Radfield Home Care Ltd

# Radfield Home Care - Cheshire

## Inspection report

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Date of inspection visit:
03 April 2017
04 April 2017
06 April 2017

Date of publication:
25 May 2017

## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place between the 3 and 6 April 2017 and was announced.

This was the first comprehensive inspection of this service since the office moved address.

The service provides personal care to people in their own homes. At the time of the inspection support was provided to 30 people.

There was a registered manager in place. 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. The service was managed day to day by a care manager and we were told she was responsible for oversight of the regulated activity.

At the inspection, we identified a number of breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People did not always receive support in line with their preferences and wishes. Some people told us that they did not receive a call at the time of day that suited them best and there were wide variations in their planned call times. Others told us that they felt uncomfortable receiving support from a carer of the opposite gender. Some people did not feel able to feed back their experience of the care they received.They said that they liked the staff and so did want it to reflect badly upon those individuals

People were involved in developing their care plan which staff could follow in order to provide the required level of support. These included people's wishes and preferred routines as well as how staff were to ensure support was delivered safely. We found that changes in need, information about a person's diagnosis or other pertinent risk factors were not always incorporated into the care plans. This meant that there was a risk that staff did not have all the necessary information available to them. Staff less familiar with the person may not be able to provide the right level of support.

People received support with their medication and care plans indicated the level of assistance required. There was sufficient information for staff to know how and when a medicine was to be administered or offered. However, mental capacity assessments had not been completed around people's ability to make decisions with regards to medication or whether decisions had to be made in their best interest.

Staff had received training in aspects of their role that the registered provider had deemed as essential. New staff had undertaken an induction programme that followed the standards set out by the Care Certificate. Staff had not received training and observations to ensure that they were competent with all aspects of their

role. Relatives told us they felt that some staff lacked in knowledge about specific medical conditions such as dementia, Parkinson's disease or diabetes. Staff also undertook specialist procedures such as the taking of blood glucose readings with no assessment of knowledge and skill. Some medicines were given in the form of eye drops or inhalers but there was no record of staff having been assessed and observed as being competent to administer in this way. This meant that there was a risk that a person may not get these as prescribed.

There were quality assurance systems in place but these were not used effectively to monitor the overall safety and effectiveness of the service.

There was a lack of consistent and detailed information to allow a full and thorough audit of accidents and incidents. There was a lack of robust oversight to ensure the monitoring of missed, short or late visits. This was not embedded in the quality assurance system.

The registered provider had processes in place to ensure that staff underwent a number of checks prior to the commencement of their employment. This included the completion of an application, an interview, references and a check from the Disclosure and Barring service. However, steps were not always taken to ensure that the information provided was accurate and authentic. This meant that there was a risk that staff of unsuitable character or skill could be employed

People told us that they liked the staff that came to them and that they were treated with kindness. Staff had an understanding of safeguarding and how to recognise signs of abuse. However, the registered provider had not ensured compliance with the local safeguarding policy to report concerns around poor care. Staff took the time to get to know people and valued their personal history and background. Staff were able to describe to us how they ensured that people were treated with dignity and how they maintained their privacy during personal care tasks. Information about people was held safely and securely to ensure that confidentiality was maintained

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible. The registered provider had policies and systems in place to support this practice but they were not fully implemented. We made a recommendation that the registered provider ensure that they are able to demonstrate compliance with the principles of the Mental Capacity Act 2005. People told us that staff always asked their consent before undertaking any tasks. They also told us that staff did not prevent them from making unwise choices where they understood the risks.

## 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 completely safe.

People did not always receive safe care and treatment. The administration of medicines was not fully safe as staff had not been trained in certain techniques. Accidents and incidents were not fully investigated to ensure learning from incidents.

Recruitment policies and procedures were not always followed and so there was a risk that people received support from people not deemed to be of suitable character and skill.

Staff were aware of safeguarding adults but the local safeguarding protocol had not been followed. This meant that concerns around poor care had not always been reported.

### Is the service effective?

**Requires Improvement**

The service was not fully effective.

The service did not record how it assessed and followed the principles of the Mental Capacity Act 2005. This meant that care may not be always being provided with informed consent.

Staff received induction, training and support. However, this was not robust enough to ensure that they were skilled, competent and confident in all aspects of their roles.

People received the supported they required with diet and fluid intake in order to maintain their health.

### Is the service caring?

**Good**

The service was not always caring.

People and their relatives said that the service did not always meet their preferences for time of call or gender of staff member.

People said they were treated kindly and staff were respectful in speaking to them.

Staff assured that a person's confidentiality was maintained and

records were stored safely.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People did not always receive support that was consistent and met their needs. Person Centred Care plans were available to support staff in meeting a person's needs.

Complaints were identified but lessons were not learnt. The areas of concern were still evident on inspection.

## Is the service well-led?

**Requires Improvement**

The service was not well led.

There was a registered manager but she did not have the day to day responsibility for the service.

People and their families said that the office staff were always available and responded to them.

There were quality monitoring systems in place but they had not been used effectively to identify and address concerns.

The registered provider failed to notify the CQC of safeguarding events that had occurred in relation to the service.

# Radfield Home Care - Cheshire

**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 registered 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 took place between the 3 and 7 April 2017 and was announced. We gave 48 hours' notice because the location provides a domiciliary care service and the manager is often out during the day; we needed to be sure that someone would be in.

The membership of the inspection team was one adult social care inspector.

Before the inspection, the 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.

We also reviewed any information that we had received from or about the service in the way of notifications, questionnaires, compliments or complaints. We contacted the local authority commissioners who had no information to share in regards to this service.

We spoke with eight people who used the services over the telephone but also visited three others at home. We interviewed staff over the phone.

We looked at a sample of records for each person receiving regulated activity: this included care plans, daily notes, and care logs. We also looked at information pertinent to the overall governance of the service: this included staff rotas, recruitment files, spot checks, induction checks and training records. We also reviewed relevant polices, accident records, complaints/ compliments and quality audits.

Requires Improvement

# Is the service safe?

## Our findings

The majority of people said that they felt safe with the support received from the service. Comments included "I can rely on the staff not to let me down so that makes me feel safe", and "The staff are good at making sure I don't hurt myself by doing anything silly". However, one relative stated, "It's rare, but sometimes they are late or miss a call and that rocks my confidence" and another said they did not feel as safe with newer staff as they were "Often paired up with someone, who in my opinion, does not have much more experience".

A record was kept of accident and incidents but documentation did not always contain all of the information required, such as the name of the staff, the person or the time of the occurrence. An investigation report was not compiled for significant incidents in order to demonstrate a thorough investigation, lessons learnt, or any trends established. For example, two different people had fallen from a shower chair in the last 12 months whilst support was being provided. A full investigation was not evident to explain how this had occurred, to ensure that adjustments to support, equipment were made or whether further staff training had been considered. Another person had hit their head whilst being transferred in a hoist but there was no staff competency check to be assured staff were confident in using this equipment.

People told us that, more often than not, they had regular staff that supported them. If a new member of staff came they often worked with another staff member for a short period of time before they worked alone. Some people expressed a concern that new staff did not always work alongside very experienced staff to "Ensure they know the ropes". We spoke with three people who required two staff members to attend to their needs. All of them told us that on occasions the two staff members did not always arrive at the same time and one person started to deliver the support alone. Daily logs we looked at confirmed this and in one example we found that on three occasions the staff members had not arrived together: One day the first staff signed to say they had arrived at 08.38 and the second at 09.10. We asked the manager to investigate this further as a potential safeguarding matter as there was a risk of harm to both the person and the staff.

There was an organisational safeguarding policy to guide staff and they also had access to safeguarding information and contact numbers. However, neither the registered manager nor the staff were familiar with the local safeguarding policy. There was a requirement to report concerns of a low level such as medication errors, missed calls or situations where the care plan had not been followed. During the inspection we identified concerns of this nature that the service had not always recognised as safeguarding, addressed or reported as such. By the conclusion of the inspection, the manager had made contact with the local authority to clarify their on-going responsibilities in regards to this.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 because the registered provider had failed to ensure that care and treatment was provided in a safe way and to prevent avoidable harm or risk of harm.

Staff had an understanding of safeguarding adults and what this meant in their day to day work. They were able to identify what could be considered as potential abuse. Staff were able to tell us how they would

report such concerns. We saw, from records, that staff had appropriately raised concerns of this nature with the manager. Staff were also clear about 'whistleblowing' and stated that they would have no concerns about reporting any issue that they had. A whistle-blower is a person who raises a concern about a wrongdoing in their workplace.

People told us that staff calls were not regularly missed but could be late or cut short due to staff sickness or other types of emergency. One person said "In the majority of circumstances, they let me know if they are going to be really late". We spoke to the registered manager and the manager who confirmed that staff had recently, on occasion, had to cover additional calls due to staff having left or sickness. The registered provider had now introduced a "stand by" role so that a designated staff member was available should another be unable to do a visit. This ensured people's needs were always met.

Not all people were able to manage their medications without some level of assistance from family or staff. The level of support required and how this was to be provided was written in the person's care plan. Staff used an electronic record to state where medication had been administered or prompted as required. This record contained information for staff as to the dose of medication, the condition for which it was prescribed as well as any specific requirements such as time or method of administration. Staff said that the electronic system meant that changes in a person's medication were immediately brought to their attention. Where medication had been prescribed on an 'as required' basis (PRN), there was information for staff as to when and how often this was to be offered. It is important that this information is recorded and readily available to ensure people are given their medicines safely, consistently and in line with their individual needs and preferences.

We looked at recruitment processes that were put in place to ensure that people employed were of suitable character and skill. Prospective employees were required to complete an application form pending an interview at which this information was collaborated. We found that, in some instances, there was no written explanation of any gaps in employment. A minimum of two references were requested and written references were on file. However, there was not always evidence to indicate from where they had been requested or that they had been verified and validated as authentic. One person left the service only to return a few weeks later but no reference had been taken at the time of the inspection from the interim employer. This was subsequently completed. A check with the Disclosure and Barring Service (DBS) was carried out prior to a person commencing employment. The DBS provides information to employers around whether prospective staff are barred from working with vulnerable adults, or have any criminal convictions. This helps employers make decisions relating to the suitability of staff.

The registered provider had processes in place to assess the risks to staff whilst they provided support. An environmental risk assessment was undertaken to record and identify risks from the use of electrical or gas appliances, chemicals and equipment. A log was kept of all equipment staff were required to use along with information as to when it was last serviced to ensure it was functioning correctly. There were also clear instructions for staff as to what checks they were to carry out prior to using it.

Where risks had been identified in regards to carrying out personal care tasks, these were recorded within the care plans along with actions required to minimise the risk e.g. moving and handling, pressure care, nutritional concerns. We spoke with the registered provider about the need to have more robust risk assessments in place where there were risks associated with fire due to a person smoking within their own home.

Staff were aware of infection prevention and control. People told us that staff used gloves and aprons whilst carrying out support tasks. Staff confirmed that supplies of personal protective equipment (PPE) were

readily available to them. This meant that the risk of cross infection was minimised.

Requires Improvement

# Is the service effective?

## Our findings

People we spoke to commented that staff met their needs and respected their choices and decisions. One person said, " I sometimes eat things that I shouldn't but that's my choice and staff respect that" and another stated " Staff seem to know what they should be doing but it takes some more time to get used to things than others".

All new staff were expected to complete an induction programme based on the Care Certificate. This qualification aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. Staff told us this was thorough but the practical elements such as moving and handling, basic life support and medication administration were all done in one day and this was intensive. Not all of the staff had any previous background of working in the care sector. This meant that they may not initially have the skills, knowledge and values to provide safe and effective support. An assessment of the learning and training needs of staff should be carried out at the start of employment and reviewed throughout. There was no initial assessment evident on any of the records that we viewed.

It was expected that staff would shadow a more experienced staff member until they had been deemed able to work on their own. The registered provider requested weekly spot checks for new starters but we found this this did not always occur with such frequency. There was no feedback recorded from staff that had been responsible for the learning and shadowing of new staff during that period. This meant that the registered provider could not be assured of the skill level and development of new staff.

A record was in place for each staff member to show that they had achieved the level of competency required for elements of the care certificate but this did not always cover all the support tasks required. Some aspects of a staff member's role (such as moving and handling or medication administration) required a practical competency assessment of their skills to ensure that staff understood all the principles of the training and could follow it.

Where medication required a specialised route such as eye drops, creams, inhaler or transdermal patches there was no evidence that staff had received direction from a clinical practitioner to ensure competence before they carried out this task. This meant that there was a risk that people may not receive their medications as prescribed Staff took blood from people in order to monitor blood glucose levels but there was no assessment of their competency to carry out this procedure. This meant that there was a potential risk to people as staff had not been trained and therefore could accidentally cause harm.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured that persons providing care had the competence, skills and experience to do this safely.

We looked at staff supervision and appraisal files which showed that formal one to one supervision took place. Annual appraisals gave staff feedback on how they were meeting people's needs as well as identifying areas for improvement. Staff told us supervision was helpful, they felt able to discuss any personal or work

issues that affected them, and they felt supported.

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.

Staff told us they had received MCA training. They said this training provided them with a better understanding of the importance of giving people the opportunity to make their own decision.

People told us that staff sought their agreement before carrying out any personal care and that staff respected their wishes. One person told us, "They always check how I would like things to be done" and another stated "The respect my decision if I don't want them to do something or tell my family about an issue". Staff we spoke with understood their roles and responsibilities in regards to gaining consent and what this meant or how it affected the way the person was to be cared for. Care plans indicated what decisions a person was able to make for themselves.

Care plans did not indicate clearly where a person was not able to make an informed decision and so staff or family had to act in their best interest. The registered provider required people who used the service to sign to say that they consented to care and treatment. However, we saw that in some cases these had been signed by the person's 'representative'. Checks had not been undertaken to ensure that this was someone who had the legal authority to do so through a Lasting Power of Attorney. The manager had an understanding of this process and how the assessments should be completed. By the conclusion of the inspection, they had completed one assessment to demonstrate this to us.

We saw a number of people received medicines from the staff but the registered provider's own guidance had not been followed. In some cases the person had consented to this but for others a relative had consented to its administration. There was no supporting evidence to demonstrate that the person lacked in mental capacity and therefore this decision had been made in their best interests. The manager told us that sometimes people had mental capacity but asked their relatives to sign on their behalf; but the documentation did not make this clear.

We recommend that the registered provider ensure that records are reviewed to ensure that they demonstrate that the principles of the MCA are applied where appropriate to do so.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Any applications to deprive someone of their liberty for this service must be made through the court of protection. They were aware of this legislation and were happy to seek advice if they needed to.

People we spoke with had different levels of support to ensure that they had adequate nutrition and fluids. People said they were supported according to their needs. Staff knew what level of support each person needed. Staff told us they always offered a choice of meals where possible. Care plans indicted the level of support required and guidance for staff such as "[person] eats better when they are encouraged to sit at the table".

Where concerns had been highlighted in regards to nutritional intake, additional records were kept by the staff as to what had been offered and consumed in order to inform future care and intervention.

People and relatives said staff supported them with their health care when they needed it. This could involve support to appointments, or ensuring they were ready in time for their appointments or being there when a Dr or Nurse visited. We found that where people required further support from other health care services, guidance or referrals were made with the persons consent. For example, a staff member told us that when they found a person's skin was becoming sore they contacted the district nurses to seek advice.

Good

# Is the service caring?

## Our findings

People and relatives had no significant complaints about the staff that provided their support. Comments included "All the staff are very kind", "I like most of the staff, but you do get on better with some than others: that's human nature" and "They are excellent, they are our lifeline really". Other people commented "They sometimes can be late"; "They don't always come on time or stay the full half hour. They need to use more initiative when tasks are completed to fill the time" and " Sometimes I see a new name on my rota, I worry who they are and will I like them if I have not met them first".

Some people spoke to us about their experience of receiving support from a staff member of the opposite gender. Not everyone was comfortable with this and one person said "The way I feel it was put to me was, it's this or nothing". Another said that they had agreed to accept as an emergency but were anxious that at weekends, sometimes a male attended all their calls. We discussed this during our feedback with the registered provider who assured us that people were always asked if they were comfortable with a male or female member of staff. The registered provider assured us that they would immediately revisit this choice with people with a face to face review.

Staff knew about the needs of the people they cared for. Staff told us that they would always speak with the person to ensure they were providing care to them the way in which they preferred. People told us that staff always respected their decisions about their care and accepted that they may sometimes refuse to accept support. However we found that on several occasions calls were cut short for some people which meant that there was a risk they did not receive the care they required, or that the care was rushed.

Staff spoke to us about the importance of getting to know the person that they were supporting and how their personal and social history could impact upon their care. One person said, "I always try to find out about a person before I go to them as knowing their interests etc. gives you a good starting point for meaningful conversation". People also told us that the enjoyed having a chat with the staff as sometimes they saw no one else all day.

Staff understood the need to treat people with dignity and respect and was able to discuss with us how this was achieved. One person told us that they attended a call and the person was upset that it was a staff member of the opposite sex. They explained how they tried to reassure the person and looked at ways of promoting dignity and privacy whilst delivering the required assistance. They explained how they suggested the person turn away from them to "Protect their modesty" and put on their night dress on before asking them to remove their undergarments.

Care plans gave details for staff has to how and when to enter a property so that they did not go in without being invited. Staff also took an interest in a person's safety: as part of the on-going assessment, they spoke to people about who staff should allow access to; should the person not be able to open the door themselves. One person told us "There are so many bad people about these days, the staff always check who is at the door and make sure I want to see them".

The registered provider had a system in place whereby all records were kept electronically. This was password protected to ensure that staff only accessed those records applicable to their rota and that information was kept safe. This also ensured that confidential information was not left in a person's home. The person receiving support had a hard copy of their care plan and could, as family were able, choose to access their own records on line. Records in the office were stored safely and securely.

The registered provider had a website that provided a range of information for people who used the service and their representatives. It demonstrated that the registered provider kept abreast of changes to practice, policy and good practice and made this available to others. People were also provided with information at the commencement of the service.

Requires Improvement

# Is the service responsive?

## Our findings

People felt that the service they received met their needs. Comments included "The staff are very good and do exactly what I need them to do", "They are lovely and look after me well" and "I have not had to make a complaint but I know I am supposed to ring the office if I needed to".

The registered manager told us that all personal care calls were a minimum of 30 minutes. They told us this was because any less than this would mean there was not enough time to ensure people were cared for safely, without having to rush them. However, we found that records indicated that sometimes staff were not staying for the full length of the call and there was not always a written record of why this case. For example, one person had quite significant needs and required assistance with personal care, meeting continence and nutritional needs, application of topical medications and completing physio exercises. We found that records demonstrated that staff had regularly carried out these tasks in 14 minutes or less. We found that other calls that were supposed to last an hour were regularly completed in far less time.

It was difficult to establish from records, what time people had originally wished to have their support. One person told us that when they started receiving support they had requested 08.45 and 20.30 but it had gradually crept forward. They were now on the rota with some calls having a variance of 90 minutes or more later. Their representative commented that this impacted upon the times that they received essential pain relief. The registered provider informed us that staff had a 30 minute lea-way either side of the planned call time to allow for unforeseen circumstances. People commented, however, that the 30 minute leeway often meant an even greater variation in the actual time. Rotas indicated a wide variation in the planned times of calls. One person pointed out that their relative had a morning call planned with the earliest being 07.00 and the latest 09.15. Their night call varied from 20.00 to 21.40. They felt that a better routine was required due to the person's poor memory loss. Other rotas indicated morning call ranges from 09.10 to 11.15, 06.30 – 08.15, 07.00 – 10.00 or night variation between 22.15 – 23.30. One person liked to have an early lunch call around 11.30. On one occasion we saw that their rota indicated this was to be provided at 10.30 and on another day 12.20. Another person had the first call of the day but this deviated from the rota on a regular basis. This meant that people did not have consistency and their care might not be provided in line with their needs and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured that people who used the service had person centred care that met their personal preferences wherever practicable.

The registered provider used an electronic care planning system that made instant changes so staff were able to immediately see any changes to their calls, a person's care needs or if the person had any changes in their medicines. People had a care plan that indicated what tasks would be completed and the duration of their call. The care plan was laid out as a series of tasks to be accomplished which staff then signed off as completed.

Each of these tasks took account of people's personal preferences, such as what they liked to wear, what

cosmetic products they liked to use and what foods they liked to eat. There was also clear direction for staff as to how to use equipment for moving and handling, pressure relieving cushions and how to put on splints and support stockings. Some people had a catheter to manage their continence needs and there was good guidance for staff as to how to manage this and to change or empty bags.

We found that people's needs were assessed but care plans were not always updated in a timely manner when new information or risks came to light. A person had a catheter removed and this was first recorded in the daily notes on the 31 March 2017 with the additional information that staff were to monitor the use of a pad underneath the person's pants. This information had not been uploaded into the care plan and staff had continued to tick the task as not completed as there was no catheter in place. Another person had been given a life changing and life limiting diagnosis but this had not been updated into the care plan. Although the staff team were aware of these issues, it is important that records reflect this information so that staff, less familiar, with the person would be able to provide the required level of support.

Some relatives commented that staff were not always aware of the impact of a person's illness and diagnosis on their behaviours and presentation. We looked at the records of one person and saw that there was little information in the care plan around their illness or how to manage some of the behaviours exhibited that challenged and posed a safety risk. Another person had a condition that impacted upon their ability to recognise people but there was no record of this in their care plan.

Some conditions pose a specific risk to a person's health such as diabetes. There was insufficient information with regards to the monitoring of this. Staff was able to tell us what they did to support and this involved the taking and recording of blood glucose levels (BM's). There was no information in the care plan to guide staff as to what were the risk factors for someone with diabetes, the symptoms of high or low blood sugars or the actions they would take should BM's outside of the acceptable range. Staff we spoke with had a variable level of knowledge and there was no consistent approach to when to alert medical professionals when the readings were extremely high.

Daily records and high risk reports indicated that there were identified concerns in regards to specific individuals for which staff needed to be vigilant. These were not incorporated into the care plans so that staff, less familiar with the situation, would be able to monitor or report any occurrences.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured that the records relating to care and treatment were complete and up to date.

People told us that they had an initial assessment before they began using the service. People said that after that someone from the office would check to see if they were happy or wanted to change their care plan. They said that following this they had other reviews but these were mostly over the phone.

People we spoke with said that they did not always like to raise a concern as they were grateful to receive a service. Comments included "They were good enough to take us on quickly so I don't want to rock the boat" and "The rural areas are hard to cover so there is not much choice as an alternative if you are not happy". The registered provider had a complaints procedure for people, relatives and staff to follow should they need to raise a complaint. We found that the registered provider had provided information to people about how to raise a complaint. This information gave people who used the service details about expectations around how and when the complaint would be responded to, along with details for external agencies were they not satisfied with the outcome. The manager provided us with a log of complaints received and how they were responded to. These complaints reflected the findings of the inspection as they were mainly

around missed calls, late calls, call duration and preferred gender of staff.

Requires Improvement

# Is the service well-led?

## Our findings

People were generally satisfied with the organisation. One relative said "They took on the care package when no one else would" and "They are accommodating" and another said "All the staff at the office are great , they try to resolve issues as best they can but some things are out of their control".

There was a registered manager for the service who had been registered since December 2015. She was also the regional manager. However, she had devolved the day to day management of the service to a care manager who was planning to apply to CQC to become registered.

The Care Quality Commission had not been notified consistently about safeguarding matters relating to people who used the service. The registered manager informed us of a number of issues that they had reported to the local authority for investigation under Safeguarding but the registered provider had not told us about this. This meant that the registered provider had not ensured that the CQC were kept up to date with events of significance within the service, as required by law.

Some people told us and records confirmed, that staff were sometimes late, missed calls or did not stay for the full duration. The registered provider used an electronic care planning system which required care staff to "log in and out" of each call and also to indicate that all the required care tasks that had been offered or completed. They informed us that this, however, was not currently being used as an electronic monitoring system to generate actual call times. There was no robust system in place to ensure that any call times entered on the electronic records or staff time sheets were audited to ensure that times or durations were adhered to. This meant that there was a risk that care was not being delivered in line with the care plan or rota and the registered manager would not be aware. There was a lack of robust oversight to ensure the monitoring of missed, short or late visits as this was not embedded in the quality assurance system.

Some of the rotas indicated that staff were to be in two places at the same time. These were occasionally for double-handed calls which would indicate a 'knock on effect' for other planned visits. The manager informed us that this sometimes occurred when calls had to be covered for sickness. However, there was no systematic review of the rotas to ensure that any discrepancies were highlighted and explained.

There was a central on-call team that covered all of the office branches managed by the registered provider. This system was there to pick up where staff had not logged calls has completed or when staff called in absent. We found that this system was not always robust. We were alerted by a relative to a missed call in which medication had not been administered. The person's records confirmed this. However, the on-call log stated that the carer had forgotten to log the call as complete which was not accurate. There were other instances when the on call system had failed to pick up that staff had not arrived and the call only highlighted as missed by the next staff member attending. We brought these matters to the attention of the registered provider for investigation to establish what had occurred and to ensure it did not happen again.

Accident and Incident information was requested but the manager and the quality governance manager both provided us with differing information. Key information was missing from the records and in many

cases there were no actions or lessons learnt. This meant that overall themes and trends could not be established in order to ensure that risks were minimised for the future.
We asked the registered provider to provide us with information as to the quality audits that had taken place in the last 12 months. We were provided with an audit that had taken place of staff recruitment files, training and care plans. These had failed to pick up all of the concerns highlighted on this inspection.

The quality audits in place were not robust enough to identify concerns with the quality and safety of the service in terms of care delivery, complaints, accidents / incidents, medication administration, complaints and record keeping.

This was a breach of Regulation 17 of the Health and Social are Act 2008(Regulated Activities) Regulations 2014 because the registered provider failed to ensure that effective governance, including assurance and auditing systems were currently in place.

Following the inspection, the registered provider shared with us a number of quality audits, staff competency assessments and checklists that they had developed. They had already acknowledged and recognised that improvements were required. These were more comprehensive than the current system, but had not yet been introduced. They felt that they would, in the future, provide a better oversight of the safety and effectiveness of the service. They also informed us of changes they would be making to ensure that care was delivered in a more timely manner and for the required duration.

A meeting was held with senior care staff each week to discuss persons deemed to have complex needs and high risk factors. A report was then submitted to the regional office for oversight. Not all of the actions and information from these meetings was incorporated into the care plans for staff not at this meeting.

Team meetings were held each month and used as an opportunity to raise concerns, pass on compliments and cascade information. A record was kept of the discussions at these meetings. We noted that issues raised included the timing and duration of calls, completion of the electronic log, staff absence and maintaining professional boundaries. It came to light during the inspection that some staff members shared personal information about themselves with people who used the service and their relatives. This allowed people to search the internet if they so wished and to find out further things about a person's private and personal life that they may not have chosen to disclose such as convictions. We brought this to the attention of the registered provider who assured us that the issue of confidentiality will be reiterated to staff in a staff meeting

The manager had looked at ways of rewarding staff and saying thank you when they had covered extra shifts or gone that extra mile to do something positive for a colleague or person that was supported.

The registered provider had recently undertaken a survey to seek the opinion of people who used the service at staff .The staff indicated that they felt the service provided was excellent or good in all areas. Areas where views were mixed were around travel time and support from on call services. Thirteen people had returned their survey and indicated that they were satisfied with the service and would recommend them.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The registered provider had failed to ensure that people using the service had care that was personalised and based upon an assessment of their needs and preferences. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider failed to ensure that people were fully protected from the risks associated with unsafe care and treatment. They failed to ensure that staff had the competence, skills and experience to do so safely. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider had failed to ensure that there were effective systems and process in to place to assess and monitor the service. They failed to ensure that they fully assessed and mitigated the risks relating to support provision. Records were not always accurate or complete. |