

Apex Prime Care Ltd

Apex Prime Care - Portsmouth

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on the 20 and 21 August 2018 and was announced by giving the provider 72 hours' notice. We gave notice of this inspection to ensure people were informed we would be contacting them for their feedback about the service and to check the staff we needed to speak with were available.

Apex Prime Care – Portsmouth is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older and younger adults, including people living with dementia, physical disabilities and sensory impairments. At the time of our inspection the service was supporting 164 people.

A registered manager was in post; 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 registered manager was also the providers regional manager for the south and south east of England. The day to day running of the service was delegated to the manager who was applying to become the registered manager for the service. We have referred to 'the manager' throughout the report which is the person with day to day responsibility for the service and not the registered manager.

We found that the registered person had failed to notify the Commission without delay of any abuse or allegation of abuse in relation to people who use the service. It is important that we are notified, to enable us to monitor the quality and safety of the service people receive.

Whilst a system of audits was in place to monitor and assess the quality and safety of the service provided, these audits were not always completed and had not been effective in identifying and addressing all the concerns we found.

We found that risks to people were not always communicated to senior staff responsible for the assessment and management of risks. When risks for people were known, they were not always fully assessed. Guidance was not always provided to staff on how to minimise the risk and care for people safely and appropriately.

People's medicines were not always managed safely. We found the records kept to evidence people had received their medicines as prescribed were not fully completed. This included the records for topical medicines (those applied to the skin). Care plans did not always include accurate information about the support people required with their medicines or that the correct support had been given by staff. This meant people were at risk of not receiving their medicines which could lead to a deterioration in their health or in them experiencing pain.

Overall there were sufficient staff to meet people's needs. However, people told us they did not always receive their care in an informed, consistent and timely manner that met their preferences. Staff were

recruited safely to protect people from the employment of unsuitable staff.

Staff understood their responsibilities to protect people from abuse and records showed safeguarding concerns were acted on appropriately with the involvement of the local authority. People told us that incidents such as falls were safely managed by staff. However, it was not evidenced that learning from incidents was used to make improvements to the service people received.

People's records did not always evidence a mental capacity assessment had been completed to determine if the person had the capacity to agree to their care and treatment. We found inconsistent and incomplete information in people's care plans about their capacity to consent. Not all staff were aware of the principles of the Mental Capacity Act (2005) and how these should be applied to support people to have maximum choice and control of their lives.

People's needs were assessed when their package of care commenced and this included their needs in relation to some of the protected characteristics under the Equalities Act 2010. Information about people's race and sexual orientation was not included in the needs assessment. This could mean some people's needs would not be known or considered by the service, if people were not asked about them.

People were supported by staff who had completed an induction and training in line with the provider's requirements. Staff were supported by senior staff and the manager through regular supervision. Annual appraisals had been planned.

People told us they were mostly satisfied with the support they received with eating and drinking. People were supported to access healthcare services as required.

People told us they received kind and compassionate care which was mostly provided by familiar and consistent staff. People told us their privacy, dignity and independence was promoted and respected by staff. People said that care staff listened to them and respected their decisions, however, some people told us they did not always find this to be the case with the office staff.

We received positive feedback from staff about the leadership of the service. The manager was working to improve the culture of the service and the communication between care staff and office staff. Staff were supported in their roles and responsibilities and action was taken to address performance issues. Improvements were being introduced to improve the systems and monitoring of the service people received.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commissions (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Risks associated with people's needs were not always identified and communicated, or assessed so that plans to mitigate these risks were developed and recorded.

The management of people's medicines required improvement to ensure people were safely supported with their medicines.

Overall there were sufficient staff to meet people's needs and staff were recruited safely

People were protected from the risk of abuse, because staff understood how to identify, report and address safeguarding concerns.

Incidents were acted on to support people safety. Learning from incidents could be improved to drive improvements.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Not all staff were clear about the principles of the Mental Capacity Act (2005) and how to apply these in their work to support people to have maximum choice and control of their lives. There was inconsistent and incomplete information in people's records relating to their capacity to consent to decisions made about their care.

People's needs were assessed; however, the assessment did not take account of people's diverse needs in relation to all the protected characteristics under the Equalities Act 2010.

Staff had completed training to support them in carrying out their role effectively.

People were supported to eat and drink safely and appropriately and to access healthcare as required.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Whilst we received positive feedback about the care, kindness and compassion of most care staff, people did not always receive safe, respectful and responsive care. This meant the service was not always caring.

Most people told us that care staff listened to them and they were involved in decisions about their care.

People's rights to privacy, dignity and choice were respected by care staff.

Requires Improvement 

Is the service responsive?

The service was not always responsive.

People's care plans were not always accurate. Care plans did not always reflect people's choices, preferences, personal history and important information to ensure staff would know how to provide person-centred care when they did not know the person well.

Processes were in place to document, investigate and respond to complaints. People told us they did not feel their concerns were always listened to or responded to by the service. Concerns were not effectively used to drive improvements in the service.

Although nobody using the service was currently receiving end of life care at the time of our inspection. An end of life policy was in place to guide staff on how to support people appropriately during this time.

Requires Improvement 

Is the service well-led?

The service was not always well-led.

Notifications about allegations of abuse were not submitted to CQC as required by the Regulations.

Quality assurance processes were in place to monitor and assess some aspects of the quality of care people received. However, these were not consistently effective and did not always enable the provider to identify where quality and safety were being compromised.

Staff spoke positively about the leadership of the service. Staff

Requires Improvement 

were supported in their role and responsibilities through supervision, team meetings and performance management.

The manager and senior staff were acting to promote a more positive culture between office and care staff.

Apex Prime Care - Portsmouth

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 21 August 2018 and was announced. We gave the service 72 hours' notice of the inspection visit to ensure people were informed we would be contacting them for their feedback about the service and to check the staff we needed to speak with were available.

The inspection was carried out by two adult social care inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts who supported the inspection had experience in caring for older people living with dementia who used regulated services.

Before the inspection, we reviewed all the information we held about the service including notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. Prior to the inspection we reviewed information included on the 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 used this information to help us decide what areas to focus on during our inspection.

Inspection activity started on 17 August 2018 and ended on 22 August 2018. We visited the office location to see the registered manager, the care manager and staff and to review care records and policies and procedures. We carried out telephone interviews with 27 people who used the service and 9 relatives or friends of people who used the service. We requested and received feedback on the service from the local authority adult social services teams. We spoke with the registered manager, the manager, the deputy manager, a care co-ordinator, a senior carer and thirteen care staff.

We reviewed records which included 13 people's care plans; visit records and the Medicine Administration Records (MARs) of seven people; the staff training and supervision matrix; three staff recruitment files; and staff meeting minutes. We also looked at records of incidents and complaints along with records relating to the management of the service, such as quality assurance audits, policies and procedures and feedback received from people who use the service.

This is the first inspection of this service since it was registered in August 2016.

Is the service safe?

Our findings

People we spoke with told us they felt safely cared for by the provider's staff. Their comments included, "I do, it's all very good, I'd tell them in no uncertain terms (if there was a problem)" and, "Yes I do feel safe, because I have got used to the carers who are lovely". Other comments included, "Yes, because I do feel that the carers do a good job" and "Yes, they are so gentle, and make me feel safe every day." However, despite people's positive feedback, we identified areas of care which was not consistently safe.

Some people told us about incidents whereby they had not felt safe receiving care from care staff. We checked to see whether the service had known about these and acted to protect people, we found examples when they had. However, some risks had not been identified or assessed. For example, one person required two members of staff to visit them to ensure they were supported to move safely, but only one member of staff had been delivering this care at times. This person was at risk of pressure sores and required regular moving by two staff members to reduce this risk. In the daily notes we reviewed we found only one staff member had attended on at least five occasions between 1 June and 12 July 2018. This had not been communicated to the manager, deputy manager or care coordinator who were unaware the person was not receiving safe care. Action was taken to address this with staff during our inspection.

Another person had been prescribed oxygen at home, following a discharge from hospital. Although care staff who visited the person were aware of this, they had not informed the office staff who were responsible for completing risk assessments and updating care plans. The person's daily notes recorded that staff were supporting the person with their oxygen and the care coordinator told us "It wasn't till I went around there and did a review that I noticed it". Oxygen is a prescribed medicine and requires clear guidance for staff to ensure they understand the risks associated with using this and how to support the person appropriately with using this. A failure to reassess this person following their discharge from hospital to be sure their needs had not changed meant staff were not given guidance to manage this risk. A risk assessment was completed during our inspection.

At times when risks associated with people's needs were identified they were not always assessed and plans developed to mitigate these risks. We found examples where risks to people had not been documented as assessed or where they had been assessed, plans to mitigate the risks contained insufficient guidance to ensure people's safety. This included risks associated with diabetes, safeguarding concerns, risks associated with people's medicines, catheter care, mental health and risks from falls. For example; two people who were diabetic did not have a clear detailed risk assessment in place to provide information for staff on the risks associated with this condition. There was no guidance for staff or risk assessments in place concerning the management of potential emergency situations, for example if the person became hypoglycaemic (very low blood sugar) or hyperglycaemic (high blood sugar) whilst staff were present.

For a third person there was no risk assessment in place for their catheter care, mental health or communication needs. These conditions can present risks for people to their health and wellbeing. A fourth person had been discharged from hospital with a pressure sore and there was no risk assessment in place to guide staff on the risks associated with this or the support needed to prevent further skin breakdown. A fifth

person experienced panic attacks and breathing difficulties but there was no risk assessment in place and no guidance on how staff could support the person's safety if they experienced a panic attack and became breathless.

Whilst staff we spoke with had a good understanding of people's needs and the care coordinator told us risks, when known, were verbally communicated to staff, if a staff member needed to refer to written guidance this would not be available to them. This posed a risk that staff could fail to take the appropriate action to ensure people's safety because risks associated with people's needs had not been appropriately assessed and plans developed which would minimise these risks.

A failure to ensure risks for people had been effectively assessed and plans developed to mitigate these risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a handover meeting between the manager, deputy manager and care coordinator. These meetings were held daily and used to discuss any information from the on-call service and to follow up on incidents, staff issues and complaints received. We observed actions were agreed in response to the information received. People told us that when they had experienced an accident such as a fall, staff stayed with them and supported them and called emergency services. One person told us this did not happen and they made a complaint which was addressed by the service. Incidents were recorded along with the actions taken in response. Four people who told us about incidents they had experienced said nobody from the service spoke to them following the incident about why it happened and how a reoccurrence could be prevented. Whilst incidents were acted on to keep people safe, it was not apparent that learning from incidents was shared to make improvements to the service.

We recommend the service seek advice and guidance from a reputable source about the management of and learning from incidents.

An environmental risk assessment was in place and we saw these were completed. Risks associated with moving and handling, showers and baths and the use of bed rails were completed. The manager told us they would develop the risk assessment tool to ensure all risks to people were assessed, as a result of this inspection

People who were supported by staff with their medicines told us this was well managed. A person said, "Yes carers prompt me to take my medication at the correct time" and "I take a collateral amount of pills for the past 4 or 5 months. They give them to me. They are very, very good." However, whilst people felt well supported with the administration of their medicines, we found that people's medicines were not always managed safely.

We reviewed seven people's Medicines Administration Records (MARs) and found that for five of these they were not always signed to reflect people had received their medicines and there was no recorded explanation for these gaps. It is important to accurately record the administration of people's medicines to be able to demonstrate people had received their medicines as prescribed and to ensure any missed doses could be monitored and acted on. The provider's medication policy clearly explained the requirement for care staff to fully complete the MAR when people's medicines were taken or not. We looked at the daily care records for two people to see if the medicines not recorded on the person's MAR were recorded as given in people's daily notes. We found they were not always recorded as given. One person was prescribed regular paracetamol for pain relief. There was no record to demonstrate this was administered in line with their prescription on 14 and 15 June 2018. Their records stated they were suffering "bad pain" on 16 June 2018.

Whilst the deputy manager said staff needed to administer this person's medicines, their care records were conflicting and this was not clearly recorded. The provider was therefore unable to demonstrate that the pain experienced by the person on 16 June 2018 was not the result of them not having been administered their pain relief. Documentation failed to evidence that people always received their medicines as these were prescribed.

Spot checks carried out with staff included checking some aspects of how staff supported people with their medicines. This included whether the carer checked for medication changes, the correct name on packaging and documented the medication given. However, current guidance recommends that staff have an annual competency assessment of their skills and knowledge in providing medicine support, this was not in place. The system in place to check people received safe medication support had not been effective in ensuring the proper and safe management of people's medicines.

Topical medicines (creams applied to the skin), were not consistently recorded as applied, as prescribed. For example, the care plan for one person stated they required topical creams to be applied at each visit, four times a day to protect their skin. The creams MAR showed over a 46-day period, 95 occasions when the creams had not been recorded as applied and no reason for this. We found similar for other people who were prescribed topical creams to support their skin integrity and prevent the risk of skin breakdown, meaning we could not be assured these creams were applied in line with people's prescriptions. In addition, people's care plans did not always include Information about the frequency of use, thickness of application and areas of the body to which the cream should be applied. This information should be readily available to the staff member applying the cream. This meant people could be at risk of a deterioration in their skin integrity if their topical medicines were not applied as prescribed.

Care plans lacked detail on the support people required with their medicines and how to administer these safely. We also found that some care plans did not always contain accurate information about the support people required with their medicines and that people did not always receive their assessed level of support. A person's visit plan indicated staff administered their medicines and stated, 'I would like you to record I have taken my medication.' We found staff had recorded 'left meds out to take later' in this person's daily notes on some occasions. The care coordinator confirmed that staff should be administering this person's medicines and signing after the person had taken them. It is important that care plans reflect the correct level of support people require with their medicines, in line with current guidance, to inform all staff of the support people need to take their medicines as prescribed.

We spoke to the manager, deputy manager and care coordinator about the failure to accurately record the administration of people's medicines. They told us they were aware this needed improvement and although staff had been reminded through spot checks this had failed to address this shortfall. The provider was in the process of implementing a new system which aimed to drive improvement with recording and aimed to increase the provider's oversight of the management of medicines. Additional steps were also being taken, these included staff supervision, training and review and audit of records associated with people's medicines.

The failure to ensure the safe and proper management of people's medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and care coordinator told us there were enough staff to meet people's needs. Whilst the manager told us that the recruitment of care staff was an ongoing challenge, they said they had the current staffing capacity to meet people's needs safely. People and their relatives who we spoke with did not report their needs were not met by staff. However, people and their relatives did express concerns about the

timings and duration of calls which we have reported on in the key question of 'is the service Responsive.' The staff we spoke with felt they had enough time to complete their duties safely and effectively. One staff member said, "I can run late sometimes but I always make sure everything is done properly". Another staff member told us, "I have the same people I visit so I know them very well. I make sure the care is right".

Appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information for three staff members. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). There were also copies of other relevant documentation including full employment histories, professional and character references, driving licences, motor insurance documentation and notes of staff interviews in staff files. These contained evidence of discussions around staff knowledge of equality and diversity, duty of care, dignity and respect and whistle blowing. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with adults at risk. .

The staff we spoke with had received training in managing infection control in line with the provider's infection prevention and control policy. Staff were aware of their responsibilities in this regard and of its importance. People and their relatives told us staff used Personal Protective Equipment (PPE) to prevent the spread of infection except for one person who said, "Yes but some don't change their gloves following tasks done in the bathroom and then commence tasks in the kitchen." This places people at risk of infection from cross contamination if gloves are not changed between tasks.

All the staff we spoke with understood their responsibility to protect people from abuse. Staff could identify the types of abuse and the correct safeguarding procedures to follow should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. Staff completed safeguarding training during their induction and this was refreshed annually. A staff member told us, "The training is pretty regular and I do find it useful". We discussed safeguarding concerns with the manager who demonstrated their understanding of the actions to take when a concern arose. They said, "We have a good relationship with the (local authority) safeguarding team, if something is wrong I will hold my hands up and take the appropriate actions." We saw records of investigations and actions taken because of concerns raised. This demonstrated that the service reviewed and investigated safety concerns and incidents and acted as a result to promote people's safety.

Is the service effective?

Our findings

People and their relatives we spoke with told us that care staff did not always ask for permission prior to providing care. People's comments included, "Yes most do, but new carers often don't" "Sometimes it does depend on the carers" and "When you first meet them they say, 'Do you mind?'. But the regular ones get on with it. They're lovely girls, we have a chat. We've got into a routine, it's lovely." Other people said staff consistently asked for their consent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Staff completed training in the Mental Capacity Act (2005) however, it was not evident this had been effective as care staff we spoke with did not demonstrate an understanding of the basic principles of the Act. We found people's records did not include consistent information about their mental capacity and who else may be involved in decision making on their behalf such as a Lasting Power of Attorney (LPOA). For example; a person's consent to their care plan was signed by their relative. There was nothing to indicate the person lacked capacity or had been assessed as lacking the mental capacity to consent to their care and treatment. There was no information on the legal standing their relative had to make decisions on their behalf. For another person their consent to care and treatment was not signed. A review document stated there was a LPOA, but there was no information about who this person was. The local authority documents referred to a person who was next of kin but no legal representative. Another person had received an assessment for the future use of bed rails, completed and signed by staff. However, their consent to this had not been recorded.

There was also inconsistency in the management of consent to care and treatment in those who lacked mental capacity. For example, one person's service user plan and client review form were consented to by the signature of the person when they had been assessed as unable to make these decisions. Another person's care plan did not contain any formal consent to their service user plan; their care review was also unsigned.

Whilst the provider had systems in place to guide staff in applying the principles of the MCA in their work with people, we found these were not fully effective or embedded into practice. This meant people could be at risk of inappropriate care and treatment that was not based on their ability to consent.

The failure to ensure that care and treatment was always provided with the consent of the relevant person in line with the MCA (2005) was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us their needs were assessed prior to the service being delivered. People's comments included, "They were very understanding, they focused on me, nothing else." Another person said, "They asked what I

wanted, and then went on from there.'" Records showed an initial assessment of people's needs was completed using a person-centred care needs assessment tool. This included information about how people would like to receive their care and their preferences. Needs assessments included some information in relation to people's protected characteristics under the Equalities Act 2010, including, age, disability, gender, marital status, and religion. Information about people's sexual orientation and race was not included in the needs assessment. This meant people's diverse needs may not be known or considered in planning their care and treatment if their needs in this respect were not asked about. We noted from care plans there was little information about cultural or spiritual beliefs. Whilst, the staff we spoke with knew the people they were visiting well there is a risk that when new or unfamiliar care staff visited they could be unaware of people's diverse needs.

We recommend the service finds out more about ensuring person centred care, based on current best practice in relation to the needs of people with protected characteristics under the Equality Act 2010.

Managers and staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. One staff member said, "We always approach the client on how they want things, everyone is an individual not everyone is the same." The manager was clear that discrimination would not be tolerated and were confident any human rights or equality needs people had would be met.

We looked at staff files regarding induction when staff first started employment with the provider. We also spoke with staff. We noted that all new staff underwent an intensive three-day induction allied to the Care Certificate before going out to work in the community. The Care Certificate is a 12-week programme and an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. Training in the induction included areas such as: Safeguarding, Manual Handling, Health and safety, Infection Control, Health and safety, COSHH and Food Safety. Upon passing the induction, staff shadowed senior colleagues until they were comfortable working alone. The staff we spoke with were happy with this process. One staff member told us, "I was new to care so I suppose the induction was important for me. I was anxious at first but I felt better and better as I went on". Another staff member said, "It (induction) was really good, I have to say. I could ask any questions I wanted and the shadowing helped a lot".

We also asked staff about the ongoing training they received. One staff member said, "I think it's good. I have some training on dementia recently because I have a few people I visit who have it". Another staff member told us, "The training is regular and I can always talk about what I need in supervision". We reviewed the training records for staff which showed most staff were up to date with their training requirements.

Staff received regular unannounced 'spot checks', carried out by senior staff. On these occasions, staff were assessed regarding appearance, attitude and knowledge of the person they were caring for.

We asked about the managerial support staff received, including formal supervision. One staff member told us, "It's fine. I come into the office for supervision every couple of months I think. Other than that, I just get on with it. I know my clients really well and what they need". Another staff member said, "Yes, I can say what I want in supervision. I know it will be confidential which is important as I always speak my mind". We saw annual appraisal had been planned to be carried out with staff and was in the process of being completed.

People we spoke with told us they had sufficient to eat and drink and that care staff supported them appropriately. People's care plans included the details of the support they required to eat and drink. Most people we spoke with who received support with their meals told us they were satisfied with the support

they received. However, one person said "I've given up asking for anything complicated. They're young and living at home with their parents. They're nervous, they can't cook. One-day last week I hadn't had much the day before and I said I'd like a poached egg on toast for breakfast. [Carer] said, 'I've never poached an egg in my life.' I said, 'Oh, I'll just have the toast.' Care plans did not include people's food likes and preferences which may have helped to identify staff that could support people with their choices.

A choking prevention policy was in place which highlighted the need for staff to be vigilant when supporting people at risk of choking. We saw examples of how people had been supported with their dietary and nutrition needs when risks were identified.

People we spoke with told us required support to access health services. We looked at care plans to ascertain whether people's health care needs were being met. We noted the provider involved a range of external health and social care professionals in the care of people, such as hospital consultants, community nurses and GPs.

Is the service caring?

Our findings

Whilst people did not always feel office staff were always kind and listened to them, most people and their relatives told us they thought care staff were kind, caring and compassionate. People's comments included, "They are very kind and caring, very nice" and "It's wonderful, it feels so lovely that they (carers) can feel that way towards people they don't know." People's relatives said, "Yes very kind and caring" and "Carers are very kind and caring to my wife." Most of the feedback we received from people and their relatives was positive about the caring approach of staff. However, we also received comments from people about staff "being on their phones" and that "younger care staff" were embarrassed about supporting a person with personal care which left the person feeling uncomfortable. Another person said staff could be "Brusque and impatient."

Although we received positive feedback from people about the caring attitude and behaviours of individual staff we also found that the providers systems did not always support the service to be fully caring. This can be demonstrated by the concerns found in other areas of this report. For example; people told us they were not always satisfied with the management of their call times and duration, how their concerns were managed, and risks to people's safety were not always identified and assessed.

People mostly agreed they were cared for by familiar and consistent staff who knew how they preferred to be cared for. The care coordinator told us that staff usually supported the same people and added, "People experience a change if there is sickness or holidays or clients want a change of carer." We were given examples by people of how staff had shown care and kindness, for example, one person told us; "I was in tears on Monday morning. I was having a down day, a worse day, I get a bit low and she said, 'I don't know what's wrong', but she gave me a big hug. She always knows when something's wrong. She's lovely." Another person said "They are very understanding. They know I want to be independent and they know I struggle too. They understand I want to do things for myself. You know they are concerned about you." "I enjoy them coming, otherwise I wouldn't see a soul, outside the family, they are all very friendly and they have time for a chat. They talk about the past, I know they're busy, I don't keep them long." One person had written to compliment the care staff who had visited them and said, "Both ladies were calm, polite, sensitive and caring."

People told us that most care staff listened to them. Although some people were not able to remember, other people told us they were involved in decisions about how their care was delivered and participated in care plan reviews. We looked at people's care plans to ascertain how staff involved people and their families with their care as much as possible. We did find evidence that care plans were reviewed regularly by staff and some evidence people or their representatives were involved in their review, although this was not always recorded.

People told us their independence was promoted by staff and their comments included, "They (carers) don't argue or insist. They take what I say and they're happy with what I say. I say I want to get things done myself and they respect that, they say, 'We understand.'" And "I try to wash myself. I say, 'Let me have a go', and they do, but they're still there in case something goes wrong, which is good. You lose your confidence." "Yes, they

know what I'm able to do and they encourage me. They do my shopping for me. I'm about to have my knee done and I've got anxiety and I don't like going out but I do want to get out more. They've said, 'When you get back from hospital, we'll go out with you in little stages and if you don't like it, we'll bring you straight back.' A person's relative said 'When they wash him, they hand him the flannel. They encourage him to do it.'

Staff we spoke with demonstrated how they provided care that was respectful and promoted people's privacy and dignity. For example; by providing care in privacy and in the way the person preferred. Most people told us they received dignified and respectful care.

Is the service responsive?

Our findings

People and their relatives told us people received the care they needed which met their needs and preferences. People's comments included, "They (staff) say, 'What do you want, a bath or a shower? I say, 'A bath please' they say, 'Whatever you want" and "The carers are very good they would do anything for me, they put the washing in the machine and take it out for me."

Another person said "Yes, if I want something different doing, they will do it."

We saw some good examples of detailed and clear guidance for staff in care plans, for example for a person living with complex health issues. We noted the care plan included specific instructions for all aspects of their day to day care. However, not all care plans contained up to date and relevant guidance for staff. For example, one person when agitated would, "thrash their arms about". The care plan stated that staff should "have a calming approach" on these occasions but gave no advice for staff concerning safety issues and how staff could protect the person and themselves when this occurred.

Care and support plans were not always sufficiently personalised to reflect people's needs and choices. People's care plans described the tasks required at each of the person's visits. Whilst the plans referred to what people would 'like', such as; assistance with moving, or assistance to get dressed. There was little information on how people would like to be supported, their preferences or personal histories in care plans. Therefore, it was not always possible to gain an insight into people's needs and preferences to support and guide staff to deliver person-centred care.

The Accessible Information Standard (AIS) is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability, impairment or sensory loss can access and understand information they are given. People's care plans did not always include accurate information about people's communication needs. For example, for a person who did not interact verbally with staff the care plan said their level of communication was 'good'. There was no information about what the person's communication needs may be. Another person's care plan said they "Were unable to communicate very well" However, there was no other information about how they communicated and the support staff should provide to support them to do this. Other people's care plans included information about whether they used glasses and hearing aids and whether they liked to chat. It is important that people's communication needs are accurately recorded as part of the needs assessment and care planning process to ensure all staff can be quickly and easily made aware of these and work to meet them.

A failure to maintain accurate and complete records for each person was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the AIS with the manager who told us they were aware of this and would meet people's communication needs such as large print, if requested. They told us information was given verbally to people who were unable to read and rotas were available for some people on request by email.

We received a mixed response from people about how their concerns were dealt with by the provider.

People we spoke with did not always feel their concerns were listened and responded to by the office staff. People's comments included, "You have to say something to the manager two or three times before it sinks in something's wrong." Another person said "Well, I must say the carers do, (respond to concerns) but with the office, sometimes I think it's a waste of time. They don't do much if you say anything, and "I had to complain to the management and they weren't helpful."

Some people we spoke with gave us examples of the concerns they had raised with office staff. These included complaints about the attitude and behaviours of some staff. Three people reported that although they had said to office staff they did not want a care staff member to visit them again this was not acted on to their satisfaction. One person who told us they had been 'frightened' by the behaviour of a staff member and said "I rang the company to say I wasn't keen on having her, but they said they might have to send her sometimes at night when they run out of people. I feel very unsettled with her; she's a bit strange. I don't feel I can be intimate with her." Two people told us their concerns had been responded to and one of these people said, "I complained and I was very satisfied, very comfortable about how it was handled."

We spoke to the manager and care coordinator about how people's complaints and concerns were managed. We were told that complaints submitted in writing are considered as formal complaints. Records showed these were logged, investigated and monitored for completion in line with the provider's policy. The provider's complaint's procedure stated that other 'relatively minor' matters can be raised with the manager or staff and resolved 'on the spot'. We looked at some of the records of concerns raised which were recorded into people's notes on the office system. However, there was no management oversight of these issues unless they were brought to the manager's attention. The issues raised were not monitored for trends to identify learning and to inform improvements in the service people received, or checked that the issue had been resolved to the person's satisfaction.

We recommend that the service seek advice and guidance from a reputable source about the management of, and learning from, concerns and complaints.

The staff members we spoke with were clear about their responsibilities in the management of complaints or concerns. They were aware of the provider's complaints policy and procedures and where to find them. We were told the complaints policy was also given to people as part of their initial assessment. People told us they would report any complaints or concerns to the office and a person said, "I've got names if I want to complain, a) I'd phone the company and b) the social worker."

At the time of our inspection the service was not supporting anyone who was receiving end of life care. The provider had an 'End of Life Care policy' in place and this described the role of the care worker in these circumstances and the principles they should apply in their care of people at the end of their lives. This included linking with other agencies, family and/or representatives involved in caring for the person. We saw the service had received compliments from people's families for the care they provided at the end of their relative's life. People's relative's comments included "I wanted to thank you personally for the care you provided for (name). She really appreciated the care and company" and "Thank you for the interest you took in (name) and their care."

Is the service well-led?

Our findings

The service did have a registered manager in post who was also the providers regional manager for the south and south east of England. The day to day running of the service was delegated to the manager who was applying to become the registered manager for the service. The manager told us they were well supported in their role by the registered manager.

The registered person is required to notify the Commission without delay of any abuse or allegation of abuse in relation to a service. However, during this inspection we found the provider had not submitted statutory notifications in respect of all safeguarding incidents. We identified 13 incidents we had not been made aware of in over the past 12 months. Records showed the appropriate actions had been taken in relation to the incidents for the safety of people, and the local authority safeguarding team were aware of these incidents. However, providers must notify CQC of all incidents that affect the health, safety and welfare of people who use the services. This is important to enable the Commission to monitor the safety of the service people receive. Whilst the manager told us they discussed safeguarding concerns with the registered manager daily this shortfall had not been identified. The provider's quality and safety monitoring did not include checks about notifiable incidents.

The failure to notify the Commission without delay of any abuse or allegation of abuse in relation to a service user was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

There was a system of audits and monitoring at the service. These systems should help registered providers to assess the quality and safety of their service and identify areas for improvement. We saw evidence of audits of the following parts of the service: service user records of care (daily logs), Medicine Administration Records (MAR's) and service user files. However, records showed and the manager confirmed these audits had not been consistently carried out since April 2018. The manager told us this was because they had "To prioritise other things." The audit of people's MAR's showed that gaps in the recording of MAR's had been identified in March 2018 but had not led to an improvement in these records. The care coordinator also told us this issue had been raised with staff during spot checks. Although staff had been reminded by managers to complete MAR's this had been ineffective. We found gaps in people's MAR's on this inspection which showed improvements had not been made or sustained. In the service user files, we reviewed we found that service user records of care had not been always been regularly collected to enable effective auditing. For example; the most recent records in some files were from May 2018. The auditing system had not been used effectively to drive continuous improvements to the service people received. In addition, these audits had not identified gaps in care plans and risk assessments.

In addition, the manager produced weekly reports for discussion with the registered manager. These included; business targets, recruitment, staff training, staffing, complaints and safeguarding. However, this system had not identified or addressed some of the concerns we found which included; a failure to ensure risks associated with people's needs were assessed and plans developed to mitigate these; a failure to ensure staff understood and consistently applied the principles of the Mental Capacity Act 2005; a failure to

ensure the safe management of people's medicines, a lack of monitoring and trend analysis of people's concerns to make improvements for people and a failure to submit statutory notifications. We found the system used by the provider to assess and monitor the service did not take account of all the relevant regulations to effectively ensure compliance with these.

People and their relatives were asked for their views via six monthly quality assurance surveys. These were distributed by the provider's central office and the manager received the results. The manager told us that if specific feedback had been received they would be informed and address this. The provider would monitor this action for completion. We saw an example where feedback about a staff member had been acted on. There was no analysis of the results to accompany the survey findings. For example, the May 2018 survey showed 12 people out of 31 had responded that they did not find office staff to be always helpful, and nine people out of 27 had responded that Apex staff do not always offer a choice where required. No action plan was in place to address this feedback.

People and their relatives told us they did not always receive their care calls at their preferred time or at the agreed time. Some people said that staff were rushed and did not always stay for the allocated time. People's comments included, "No if carers turn up late they only stay the amount of time that is left" and "For half hour visits carers may just rush in and then dash off and may not be here for 15 minutes let alone half an hour." Another person said "No not really, some often just stay for 10 minutes" and "I never get a rota so don't know who is coming. For my toilet visits the office is always changing the carers." Feedback from the local authority included that some people had raised concerns about the reliability, duration and timing of calls. People also said they were usually not informed when care staff were running late either from the office or the staff member. People did not always feel their preferences and decisions were respected by the service in relation to the times of their calls.

Ten of the staff we spoke with told us they did not always have enough travel time between visits. For those who tended to work in small geographical areas, this did not present as an issue most of the time. However, those whose duties took them over a wider area did find this a consistent problem. One staff member told us, "It does eat into the time we can spend with the clients. A lot of the time I have to go straight after giving the care. I'd like to stay but I just don't have the time". The staff we spoke with felt they had enough time to complete their duties safely and effectively. One staff member said, "I can run late sometimes but I always make sure everything is done properly".

We spoke to the manager and care coordinator about how people's calls were monitored to check people were receiving their calls on time and for the required duration. They told us people's calls were not currently monitored unless they received a complaint or care staff reported any changes to the office. The provider was in the process of introducing an electronic system which would enable the provider to monitor calls more effectively. An effective system was not in place to enable the provider to identify if people were receiving their calls at the agreed time and for the agreed duration.

The failure to effectively assess, monitor and improve the quality and safety of the services provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had sent out a staff survey for the first time recently. Feedback had not yet been received.

We received mixed feedback from people about the leadership and culture of the service. People's comments included "There's been a change in the top staff, things are up in the air, there's been upheaval, some of the senior staff have moved around, things have gone a bit awry." And "I don't really feel listened to by the office and if they're not caring, well they're running things. The carers can only do what they say."

Other people commented "It's good and I'm very happy with it" and "Yes, they do a good job."

We spoke with the manager and deputy manager about the culture of the service. We were told that issues around culture and communication between care staff and managers were now being addressed. This was reflected in feedback from some people and staff who referred to 'changes' in the office. We also received feedback from the local authority adult social services teams which referred to difficulties in communication with some key office staff who were no longer working for the provider. Care staff had not always communicated changes in people's care needs, or call times to the office which meant that important information about risks to people or feedback from people had not been known by the manager or supervisory staff. We saw newsletters distributed to staff in March and April 2018 reminded care staff to inform the office of changes in rota's or when running late. The manager was aware of these issues and along with the deputy manager and care coordinator and they were acting to make improvements.

We received positive feedback from most staff about the leadership of the service. Staff comments included, "I think the new manager is really good. They're always available and I can speak to them if I need to". Another staff member said, "I do feel listened to by the managers. If I think someone needs extra care I can speak to them and they will listen". A third staff member told us, "I do feel well supported. I ask the office if I don't know and they help. Some of the other staff don't like to talk to the office. I say speak to them. That's what they are there for". A fourth staff member said, "I don't have much to do with them day to day. I just get on with my work but if I need them, they're there. It's the same out of hours. You can always get hold of someone".

The manager said, "We (managers) try to create a policy of not 'beating staff up' when mistakes are made. It's also important to praise staff and we will always pass on compliments. We saw that action was taken by the manager to address staff performance issues and where appropriate support was offered to staff to improve the service people received. Staff were reminded of their role and responsibilities through supervision, team meetings, performance management and spot checks. We saw the minutes of a team meeting held on 15 August 2018 which reminded staff about some of their responsibilities. The manager had reflected on their own performance and leadership style. They were open about how they felt they had improved their management style and said, "I understand people have different ways and I am mindful of my approach, we are all working to the same goals."

We saw that the provider was introducing new technology which they hoped would improve the systems and monitoring of the service people received. Staff were currently being trained in the implementation.

We discussed how staff were supported in relation to the protected characteristics under the Equalities Act 2010. The manager and deputy manager evidenced were committed to ensuring all staff were treated fairly and that any discrimination would be challenged.

The manager told us that they attended meetings with the local authority and other care providers to share information and try to improve services for people. The service worked with healthcare professionals, for example, district nurses, in providing care for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Commission without delay of any abuse or allegation of abuse in relation to a service user. Regulation 18 (1)(2) (b)
Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and treatment was always provided with the consent of the relevant person in line with the MCA (2005). Regulation 11 (1)
Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's needs were not effectively assessed and plans were not sufficiently developed to reduce these risks. Regulation 12 (1)(2) (a) The provider had failed to ensure the proper and safe management of people's medicines. Regulation 12 (2)(g)
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess,

monitor and improve the quality and safety of the services provided. Regulation 17 (1)(2)(a)

The provider had failed to maintain an accurate and complete record for each person using the service.

Regulation 17 (2)(c)