, monitor and mitigate this risk.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the care staff we spoke with told us staff morale was low at the time of our inspection. They told us there were not sufficient carers to cover the calls that needed to be delivered. They were confident people received the care and support they needed. However, they explained this was only because care staff agreed to pick up extra calls which caused them to feel tired and stressed. One staff member told us, "There is just not enough staff to cover all the calls at the moment. The nice, caring staff are being put upon to pick up extra work, which means they are really stressed and tired at the moment." Another member of staff told us, "It's really hard at the moment as we are having to pick up a lot of extra calls. This is causing low morale as some staff feel they are being taken for granted." Staff also told us the manager and care coordinators regularly had to cover care calls which meant they were not always available to provide management support at the office. One staff member told us the service was going through a "staffing transition" and management were "trying their very best" to ensure the quality of care people received was not affected. They went on to say that, "We can see the light at the end of the tunnel as care staff have been recruited, but the past few months have been really hard on us."

Most of the people who used the service and their relatives told us they thought the service was short staffed and this contributed to the problem of staff running late to calls. One relative told us, "Staff ring in sick all the time and nothing seems to be being done about it. When they call in sick there is not enough cover for them which affects the timing of our visits." Another relative told us, "It's a shambles. Sometimes staff just don't turn up because they are sick and don't bother to telephone the office to tell them so my call can be covered. The management office doesn't have a clue what's going on unless I ring to tell them. As far as I am aware nothing is done to hold those staff who let us down to account."

The area quality assurance manager told us five new staff had been recruited and were due to start work in December 2015 and acknowledged that because "quite a

few staff had left recently" this had put additional pressure on the remaining staff. The acting manager also told us they were not taking on any new care packages until staff had been recruited and completed their induction. The area quality assurance manager explained they had recognised there was a problem with staff giving back work and had put a system in place to monitor and address this. However, as this was a new system which had not been fully implemented we were unable to test its effectiveness as part of this inspection.

This was a breach Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked recruitment procedures for three care workers. The files we looked at contained evidence pre-employment checks had been completed. These included disclosure and barring checks, references and checks of identity; however, there was no record of interviews in the files. This meant it was not possible to see what had been discussed and how the decision to appoint the individuals had been made. We discussed this with the area quality assurance manager who said they would ensure the process was reviewed as a priority.

We looked at the medication policy which we found was out of date and referred to previous regulations. The policy applied to administering medication in a nursing or residential care setting and did not contain specific information in relation to administering medicines in people's own homes. This meant care staff were not provided with specific and appropriate guidance to follow to ensure they followed the correct practice when supporting people with their medicines.

Where people were supported with their medicines we saw the records kept were unclear and incomplete. The acting manager and area quality assurance manager told us medication administration records (MARs) were used where staff administered people's medicines. Where staff prompted people to take their medicines if the pharmacy did not provide a MAR the medicines staff had prompted people to take would be recorded within people's daily records. Our review of records showed staff did not always ensure consistent records were kept. This meant we were not always able to establish what medicines people had taken or at what time they had been taken.

We looked at one person's care plan and saw conflicting information about the management of their medication. The medication care plan stated the person was self-medicating. However, at a review in April 2015 it stated the person needed prompting with medication. On another care plan it stated, 'Staff to prompt medication at tea-time and observe [person's name] taking their medicines and check dossette box to see if [person's name] has taken their morning medicines. If morning medicines have not been taken or [person's name] refuses please report to office.' There were no medication administration records so we were unable to check what medicines the person had taken and that staff had followed these instructions. We asked the acting manager and area quality assurance manager what they would do if staff contacted them to inform them the person had not taken their medicines as there was no information about what action should be taken in the care file or in the policy and procedure. They told us they would contact the operations manager, then call 111 and the GP. However, as there was no up to date information in the care file about the medicines this person was taking it would be difficult to establish what medicines had not been taken.

We looked at another person's care plan and found there were no up to date details about the medicines they were taking. The only information about their medicines had been documented in February 2014. The medication care plan stated the person took medicines four times a day, the care plan was not dated. It continued to inform staff the individual liked their medicines put in a small glass and that care staff must observe them taking their medicines. There was no medicines record in place for staff to complete. We looked at the daily records and saw staff recorded they had prompted the person with their medication. We also saw the district nurse recorded information about this person's dosage of warfarin. The acting manager told us care staff had nothing to do with the administration of the warfarin. However, we asked staff about this person's medication and they told us their relative left the morning medication in a "pot" for care staff to give. This meant staff could not check what medicines were in the pot so could not be certain what medicines they were supporting this person with.

The lack of information about people's current medication and recording of medicines which staff were administering

Inadequate

Is the service safe?

and prompting meant the systems for the management of medicines were unsafe. **This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Staff were aware of the protocols to follow in response to medical emergencies or changes to people's health and well-being. Staff also explained there was always a manager available on call 24 hours a day, 7 days a week. They told us whenever they had contacted the on call number they had always received prompt and effective support and guidance.

Staff were clear about what action they would take to protect people and keep them safe. They spoke confidently about how they would identify and respond to any allegations or suspicions of abuse and demonstrated a competent understanding of their role and responsibilities in protecting vulnerable people. Several staff members provided examples where they had identified and reported concerns so were aware of the correct process to follow. Staff told us the safeguarding training they received was "very good." They were also supported by the provider's policies on safeguarding and whistleblowing which provided guidance to help staff identify and respond to any concerns or allegations of abuse. Although contact details for the Commission and Local Authority Safeguarding team were not included in these policies all of the staff we spoke with told us they were aware how they could contact both departments. This led us to conclude that the provider had put appropriate arrangements in place to help reduce the likelihood of abuse going unnoticed and help protect people from the risk of abuse.

Good

Is the service effective?

Our findings

One staff member told us the training they received was "superior" to anywhere else they had worked and they liked being able to contact the in house trainer at any time if they had questions or concerns about how to apply the training to their practice. Another staff member told us the training was "first class" and ensured they had the skills to deliver safe and effective support. Records showed staff received a comprehensive training programme. Staff told us they felt supported and able to approach the management team if they had a problem or concern.

Care records contained person centred care plans about people's physical and mental health. This included detailed information about people's specific health conditions and what it meant for staff at the point of care delivery. Care staff told us they regularly read the notes left by the district nurse or community matron to see if there were any issues that may impact upon the way they supported people. We also saw staff supported people to access healthcare services and made referrals to healthcare professionals. For example, the manager referred one person to their occupational therapist because the mobility equipment they had provided was no longer appropriate. This showed us the service worked in partnership with other agencies to ensure people's healthcare needs were met. People told us staff supported them to access health care professionals when they needed to. They said if they felt unwell they informed their carer and appropriate action would be taken to ensure they received the treatment they needed.

We asked care staff what they did to make sure people were in agreement with the care they provided. They demonstrated a competent understanding of their responsibilities under the Mental Capacity Act 2005 (MCA). They described how they always explained to people what they intended to do and asked people if they were happy for them to proceed before providing support. They then continued to talk to people while they assisted them so they understood what was happening. Care staff explained they did this on every visit and did not rely on the fact people had provided consent in the past to imply consent. They also provided examples about how they used different communication techniques to obtain consent from people who were unable to communicate verbally such as interpreting facial expressions and body language. We spoke with care staff about people's capacity to agree to their care arrangements. They had a good knowledge of the people they supported and their capacity to make decisions and explained that whilst people's relatives could provide them with useful information it was important to always listen to the person who used the service and ask them what they wanted. This knowledge was supported by capacity care plans which outlined what decisions people were able to make for themselves and where additional support of family or advocacy was required.

Most people were supported with their meals by members of their family. However, where people did received some nutritional support from staff we saw person centred care plans were in place which contained detailed information about people's preferences, likes, dislikes, any known food allergies as well as practical information such as where kitchen items could be located. In one case we saw a nutritional risk assessment was not in place where the person may have had a previous risk of malnutrition. This person received most support with meals from their family and their weight was stable at the time of our inspection. Care staff were able to tell us about the specific requirements people had in relation to their diets and how they catered for them. This showed us where support was needed care staff helped people to have a healthy balanced diet.

Requires improvement

Is the service caring?

Our findings

All of the care staff we spoke with had a detailed knowledge of the people they supported. Most staff described how they had supported the same people for "many years" which had enabled them to really get to know people. One staff member described how they had supported people for so long it felt like they were "caring for members of my family." Staff were able to describe precisely how people preferred their care and support to be delivered and what people's likes and dislikes were. The detailed knowledge and understanding staff demonstrated showed us they had worked hard to develop meaningful relationships with the people they supported. One staff member told us, "I support people how I would want myself or my mum to be cared for because our service users deserve the very best."

Many people we spoke with told us they received a good standard of care and provided positive feedback about the staff who supported them. Some people told us they had formed close friendships and a good rapport with the staff who supported them. One person told us staff were "very pleasant and caring." Whilst another person said, "All my carers are nice people. If there was anything wrong I would be the first to complain." One family member told us, "They are all really good with [my relative]. If I didn't like anything I would say. They engage [my relative] in conversation and have time for me too. I am extremely happy and have a nice mixture of carers."

Despite the positive feedback people provided about many of the staff who supported them, people told us the quality of carers and standard of care they received was not consistent. One relative told us, "Some staff are rude and unprofessional." Whilst another family member told us**,** "They are not reliable at all and out of all of the staff I would class only five of them as caring." Where people told us they had fed back about the attitude of some care staff they felt the management team had not kept them informed about what action had been taken to address the issues they raised. Most people also told us their experience of the standard of care provided was influenced by staffing issues. People told us that because the service was "short staffed" this had often led to inconsistencies in the time of their calls and the carers who supported them.

Staff provided examples of how they protected people's dignity and privacy. Such as ensuring doors and curtains were closed before providing support with personal care. Through our conversations with staff they demonstrated an awareness and respect for people's culture, background and personal property. For example, one staff member described the importance of taking their shoes off before entering to ensure they did not get mud on carpets and because this was seen as a sign of respect in some cultures. All of the people we spoke with told us they had never felt discriminated against in any way by the staff from this service. People told us care staff respected their privacy, dignity and independence and supported them in a discreet and respectful manner. One person who used the service told us, "I am really happy, they are nice and helpful, keep me in touch with what is going on. They know their boundaries." However, two people told us some care staff could improve their practices to ensure they consistently treated people and their home with dignity and respect. This led us to conclude the provider needed to make improvements to ensure consistency in the attitude and approach of care staff.

Care records contained person centred information which demonstrated that they had been developed in consultation with people and their family. For example, one person's care plans detailed they liked to use talcum powder on their back before dressing but preferred cream on their legs and that during meals they liked to have a tea towel on their lap to protect their clothing. People told us the staff who supported them on a day to day basis provided them with the opportunity to discuss and communicate their needs, views and preferences. Most people told us their main contact was with their care staff and they would like to speak with the management team "more often." One person told us, "My relatives needs have changed and I want to sit down with them and discuss what needs to be done and change the care plan." This was consistent with the information we saw within care records which was often out of date. This led us to conclude that improvements were needed to ensure people and their families were consistently involved in the care planning process.

Requires improvement

Is the service responsive?

Our findings

Most people told us the times of their calls were often inconsistent which meant the care they received was not always responsive to their needs. This was reflected in the care records we reviewed. For example, one person had calls scheduled in their care plan to take place from 8:30am to 9:00am. That person's daily records showed there was no consistency to the times of calls. We noted the situation regarding late calls had deteriorated from the beginning of October 2015 onwards. For example, on 12 October 2015 the call was delivered at 9:05am, whereas on 27 October 2015 it was delivered at 10.30am.The care plan showed staff prompted this person with their morning medicines, assisted them to wash and with their continence needs. The variation in call times meant medicines were not being given at consistent times and it was difficult for this person to get into a morning routine.

In another care plan we saw the person was scheduled to have two care workers call from 7am to 8am to assist them with their personal hygiene and personal care. When we looked at the daily records we saw at times this call was being made between 8am and 9am and on some occasions as late as 9:30am to 10:30am. This meant this person was not receiving care and support at the times identified in their care plan.

All of the care staff we spoke with told us there had been no missed calls to people, but calls were often late. They told us this had got worse over the last "couple of months." This was confirmed by the records we saw and the people we spoke with. People told us although their basic care needs were being met, the inconsistency of the call times impacted upon their ability to get into a routine and plan their life. One person explained the impact by saying, "They are short staffed it's not their fault, but I need to make arrangements for going out and sometimes I don't know when they are coming." A family member also told us, "We were delighted at first but there has now been a lot of staffing issues, no regular person or poor time keeping which causes some anxiety".

Most of the people we spoke with and whose care records we reviewed lived with family members. We saw evidence and were told that often family members had to provide additional support to ensure the care and support people needed was provided. For example, one family member described how they had to arrange to work from home to ensure they were there in case staff called in sick or arrived late as it had happened so often in "recent weeks."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with also told us that the inconsistency of call times was due to a shortage of staff and a lack of planning by the provider. For example, one relative told us care staff did not get travelling time which meant they quickly ran behind with their call run. They said, "I never know who is coming and at what time. They are here at 8am for half an hour but need to be at the next one for 8.30am and get no travelling time, so it's impossible. They are always rushed."

Care records were person centred and contained detailed information about how people liked their care to be delivered. For example, they contained an assessment called "All about me." This contained detailed information about what was important to the person in all aspects of their daily life. However we found care records were not always up to date and accurate which risked that responsive care was not consistently delivered. For example, for one person we were unable to establish whether they had received responsive care because the information relating to the times of their calls and what their needs were for each call dated back to September 2012.

The provider had a complaints process in place. A copy of this procedure was provided in the service user welcome pack. We saw examples where formal complaints had been investigated and responded to in line with the complaints policy. We also saw one example where a relative had raised concerns about the attitude and timekeeping of some care staff. A member of the management team had met with them and used the provider's performance management procedures to monitor and encourage improvement in the care practices of these staff members. From the evidence we saw it was clear the provider was trying to pro-actively resolve this issue. All of the people we spoke with felt confident to express their concerns and complaints to staff. Some people we spoke with also told us of examples where they had raised complaints and these had been dealt with appropriately. For example, one person told us they had complained about one carer on

Requires improvement

Is the service responsive?

behalf of their family member. They told us they were "Now back with one of the original carers who [their relative] likes." Another relative told us, One person told us, "There was a mix up with call times a few months ago but this has been sorted."

However, other people told us the management team had not responded to their concerns in an appropriate way. One family member told us, "I am sick of calling the office to raise the same things over and over again. I feel like they don't do anything constructive because the same things then happen again." This demonstrated the provider was not consistent in how it dealt with the complaints people made. We also saw that because daily notes were not being regularly audited and checked there was a risk that people's feedback and potential complaints were being missed. For example, one person had used their relative's daily notes to record feedback about a care worker not providing appropriate support to their family member. We asked one of the care co-ordinators about this and they told us this staff member no longer worked for the company. We asked for the complaints log so we could see if this had been picked up as a complaint. However, the complaints log could not be produced on the day of our visit. Following the inspection we received the complaints log by email and saw evidence the issue with this individual member of staff had been dealt with but no response to the relative had been documented. This inconsistency in approach risked that people's feedback was not being always used to ensure the quality of the service was improved.

The area quality assurance manager explained the provider had a system in place to seek the views and opinions of people who used the service. This included an annual care review, an annual questionnaire and quality phone calls. We reviewed the service user feedback received in August 2015. At that time inconsistent call times and staff being late was the key concern raised. The fact this was still being raised as an area for improvement during this inspection showed the provider had not taken appropriate action to address this issue and act on the feedback people had given. The people we spoke with who had completed a questionnaire told us they were of "little use" because they had not seen any improvements or heard back about what the provider was doing to address the issues they had raised.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

The provider completed a monthly audit based on the Commission's old inspection methodology. The area quality assurance manager explained they were revising this process to bring it in line with the Commission's new inspection approach. The audit assessed the quality of care across key areas and included reviewing documentation such as care records and speaking with people who used the service. We looked at the audit for September 2015 and saw the service received a score of 77%. This showed the provider recognised there were areas for improvement and they had an action plan in place to address the areas identified. We found this audit system was not sufficiently robust. We identified concerns with a number of aspects of service delivery including; the management of medicines, staffing, incomplete and ineffective care records. These had not been addressed prior to our visit and were not included on the provider's action plan. As part of a robust quality assurance system the registered manager and provider should actively identify improvements on a regular basis and put plans in place to achieve these and not wait for the Commission to identify shortfalls.

The provider did not complete a comprehensive medicines audit. This meant they were unable to assure staff managed medicines in a safe and appropriate way. We also found appropriate arrangement were not in place to ensure care records were consistently reviewed and updated. Some of the care records we saw had not been regularly updated and some did not contain sufficient detail about people's current needs.

Appropriate systems were also not in place to ensure documents were appropriately archived. Some people's care records contained documentation from 2012 which was no longer relevant and other documentation that we requested could not be located on the day of our inspection. For example, we requested the daily notes to cover the last two months for four people. Two people's notes to cover this full period could not be provided. This meant we were unable to evidence that these people had received appropriate care and support.

In the daily records we were provided with we found some gaps which had not been identified and addressed through a robust system of audit. For example, we saw examples where staff had not recorded the time of their visit and some visits where entries in the daily notes had not been recorded. This meant we were not always able to evidence that people had received the calls they needed. The manager explained they had recognised a more robust daily records system was needed. Previously a book was used which was only returned to the office when the book had been filled. This made it difficult for the manager to review and monitor daily notes to ensure people had been provided with appropriate care and that any poor practice or changes had been picked up and addressed. At the beginning of October 2015 a new system had been introduced where record sheets were used and returned to the office to be reviewed on a weekly basis. However, we found due to staffing shortages the manager had not always had time to review them. This meant despite this new system being introduced, some issues were still not being identified and addressed. It was also clear that care staff had not been consulted in reviewing and revising this process as they explained they would have preferred to return notes on a fortnightly or monthly basis because if they had not supported a person for a while they found it useful to read back and see if there had been any issues or changes in recent weeks.

Staff provided positive feedback about the acting manager. They said they "genuinely cared", took an interest in staff's wellbeing and always put the needs of the people who used the service first. Staff told us the acting manager regularly provided hands on care in order to ensure people received their calls. They said this had become more "usual" and "frequent" in the past two months due to a shortage of care staff. On the day of our inspection the manager had to leave the office to cover some calls due to staff sickness. We saw evidence that because this had become a regular occurrence this had a negative impact upon the quality of care records and consistency of management checks. Whilst it is important that calls are covered to ensure people receive the care and support they need, the provider should have a robust contingency plan in place to ensure sickness and unexpected absences are responded to without impacting upon the standard of care records and performance of management duties. We spoke with the quality assurance manager about this and they said they would discuss it with the provider to ensure a more appropriate arrangement was in place.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Systems were in place to seek the feedback of people who used the service and their families. We saw examples of the provider using this feedback to help improve the quality of care provided and to ensure a more person centred approach to care delivery. We also saw examples where management staff had met with people to discuss issues and concerns in person. This showed us the provider could be proactive and inclusive when dealing with people's feedback. However, the feedback from people was that this was not always the case. Most people said they did not have a direct relationship with management staff and had to trust that care staff passed important information back to the office because they rarely spoke with the office themselves. They told us when they raised issues they did not hear what had been done to address them. People told us the management team should be more "visible" by visiting them at home more frequently and many described how they had never been actively involved in a care review or providing formal feedback about the service.

The registered manager was on maternity leave at the time of our inspection. Whilst the provider had made suitable arrangements to ensure their duties were covered by the acting manager, they had not ensured a statutory notification had been sent to inform the Commission that the registered manager was due to be absent from the service. The provider explained this was a mistake and would not happen again. From the information we hold about this service we know they have informed the Commission of other important information and incidents that have occurred in the past. Following our inspection we wrote to the provider to remind them of their legal duty to inform the Commission of certain incidents and events that affect the running of the service. We explained if we found evidence they had failed to notify the Commission of these events in the future this could result in enforcement action being taken against them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 Medicines were not always managed in a safe and proper way. Regulation 12(1)(2)(g).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of qualified, competent, skilled and experienced staff were not deployed at all times. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and operated effectively to ensure the service; Assessed monitored and improved the quality and safety of the service provided. Did all that was reasonably practicable to mitigate risk. Maintained secure, accurate, complete and contemporaneous records. Acted upon feedback from relevant persons to ensure the service was continually evaluated and improved. Regulation 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:
We served a warning notice on the registered provider. The notice stated that they had to take action to ensure they met this regulation by 1 February 2015.