Nightingale Homecare and Community Support Services Ltd

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Inspection report

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Ratings

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

Summary of findings

Overall summary

The inspection visit took place at the service's office on 29 and 30 July 2015. On both days we visited people who used the service in their own homes.

Nightingale Homecare and Community Support Services Ltd are registered to provide personal care to people living in their own homes in the community. They provide care and support to a wide range of people including, older people, people living with dementia, learning disabilities and mental health needs. The support hours varied from 24 hour support to one to four calls a day, with some people requiring two members of staff at each call.

The service also provided care and support through the supported living scheme. These people lived in shared accommodation such as two/three bedroom houses where they shared communal areas with other people. Staff also supported people with their personal care who lived in extra care units, in purpose built accommodation. Each person had a tenancy agreement and rented their accommodation.

At the time of the inspection 109 older people were receiving care and support in the community, 59 in the extra care housing units and 33 people in the supported living accommodation.

The service's office is based in a business park on the outskirts of Folkestone and offers support and care to people in Folkestone, Hythe, Dover, Deal and surrounding areas.

The previous inspection of this service was carried out in February 2015. At this inspection we found that the provider was in breach of three regulations, safe care and treatment, person centred care and good governance. The provider had sent an action plan to CQC in March 2015 with timescales as to when the service would be compliant with the regulations.

At this inspection the plan had not been fully actioned by the provider and the three breaches of the regulations issued at the previous inspection in February 2015 had not been met. The service continued to be in breach of three regulations, safe care and treatment, person centred care and good governance. We have started the process of taking enforcement action against the provider.

The service had improved in several areas, such as continuity of staff, communication with people, and supporting staff.

There was no registered manager in post. The registered manager had recently resigned from the position. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The provider told us that a new manager had been appointed who was in the process of applying to CQC to become the registered manager. There was a branch manager in post who dealt with the day to day running of the service and supported the inspectors with the inspection.

Risks associated with people's care had been identified, but there was not always sufficient guidance in place for staff to keep people safe.

There was a lack of risk assessments in place to ensure that people received their medicine safely. Medicines were not listed or recorded safely so it was not clear what medicines people were taking. Some medicine records were not clear or accurate.

Everyone using the service had a care plan in place; however these varied in detail to show how people's needs were being met. A new system of care planning covering the assessment process, was being introduced, which was due to be completed in June 2015 but at the time of the inspection there was less than half of the 109 older people living in the community who had the new care plan in place. Therefore some people's care plans were not up to date and did not have all of the personalised information staff needed to make sure people received the care they needed, in line with their

Summary of findings

choices and preferences. There was also a lack of information in the care plans for staff to support and monitor people living with medical conditions such as diabetes.

Staff understood how to support people to make decisions and consent to care and support, however mental capacity assessments were not always completed. Staff had received training on the Mental Capacity Act 2005. The Mental Capacity Act provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

Records were stored safely but were not always accurate. Some medicine records were hand written and not double checked to make sure the correct medicines had been recorded. Care plans and risk assessments were not consistently signed and dated by the staff who had completed them.

People were supported with their nutritional needs. People told us that they chose what they wanted to eat. Staff prepared meals and made sure people had enough to drink.

There was enough staff employed to give people the care and support that they needed. Staff had received training in how to keep people safe and demonstrated a good understanding of what constituted abuse and how to report any concerns. Accidents and incidents were reported and action taken to reduce the risk of further occurrences.

New staff had induction training which included shadowing experienced staff, until staff were competent to work on their own. There was an ongoing training programme in place. Staff had a range of training specific to their role, but there was a lack of specialised training being provided such as, learning disability and epilepsy.

Staff had regular one to one meetings with a senior member of staff. At these meetings they had the opportunity to discuss any issues or concerns. Staff competencies were being 'spot checked' to make sure they were caring and supporting people safely.

People were treated with respect and their privacy and dignity was maintained. People we visited told us the staff were kind and respectful. They told us that staff listened to what they wanted and always asked if there was anything else they needed before they left. Families also told us that the staff had a good relationship with their relatives and knew their daily routines and how they wanted their care to be delivered.

People and their relatives were confident to raise concerns and complaints about the service. Complaints were logged and responses given explaining what action had been taken to address the issues raised.

There was a lack of oversight and scrutiny to monitor, support and improve the service. The timescales within the action plan were not met, and the provider remained in breach of the regulations. The provider was open and transparent and acknowledged that the action plan had not been completed; therefore not all of the required improvements had been achieved in the agreed timescales.

Staff said they understood their role and responsibilities but due to the changes in the management structure of the service they were unsure who was responsible for the different areas of the organisation.

The service had systems in place to audit and monitor the quality of service but there was a lack of evidence to show how the results of these checks had been actioned to continuously improve the service.

The provider had made sure that people were able to feed back about the quality of the service. Telephone and quality assurance visits had been carried out to ask if people were satisfied with the service. People confirmed that this process had taken place and at the time of the inspection everyone we spoke with or visited was satisfied with the service. However, feedback had not been sought from a wide range of stakeholders such as staff, visiting professionals and professional bodies to ensure continuous improvement of the service was based on everyone's views.

We found three ongoing breaches and two additional breaches in 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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe as there was an ongoing breach of regulation with regard to safe care and treatment.

Risks associated with people's care had been identified, but there was not

always sufficient guidance about how to deliver people's care in the safest way. People's medicines were not always managed safely.

Staff knew how to keep people safe, when there was an emergency or if people were at risk of abuse.

There were sufficient staff on duty to meet people's needs. Staff were recruited safely and they had the skills and knowledge to look after people safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

There was a lack of guidance for staff to follow to ensure people's health care needs were met.

Staff had received appropriate training, which included induction training and observations of their skills and competencies. However further specialist training was required so that staff were aware of people's specialist needs.

Some people did not have mental capacity assessments to ensure that they were supported to make decisions about their care.

People were supported with their meals and encouraged to eat a healthy diet.

Is the service caring?

Good

The service was caring.

People said staff were kind and caring. They said they were treated with respect and their privacy and dignity were maintained.

Staff encouraged and supported people to maintain and develop their independence and were supported to make decisions about their care.

Is the service responsive?

Requires improvement

The service was not consistently responsive as there was an ongoing breach of regulation with regard to person centred care.

People did not have all the information in their care plan to give staff the guidance to ensure people received the care and support that they needed. Not all care plans had been reviewed and updated.

People and their relatives said they were confident to raise any complaints and said the management or staff would take action to resolve any issues.

Summary of findings

Is the service well-led?

The service was not well-led as there was an ongoing breach of regulation with regard to good governance.

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor, support and improve the service.

Actions plans to improve the service had not been completed within the agreed timescale to ensure compliance with the regulations.

The service had systems in place to audit and monitor the quality of service

people received, however these checks had not been linked to the action plans to improve the service.

Records were not suitably detailed, or accurately maintained.

People had opportunities to provide feedback about the service they received; however staff and other relevant bodies had not been included.

Requires improvement

Nightingale Homecare and Community Support Services Ltd

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 was 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 29 and 30 July 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure we are able to speak with people who use the service and the staff who support them. We went to the service's main office and looked at care plans; staff files, audits and other records and we visited and talked with people in their own homes.

Two inspectors and an expert-by-experience, with a background of older people and domiciliary care, completed the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we received since the last inspection, including notifications. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we visited and spoke with thirteen people and two relatives in their own homes. We spoke with the branch manager, two co-ordinators who organised the work for the staff and fourteen members of staff. We reviewed people's records and a variety of documents. These included twenty-one people's care plans and risk assessments. Thirteen care plans were looked at in peoples own homes and eight care plans were looked at the service's office. We looked at five staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys.

After the inspection the expert by experience contacted twenty five people by telephone. We also contacted three members of staff by telephone to gain their views and feedback on the service.

Health and social care professionals told us that they were working closely with the service and being regularly updated with the progress the service was making with their action plan to improve the care and support delivered to people.

The previous inspection of this service was carried out in February 2015. At this inspection we found that the provider was in breach of three regulations. These were ongoing breaches since September 2014.

Requires improvement

Is the service safe?

Our findings

People said that they felt safe when they were receiving their care and support. People told us they trusted the staff. People said: "Yes I feel safe, the carers know what they are doing". "Absolutely safe", "Usually I feel safe, but I am cautious so I ask their names and look at their identity card". "If I don't know the carer, I only let them in when I have looked at their name badge". "'They always walk me right down to the coffee room with my walker, to keep me safe". "I definitely feel safe, I trust my carers".

At the last inspections in September 2014 and February 2015 we asked the provider to take action to make improvements to protect people from the risk of inappropriate and unsafe care. Following the inspection the provider sent us an action plan to tell us of the improvements they were going to make by 15 June 2015. There were new systems in place to assess and manage risks relating to the health, welfare and safety of people. However, the system had not been fully implemented to show that the new process was effective and was reducing risks for people.

The provider told us that the new system would be fully operational by June 2015. The example documentation showed all risks would be fully identified and assessed and that staff would have the guidance and information to make sure the person received the care and support that they needed in the way that was safest for them. Each person was being reassessed and a new care plan with relevant risk assessments was being implemented. However, less than half of the109 people older people living in the community had been visited and new care plans had not been developed and implemented therefore risks were still not being fully managed.

Staff did not have the guidance and information they needed to make sure people received the care and support that they needed, in the way that was safest for them. There was a lack of risk assessments in care plans relating to moving and transferring people safely, administering their medicines and reducing the risks of pressure sores developing. Some people had been identified as being at high risk of falls but there was no risk assessments in place to tell staff how to keep this risk to a minimum, like making sure they had their walking aid close by or keeping the area free from clutter or obstacles that might cause risk to them falling. When people were at risk of developing pressure sores or leg ulcerations there was no information about what staff should do to monitor people's skin, what signs to look for and what action to take if there were any concerns.

When people had medical conditions like diabetes or epilepsy there was no information for staff to help them recognise the signs that might indicate their condition was becoming unstable and what action they had to take. When people had fallen or their medical condition was unstable, this had not prompted staff to review the risks and look at other ways of keeping people as safe as possible. Moving and handling risk assessments did not always contain enough detail to show how staff were to manage the risk safely. Some people were moved using special equipment like hoists and slings but some risk assessments did not tell staff how to do this safely.

People said the staff were competent when they were being supported with their mobility. They said: "They all use the hoist well and now that I've had a new wet room installed, they all know what to do". "They are trained, and I have a really good team now". My carers use a bath hoist and make sure it is all done properly". Relatives said: "The staff cope well with the bath hoist. "They know what needs doing when they come in". "The staff use the hoist competently."

Staff were able to explain how they moved people safely, taking into account their medical conditions, however this information was not recorded in the care plan.

Some people needed support with their behaviour. The interventions recorded in the care plans did not identify any known triggers to the behaviour and strategies were not in place to minimise any future occurrence. However one person said that at times there were issues with their behaviour but had agreed what strategy should be in place with the care staff and this had been recorded in the care plan. They said: "I am happy with my care package it has all been good".

There was information for staff to record any incidences of behaviour and to ring the service's office. There was no further guidance to show staff how to support the person during this behaviour in order to reduce their anxiety and minimise the risks.

Care and treatment was not provided in a safe way for people because the provider did not have sufficient

Is the service safe?

guidance for staff to follow to show how risks to people were mitigated. This was an ongoing breach of Regulation 12 (1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive their medicines in a safe way. There were policies and procedure about how to administer medicines safely but they were not easily accessible to staff. Assessments and guidance for how people received their medicines were inconsistent and unclear. Some people's medicine plans in one part said to prompt them and in a later part stated to assist them so were not clear. The daily records indicated different staff were giving people their medicines in different ways. Some staff were leaving medicines in pots for people to take later and signing they had been taken. Other staff were watching people take their medicines. There were no risks assessments in place to make sure people were receiving their medicines as safely as possible. The information was not recorded in people's care plans to make it clear what level and type of support people needed with their medicines.

In one person's daily reports it was recorded by staff that a medicine had been given for chest pain. It stated, "In pain. Had to give spray". There was nothing on the person's medicines record sheet that this medicine had been prescribed for them. There was no direction in the care plan on how or when this medicine was to be given and what the staff were to do if the person did complain of chest pain. The daily records for the next five days stated that the person was in pain but there was no record of what action staff had taken to support the person. Another person was prescribed by their doctor a skin patch for pain relief. It stated that it was to be changed weekly. There was no instructions about who was to do this, there was no record of it being done. The medicine record was not available at the service's office to cross reference if the skin patch had been applied to the person's skin.

Senior staff had made hand written entries on some of the medicine administration records. This had not been countersigned by another member of staff to show these entries had been checked and were accurate. Some medicines records had not been signed or dated by staff who had written the medicines down which meant if there was an error it would be difficult to trace who had made it.

There was a risk of people not receiving their medicines as prescribed. The provider had failed to ensure that people were receiving their medicines safely. This was an ongoing breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received their medication when they needed it and told us they were happy with the way their medicines were managed. They said: "I am diabetic so I need my feet to be creamed. They make sure I am dry, and then do the cream". "Creaming my feet' is one of the things my carer does well". "They help me with my eye drops, I can do it myself, but it is difficult'". "They take them out of the pill box as I can't see very well now. They take the repeat prescription form over to the surgery for me as well." One relative told us how the staff gave their relative their medicine safely and then completed the medicine record sheet.

All staff had received medicine training during their induction. The branch manager told us that in addition to this that seven staff were completing level 2 medicine training on line and this training was also being replaced by level 3 medicine training. All staff were going to attend the course.

Staff had completed training about how to support people safely and recognise the signs of and how to report abuse. They knew the actions to take, such as reporting issues to their manager and other agencies such as the local authority safeguarding team. Staff told us about the whistle blowing process and the 'whistle blowing telephone number.' The telephone number meant that staff could speak with a senior member of staff immediately if they had any concerns.

Staff told us that the service had improved and there were sufficient staff on duty. They said the office and management team supported them and the on call arrangements were available for support when the office had closed. One relative told us that when they called the out of hours telephone number early one morning there was an answer phone which was not helpful. There were plans in place in case of emergencies, such as bad weather, when staff may not be able to get to calls.

People told us there was enough staff to cover their calls. Some people told us they had been involved in making decisions about the time of their calls. They said. "They wanted me to have a visit every morning, but I said not on a

Requires improvement

Is the service safe?

Sunday, because I go out to church, so they respected my choice about that, and it is six days." "Mr regular carer has been away for a long time but is hasn't been a problem at all". "There have been no problems with cover this holiday time". "I was unhappy at the amount of carers visiting me, so I asked to have four carers at the most, they listened to me and this is what happens now".

The service had improved the continuity of care to make sure people received their care from regular staff who knew them well. Missed calls had been reduced significantly and prompt action was taken to reduce the risk of re-occurrence. People told us that staff arrived on time and stayed for the duration of the call. People said: "The staff are more or less on time. It is normally okay". "They are mostly on time". "Times do vary but they are not very late". "Yes, staff are on time and sometimes they stay even longer". "Sometimes they are a bit late, but only 10 minutes and it is not often". "They always apologise if they are 10 minutes late and I say, don't worry about it". People did say that the office would ring to inform them if the staff were going to be late. One relative told us that they had concerns as staff did not get travel time included in their rota which can make the staff late for their calls.

Staff told us that when travel time had not been included in their schedules it had an impact on the call times varying and they were concerned that some staff did not spend the full duration of the call at one person's visit to enable them to keep to the times on their schedules. Other staff said that their schedules were geographically placed and travel time was not an issue. The recent quality assurance survey sent to people had highlighted that travel time was an issue and it was stated that the office staff were amending rotas to include travel time for each schedule. Some staff told us that they were working lots of overtime in the extra care service to make sure people had the care they needed. The service had recruited new staff and it was hoped this would reduce the overtime once staff had completed their induction training.

Staff were recruited safely to make sure they were suitable to work with people who needed care and support. Staff recruitment showed that the relevant safety checks had been completed before staff started work. The manager or senior staff interviewed prospective staff and kept a record of how the person preformed at the interview. Staff had job descriptions and contracts so they were aware of their role and responsibilities as well as their terms and conditions of work. Staff were issued with handbooks detailing the service policies and procedures.

Accidents and incidents involving people were recorded. The manager and provider reviewed accidents and incidents to look for patterns and trends so that the care people received could be changed or advice sought to keep them safe.

Requires improvement

Is the service effective?

Our findings

People were satisfied with the care and support they received. They told us that the staff were well trained and knew their daily routines. They said the staff supported them to make decisions about their care and were always asked for consent. They talked about how staff offered them choices, such as what meals they would like and if there was anything else they needed. They said: "They look after me wonderfully well. I cannot speak too highly of them all". "They are all very good, they know their job".

Two relatives said that they had been involved in the setting up of the care package. They said: "They came and asked me what times I wanted". "I wanted ones who would have a good rapport with both my parents, and they have".

At the last inspections in September 2014 and February 2015 we asked the provider to take action to make improvements to protect people to make sure people received the care and support they needed regarding their health care needs. Following the inspection the provider sent us an action plan to tell us of the improvements they were going to make by 15 June 2015.

The examples of documents we saw showed how personalised health needs would be fully identified and assessed. Staff would have the guidance and information to make sure the person received the support they needed to manage their health care. The action plan stated that each person was being reassessed and a new care plan with relevant risk assessments was being implemented. However at the inspection in July 2015, less than half of the 109 older people living in the community had been reassessed and people's health care needs had not been fully identified and new care plans had not been implemented therefore we could not be sure people were receiving the health care they needed.

Care plans did not identify that some people may need care and support to keep their skin healthy and intact. There was no information in any of the care plans to inform staff on how to deliver care to people whose skin may be at risk of breaking down. There was no information about what signs to look for in case sores were developing and what action they should take, like contacting the doctor or district nurse. There was information in the daily records to indicate that staff were applying creams to people's skin but there was not always direction where it should be applied and what cream should be used. There was no information about how people should be positioned or what equipment needed to be in place to prevent their skin from deteriorating further. When people did have pressure sores the local district nurses were visiting them.

A person with diabetes was refusing all their medicines but the care plan had not been updated to reflect the changes. There was no guidance for staff about what signs they should look for if the person's condition became unstable and what action they needed to take.

People were at risk of receiving inappropriate care as the provider has failed to make sure that people received person centred care and treatment that was appropriate, meet their needs and reflected their personal preferences. This was an ongoing breach of Regulation 9 (1),9(3)(a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were observed taking action to support people with their health care needs. They were discussing the person's medicines and were going to speak with the family and doctor to clarify what medicine the person should be taking.

People told us that the staff supported them with their immediate health care needs. They said that staff were good at recognising when they did not feel well and would suggest if they needed to see a doctor. One person told us the staff acted promptly when they had taken the wrong tablets and called the paramedics. They said: "I was short of breath, so it was important" Another person said "They phoned for an ambulance when I had a mini stroke. They waited with me and did everything right". "The staff usually advise me when to see my doctor, and that's good because I need that". One family member said that their relative had been taken ill recently, when the carer had been present. They said: '"The carer actually spoke to the doctor's receptionist on the phone, and then to the paramedics. She waited with us until the ambulance arrived, she coped well."

People that we visited in a supporting living setting were being supported with their medical conditions, such as dementia, and they regularly attended clinics for screening and memory loss. They were also supported with their speech and language skills and their medicines had been reviewed.

Requires improvement

Is the service effective?

People told us and we observed that staff asked for consent from people before undertaking tasks.

Some people were not able to make complex decisions about the care and treatment they received. Some people were able to make simple decisions, such as what they wanted to eat or drink but needed the support of others to make decisions for more complex matters. Records showed that meetings had been held with health and social care professionals to support people to make complex decisions about their care. However, assessments of people's capacity to make specific decisions had not always been completed to show what, if anything, needed to be done to support people to make decisions in their best interest.

Deprivation of Liberty Safeguards (DoLs) provides a process by which a person can be deprived of their liberty, in a care home or hospital, when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. However in supported living services these safeguards are only available through the Court of Protection. There were no assessments or guidelines in place for people living in supported living services. The service was currently liaising with the local authority to determine whether applications should be made to the Court of Protection in relation to people using the service.

The provider had failed to ensure that appropriate assessments had been made in in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that the staff were well trained and knew how to care for them well. They said: "Both of my carers know what they've got to do, and get on with it" "The regular ones all know what they are doing". "Staff have been trained and the older ones have a lot of knowledge".

Staff told us they received training relevant to their role. The provider had listened to feedback from staff when they said the yearly updated training was too much information to take in on one day. The training to update staff was now provided over a two day period to ensure that staff were able to cover all of the topics thoroughly. Staff training was recorded on a computer system which alerted the trainer when the staff needed refresher training. The current trainer was leaving the service and the provider was in the process of recruiting a new trainer.

The provider was aware of the new 'Care Certificate'. The 'Care Certificate' is an identified set of standards that social care workers adhere to in their daily working life. The provider was outsourcing this training to ensure new staff members would work towards the qualification as part of their induction. New staff shadowed experienced staff to help them provide care consistently and then worked alongside more experienced staff until they were deemed competent to work alone. The provider told us that the induction was on going and they were sourcing additional training for each member of staff in line with the Care Certificate requirements.

When staff started to work for the service they received a formal induction, which consisted of a four day programme delivered by one of the trainers. This included staff's duties and responsibilities, practical sessions on how to support people with their personal care and what to do if people refused care. There were sessions on skin care, catheter care, communication, emergency procedures, safeguarding, whistle blowing and complaints, food hygiene, infection control, fire safety, first aid, medication, the Mental Capacity Act 2005, and dementia awareness. There was a whole day practical session on moving and handling people safely. Staff were given a staff handbook and information leaflets on topics covered during the training. Staff told us that they thought the induction training was good. Following the induction programme new staff shadowed senior staff, and completed a probationary period before becoming permanent staff.

Shortfalls in specialised training, especially for the staff supporting people with learning disabilities in the supported living houses had been recognised by the provider. They were in the process of enrolling staff on level 2 Understanding of Autism, and also level 2 Understanding Learning Disabilities. Staff told us that communication with the management had improved and they had listened to their development needs.

Staff met with their line manager regularly to talk about their role and the people they provided care and support to. Although records showed that all staff had received an annual appraisal to discuss their training and development, two members of staff told us that they had

Requires improvement

Is the service effective?

only completed their initial self-assessment and the full appraisal had not been processed. One staff appraisal had not been completed properly and did not show how the staff member's performance had been discussed and what their training and development needs were. People and their relatives told us that staff knew what to do to care for people. They said they received the training to have the skills and knowledge to do their job well.

People's needs in relation to support with eating and drinking had been identified when they first started receiving care. People told us that the staff always wore gloves while preparing their meals and staff supported them well with their choices. They said: "My daughter puts them all in the freezer so they go by these choices". "They cook me fresh food, they cook two meals and freeze one, which works well. I am a vegetarian, so I am teaching them all about it". "They buy it and cook it for me. It is fine, they are good at cooking". "It is only breakfast, but I always choose which cereal to have". One person preferred a sandwich and a drink and said that they always chose what they would like.

A relative whose family member needed constant care was happy with the way in which the staff made the meals and added: "They come up with good ideas of their own as well as going by mine, using seasonal stuff, which is great".

Good

Is the service caring?

Our findings

People and relatives told us that the staff were kind and caring. They said: “The staff even tidy up when they don’t have to” “I can’t find fault at all at the moment”. “They go above and beyond, I am very happy with them”. “The care is fantastic”. “It is brilliant care” “I don’t know what I would do without them, they are very nice people”. “The staff are wonderful to me”. “The staff really do care, they made sure I had something to eat the other day when I was not feeling too good”. “The staff are very good at caring”. “The staff are just brilliant, smashing”.

People said the staff were very friendly and respectful, they said: “We chat and they ask if it is all okay”. “We are chatting and laughing and it’s nice to have other people to talk to”. “My carer will have coffee with me and I like that”. “The staff are more like friends now. They always leave me in good spirits”.

People told us that the staff listened to them. One person told us how the provider had asked for suggestions to improve the service. They said: “They asked for suggestions, so I gave one: I suggested that some of the office staff were allocated to us so that they know about you, so that you don’t have to go into lots of details when you phone. And I think they are doing it now”. People said the office staff were helpful, friendly and polite.

During our visits to people’s homes we observed that staff spoke with people individually and respectfully. People smiled back and responded to staff in a positive way. They were treated with kindness and appeared relaxed in their company.

People had been asked if they preferred a male or female member of staff and were called by their preferred names. People talked about their preferred members of staff and said the office made every effort to accommodate their choices. People said “It is usually the same ones, which is very good”. “‘I have three carers so there’s always one available”. “I have a really good team now”. “I have one main carer, but the others are fine too”. “We get to know each other, which are lovely”. “I have the same carer all of the time, they really know me well and help me with my daily routines. I am treated like one of the family”.

Staff talked about people in a respectful and caring way, for example one staff member said: “We always treat people as we would like to be treated ourselves”. Staff had received training in treating people with dignity and respect as part of their induction and their practice was checked in relation to this during the spot check visits carried out by senior staff to monitor staff skills and competencies.

One staff member told us that they always greeted people with a smile; they had good communication skills and worked well as a team to make sure people received the care they needed.

People told us that their privacy and dignity was always respected and staff made sure that doors and curtains were closed when providing personal care. Staff told us how they supported people to have privacy in their own homes, for example making sure they had privacy when receiving personal care. Staff told us the importance of keeping people’s confidentially and how not to discuss any private information in front of other people.

People were encouraged to remain as independent as possible. People said they were consulted about their care and that staff listened and acted on what they said. People said the care staff helped them to maintain their independence. People were encouraged and supported to do as much as possible for themselves. People’s personal hygiene care plans gave precise instructions on what people could do for themselves and the areas where they needed support. One person told us “I just need help washing my back and legs. The staff do this for me but I do everything else myself they just make sure I am Ok. It gives me confidence knowing they are around”. Another person said, "Without my visits every day I would have to be in a home. I want to stay on my own, making my own decisions about what I want to do for as long as I can, and these carers help me do that."

People with learning disabilities were supported to be as independent as they could be and were supported to develop their skills. People and staff worked together at their home to do daily tasks like laundry, tidying up and preparing drinks and meals. Staff supported people in a way that they preferred and had chosen. There was a relaxed and friendly atmosphere. People looked comfortable with the staff that supported them. People and staff were seen to have fun together and share a laugh and a joke. People chatted and socialised with each other and with staff, and looked at ease.

Requires improvement

Is the service responsive?

Our findings

People told us that the service was responsive. They said: "I phone if I am going to the day centre and they come afterwards". "A carer was coming at 11 o'clock, but I said no, so they changed it". A relative told us: "If there are any problems, or changes are needed, they all respond very quickly". "'I had the sheet with this week's times on it and I asked for adjustments, which they did". "I am happy with the service, they are good carers".

People said that staff took time to find out what they liked and supported them in line with their wishes. One person told us, "They change how they do things depending if I am having a good or bad day". Another person told us, "I am very happy with the service, they sorted out all the problems." The relative of a person who used the service said, "We raised concerns about different staff turning up, but that was sorted out and we get the same carer now."

At the last inspections in September 2014 and February 2015 we asked the provider to take action to make improvements to protect people from the risk of inappropriate and unsafe care. Following the inspection the provider sent us an action plan to tell us of the improvements they were going to make by June 2015. There were new systems in place to assess people's care needs and to fully implement person centred care plans, however the action plan had not been fully achieved and the timescales for completion were June 2015. Less than half of the 109 older people living in the community had been visited, therefore not all new care plans had been implemented so we could not be sure people were receiving the care they needed.

People who used the service had care plans in place with copies held at both the head office and in their homes. These care plans should have given staff the guidance about how people's care should be provided. The care plans did contain information that was important to people about they likes, dislikes and personal preferences. However the care plans showed that people had not been involved in the development and review of their care plans in a meaningful way. People were not all receiving the care and support that they needed. People's care needs were not reassessed regularly and this resulted in their care plan being out of date and not reflecting their current needs.

Some people needed a lot of support and equipment to move and transfer around their homes. In some of the care plans there was detailed direction on how to safely move and handle people explaining what equipment to use and how to use it. In other plans there was no information.

One person had a catheter in place. A catheter is a tube that it is inserted into the bladder so that urine can drain freely. The care plan for the catheter did not state clearly what to do if the catheter blocked or if there were other complications. It did not give staff the guidance or instruction on what support the person needed to manage their catheter as independently and safely as possible. Staff were not sure what to do, they said, "We just put the night bag on". There was nothing in the care plan about them doing this for the person and how it should be done safely to reduce the risk of infection.

There had been an increase in the amount of time staff were allocated to spend with a person. The care plan stated, 'Evening call increased to one hour. Lunch time call on a Thursday increased to one hour'. The care plan had not been reviewed and updated to inform staff about what they had to do during this extra time. The person was at risk of not having the extra needs responded to, as there was no information available for staff to tell them what to do. From looking at the daily reports staff were not doing anything different than they had been doing before the increase in allocated time.

At the supported living service for people with learning disabilities care plans were written for people, but what was written in the care plans was not always happening. Throughout one person's care plan it stated 'use pictorial prompts to communicate'. There were no pictorial prompts for the person. The staff told us they were waiting for an assessment from the speech and language therapist. Staff had not developed and implemented individual pictorial prompts for the person. The care plan had been in place for some time. Staff told us that they communicated with the person using signs, facial expressions and body language. However, when we sat with the person and showed them pictures, they responded very well to pictorial prompts.

People were at risk of receiving inappropriate care as the provider has failed to make sure that people received person centred care and treatment that was appropriate,

Requires improvement

Is the service responsive?

meet their needs and reflected their personal preferences. This was an ongoing breach of Regulation 9 (1),9(3)(a)(d)**)** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were involved with their care plans. One person said that they sat with staff to review the care plan and read their daily notes to make sure they agreed with the content of their care plan. All staff signed to say they have read the care plans and where possible, people or their relatives had signed to confirm they agreed with the care to be provided.

Some people confirmed that the care plans were being reviewed and updated. They said: “My care plan was reviewed yesterday”. ”My care plan has just been reviewed, and I always sign their paperwork”. “The care plan has been reviewed and it is all up to date now”. “They are due to come and review it, they have phoned about this and it will be soon”. A relative told us that they were unsure if the plan had been reviewed but knew all about the new care plan.

People in the supported living service were being supported with their shopping and leisure activities, for example going food shopping and out for meals. They used public transport and enjoyed day trips out such as going to the local fair. They were part of the local community and took part in events that were happening in the local area. One person was being supported by staff to work in a local shop.

A process to respond to complaints was in place. The service had policies and procedures in place to explain how they would respond and act on any complaints that they received. When people started to use the service they were given a copy of the complaints procedure that explained to them what they had to do. This was also written in a format that would make it easier for people to understand.

Records showed that the detail of any complaint was recorded together with the action taken to resolve it to the satisfaction of the complainant. People told us that in the past they had complained and the complaints were handled well. One person told us how they asked for a carer to be changed and the service took prompt action to make sure they did not receive any further care from this member of staff. Another person said they had complained about their bills and this was sorted out and staff were very helpful.

People said that the office had telephoned and asked if they had any complaints or compliments about the service. One person said: “They phone to see if there are any problems which show they are listening now”. “There are no problems with the service”. ‘I’ve never had to complain at all”. Another person also said that they had recently telephoned the office to praise them about the service.

Requires improvement

Is the service well-led?

Our findings

People were very positive and complimentary about the service being provided and told us that the agency had improved. They said: "There had been a change of staff in the office, so I think it might improve more". "I must say it was rough at first, but it is much better now". "When it first started there were one or two misses, but it is all fine now". "It is improving. I wasn't happy at first but they have drastically improved recently". "It has been through a rough patch, but it is beginning to improve". "They have improved ever such a lot since I have been with them". "The carers have been okay, it was the office that has been poor, but that has changed now, and there is good communication from the office now". "The office seems fine to me". "The office staff are good on the phone". "The office always calls if they cannot cover". "The office always sorts out any problems for me". "I am very happy with them. It is a good company, I would recommend them". "I can't think of anything they could do better for me, I am happy with the service".

Relatives told us that the organisation was very good. They said: "Everything they are doing is excellent". They know my relative really well, I would definitely recommend them".

The service had improved in several areas, such as continuity of staff, communication with people. quality assurance and supporting staff. However the provider had failed to fully implement the action plan to improve the service sent to CQC in March 2015 and the service continued to be in breach of three regulations, safe care and treatment, person centred care and good governance.

The shortfalls in the action plan were, the full implementation of the new care plans, including risk assessments, staff had not received risk assessment training, a moving and handling assessor had not been appointed or trained and the weekly key performance targets had not been completed since April 2015. The timescale for completing this action plan was June 2015. There was a lack of strong leadership and oversight to make sure that effective planning and improvements were made to become fully compliant with the regulations.

Care plans had been audited, however the shortfalls detailed in this report had not been identified or actioned to improve the service and support that people received. After the previous inspection in February 2015, in order to closely monitor the quality of care being provided, the provider had implemented a weekly report to be completed by the branch manager on the performance of the service, for example, continuity of care, missed calls, staff sickness and complaints. These reports had not been completed or sent to the provider and senior managers since the end of April 2015. The branch manager did not know why this report had stopped being completed and there was no evidence that the provider had recognised this shortfall how they were continuing to monitor the service closely.

The provider failed to ensure that systems were established and operated effectively to ensure compliance with the regulations. The systems and procedures in place in order to assess, monitor and drive improvement in the quality and safety of people were not effective. The provider has also failed to mitigate risks relating to people's health, safety and welfare. This was an ongoing breach of Regulation 17(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service was currently being run by a branch manager as the registered manager and operations manager had left the service. The provider has restructured the management team and a new manager had been appointed and was in the process of applying to be registered with CQC.

Staff told us that the communication with management had improved but they were concerned that the registered manager and operations manager had both left the service and the support may not continue. The provider had restructured the management team and new manager had been appointed to continue the support and line manage the staff. Staff told us that the service was improving but felt there had been so many re-organisations that they were not all clear of the role of the staff in the office. They told us that the last staff meeting had been cancelled at short notice and although they had received information about the new structure of the organisation they felt they still needed clarification.

At the last inspections in September 2014 and February 2015 we asked the provider to take action to ensure that proper and accurate records were in place. Although records had improved and new systems were being implemented with relevant checks of record keeping not all records were completed, accurate and up to date.

Requires improvement

Is the service well-led?

Care plans and risk assessments completed by the staff were not accurate and did not contain the information to make sure people received the care and support that they needed that kept them as safe as possible. Medicine records were not accurate and people were at risk of not receiving their medicines as prescribed by their doctors. Some records had not been signed and dated by staff to show who was accountable for completing the information.

The provider did not make sure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records. This was an ongoing breach of Regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were secured and stored appropriately and all records requested at the time of the inspection were available.

People told us that they had been asked for their views about the service. They said they had received quality assurance surveys to complete; office staff also had telephoned them to ask if they were satisfied with the service. There had been a recent survey sent to people in June 2015 and the outcome of the survey was sent to people on 27 July 2015. This was mostly positive and any issued raised had been actioned to improve the service. People said: “They are listening now. I think it is because the CQC are around. I hope it doesn’t slip back”. “The CQC keep them on their toes”.

Although feedback had been received from people, the provider had not actively encouraged feedback about the quality of care from a wide range of stakeholders such as staff, visiting professionals and professional bodies to ensure continuous improvement of the service.

Staff knew about the visions and values of the organisation and told us how they cared for people in an individual way, respected their dignity and helped to keep them as safe as possible. They told us that although things had improved there was still more work to do to ensure the quality of the care continued to improve. Staff said that they worked hard as a team to make sure people received the care they needed.

Staff said they understood their role and responsibilities and felt supported by senior staff but thought clarification was required about the new management structure. There had been a lot of recent changes within the management team and staff were unsure who was responsible for the different areas of the organisation.

There were systems in place to monitor that staff received up to date training, had regular team meetings, spot checks, and supervision meetings. This gave staff the opportunity to raise any concerns and be kept informed about the service, people’s changing needs and any risks or concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had failed to ensure that appropriate assessments had been made in in accordance with the Mental Capacity Act 2005. This was a breach of Regulation Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people because the provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated. There was a risk of people not receiving their medicines as prescribed. The provider had failed to ensure that people were receiving their medicines safely. This was an ongoing breach of Regulation 12 (1) (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were at risk of receiving inappropriate care as the provider has failed to make sure that people received person centred care and treatment that was appropriate, meet their needs and reflected their personal preferences. This was an ongoing breach of Regulation 9 (1),9(3)(a)(d)**)** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider failed to ensure that systems were established and operated effectively to ensure compliance with the regulations.

The systems and procedures in place in order to assess, monitor and drive improvement in the quality and safety of people were not effective.

The provider has failed to mitigate risks relating to people's health, safety and welfare.

The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records.

This was an ongoing breach of Regulation 17(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:
Warning Notice