Care Quality Commission

Nestor Primecare Services Limited

Allied Healthcare Keighley

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

Overall summary

The inspection was announced and started with a visit to the agency's office on 21 December 2015.

The registered provider of the agency changed last year and this was the first inspection following registration.

Allied Health Care Keighley is registered as a domiciliary care service to provide nursing and personal care to people in their own homes.

There was a registered manager 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.

Staff had an adequate knowledge of safeguarding and how to act on allegations of abuse. They said they were

Summary of findings

confident the registered manager would take appropriate action. All the required checks were done before new staff started work and this helped to make sure people were protected.

Some people were supported to take medicines and overall this was done safely. In the case of one person who had recently started to use the service we found their call times had not been organised to make sure they received their medicines at the specified times. We were concerned the initial assessment had not identified the importance of making sure the person received their medicines at set times. We found this was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not done everything reasonably practicable to make people received care which was appropriate and met their needs.

The registered manager told us they had enough staff to deliver the service and said recruitment was on-going. However, some people who used the service raised a number of concerns about staffing. These included late and missed calls, a lot of staff changes and a lack of planning to cover staff absence and leave. Staff told us they often felt rushed and some staff said they felt under pressure to work additional hours because of a shortage of staff training in the specialist skills needed to provide care and treatment to people who received continuing health care packages of support. In addition, we found there was no travel time allocated on the rotas. We found this was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured enough staff were deployed to meet people's care and treatment needs.

Staff received comprehensive induction training and there were regular updates on core skills. Staff were provided with a range of support which included regular meetings and reviews after induction and a plan of supervision and appraisal. Most of the people we spoke with were satisfied the staff were adequately trained to meet their needs

Risks to people health and welfare were identified and assessed and there were procedures in place to ensure care workers responded appropriately in emergencies.

We found the service was working within the principles of the Mental Capacity Act 2005 (MCA). All people and relatives we spoke with confirmed staff asked for permission before assistance or care was provided

When the agency was providing support to people with meals this was done appropriately.

The service liaised with external health professionals such as GP's, district nurses and community mental health care teams to help ensure people's healthcare needs were met.

People we spoke with were very complimentary about the care workers and said they were kind and caring. However, people's experience of the quality of care they received was influenced by the variance in call times. People told us they were rarely informed when staff were running late; if they were informed it was because the care workers rather than the office staff, who let them know. People also said they did not always know who was going to turn up.

The provider told us they had achieved recognition for good practice. For example, 50% of the care workers at the Keighley office had been certified as 'Dementia Friends.'

The records showed, and the care co-ordinators confirmed, people were not allocated specific call times although this was listed on the staff rotas. This led to uncertainty and/or worry for some of the people we spoke with. For example, two people told us they felt they had to make compromises to suit the service rather than the service rather than the service being flexible enough to meet their needs.

We saw variations of between one to two and a half hours in call times between August and December 2015. One person told us their night time call had been changed to an hour later than they wanted without any consultation. In the records for one person who had recently started to use the service we found there was not enough information in care plan about the care and support they needed. We found the provider had not done everything reasonably practicable to make sure people received care and treatment which was appropriate, met their needs and reflected their preferences.

We found that although the service was working their way through people's care reviews some people had not had

Summary of findings

recent or regular reviews of their care. This was confirmed by people who used the service. For example, three people told us they had not had reviews for over 12 months. This meant they had not had the opportunity to be involved in decisions about their care and treatment. The provider had not enabled or supported some people to make or participate in decision making about their care and treatment.

There was a complaints procedure in place and records of complaints and compliments were kept.

Most people said they knew how to make a complaint if they needed to. However, a number of people said they had no confidence in the providers complaints procedures because nothing every changed. Five people told us they felt their concerns had not been taken seriously and two people said it was only when they had involved other agencies that action was taken to resolve their concerns. We found the provider had failed to consistently act on feedback from people who used the service.

The majority of people we spoke with were happy with the service and said they would recommend it to others. However, other people said they would not recommend the agency. The reasons cited were related to lack of organisation and planning and not due to any concerns about the care workers.

There were systems in place to obtain people's views about the quality of the services provided. However, it was not always clear what action had been taken to respond to information received.

The provider had systems place to assess and monitor the quality of the service although again it was not always clear what action had been taken to improve the service. This was because action plans had not been completed.

The provider did not have an electronic call monitoring system, although they planned to introduce one. At the time of the inspection the service relied on complaints from people or staff to ascertain whether calls had been missed and late. This meant there was a risk poor or unsafe service would not be identified particularly given the size of the organisation and for those who did not have the capacity to realise calls were late or missed.

Audits of paperwork such as MAR charts and daily records of care were periodically undertaken to monitor call times and documentation quality. However, we found this process was inconsistent. In addition, we found the audits had not always picked up issued which we found when we reviewed the records.

Incidents including medication errors, complaints, safeguarding's, missed calls and any accident were recorded. We saw evidence that actions and lessons learnt sections were filled out detailing the individual measures taken to prevent a re-occurrence. The information was submitted to the providers head office and monitored to ensure they were actioned and closed within 28 days. However, there was no separation of analysis of these types of incidents into different categories to analyse the number of each type of incident for example per month, quarter or annually as a tool to monitor and improve performance. The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided.

We found the provider was in breach of three regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Staff understood how to recognise and report abuse and this helped to keep people safe. All the required checks were done before new staff started work and this helped to protect people.

Staff were not always organised in such a way as to ensure people's needs were met and some people were concerned that there were a lot of staff changes.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received core skills training, however, improvements were needed in relation to the provision of specialist skills training.

People were supported appropriately to eat and drink and to meet their health care needs.

People were asked for their consent before care and support was delivered. When people were unable to consent there was evidence their preferences were discussed and reviewed and a best interest decision made.

Is the service caring?

Requires improvement

The service was not always caring.

People were very complimentary about the staff and told us they were caring and kind. However, people's experience of the quality of care they received was influenced by the variance in call times and frequent staff changes.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

There were inconsistencies in the way people were supported to be actively involved in making decisions about their care, treatment and support.

There was a process in place for dealing with complaints. However, a number of people expressed a lack of confidence in the provider's complaints procedures.

Is the service well-led?

Requires improvement

The service was not consistently well led.

Although the provider had systems in place to assess and monitor the quality of the services provided they were not effective in bringing about sustained improvements.

Allied Healthcare Keighley

Detailed findings

Background to this inspection

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

The inspection was announced and started with a visit to the agency's office on 21 December 2015. We gave short notice because the location provides a domiciliary care services and we needed to be sure that someone would be available at the office.

The inspection was carried out by two inspectors. During the office visit we spoke with the registered manager, care co-ordinators and four care workers. We looked at ten people's care records and other records related to the management of the service such as staff files, training records, surveys, meeting notes and quality assurances records. Before and after the office visit we carried out telephone interviews, speaking with 21 people who used or had used the service and five staff.

We asked the provider to complete a Provider Information Return (PIR) which was returned to us in a timely manner. 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 reviewed all information we held about the provider and contacted the local authority to ask for their views on the service.

Requires improvement

Is the service safe?

Our findings

Staff we spoke with had an adequate knowledge of safeguarding and how to act on allegations of abuse. They said they were confident the registered manager would take appropriate action. We looked at an example where the provider had identified a concern and reported to the safeguarding authority. The registered manager demonstrated a good understanding of safeguarding procedures providing us with assurance that the correct processes would continue to be followed.

Care workers were asked questions about safeguarding when their work practice was checked in the community to make sure they understood how to keep people safe. People who used the service were also encouraged to raise any concerns through regular quality reviews.

Some people were supported to take their medicines. Medication Administration Records (MAR) were kept for these people. These listed the medications people received and the support provided. Gaps on MAR charts were identified through the audit process. We found these were reasonably well completed and where one person needed painkillers four times a day, action had been taken to ensure visit times were appropriate. This was to make sure enough time had elapsed between each dose of medication for them to be given safely.

In one case we identified a concern with regards to the management of medicines. One person had been using the service for a week, yet there was no information in their care file about the medicines they were taking, where they were stored or about what support they required. The assessment from the Local Authority stated it was important this person received calls at specific times due to the medicines they were receiving. Certain medicines must be given at set times in order for people to benefit from them. We looked at rota's which showed their calls were scheduled on the rota's between 05.00am and 07.30am for the morning call during the week commencing the 14 December 2015 and between 19.30 and 21.15 for the evening call. Their teatime call had also varied between 16.30 and 19.00. This was inappropriate given they required support with time specific medicines. The registered manager told us this variation was due to having to 'slot' this new customer into existing rota's, however' we were concerned that the assessment conducted by the agency had not been broad enough to identify how important it was that these medicines were given at set times. Whilst we saw consistency of calls had improved on rota's for the week commencing the 21 December 2015 there was still a variation between 19.30 and 21.45 for the evening call.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not done everything reasonably practicable to make sure people received care which was appropriate and met their needs.

There was evidence the administration of prescribed creams (topical medicines) was recorded.

The people we spoke with did not raise any concerns about the management of their medicines and staff told us they had training updates every year on the safe management of medicines.

The registered manager told us they had enough staff to deliver the service and said recruitment was on-going. They told us staff were able to pick up additional shifts and the registered manager told us other local offices run by the same provider could be contacted should they experience staffing shortages.

We asked the staff if they felt the agency employed enough staff to deliver the service. The feedback was mixed. Staff who worked with people who had continuing health care packages usually worked with same people on a regular basis and worked longer hours such as 12 hour days. These staff felt there were generally enough staff employed although some raised concerns about the arrangements for covering unplanned absence. This was, however, related to a lack of specialist training rather than staff numbers.

Other staff, particularly those who covered shorter calls, which they referred to as working in the community, said they frequently felt rushed, particularly when doing 15 minute calls. They said the 15 minute calls were particularly difficult at meal times. This group of staff told us their daily work plans did not include travel time which meant they were always going to be behind schedule. The provider told us they were in talks with the council to review 15 minute calls.

We found a lack of lack of travel time allocated on rota's. This meant that rota's were not conducive to staff spending the full allocated amount of time with each person who used the service and we concluded this may encourage them to rush calls. For example, we calculated there was

Requires improvement

Is the service safe?

over 10 minutes travel time between some locations where no travel time was allocated. Some of these calls were short 15 minute calls in themselves, increasing the pressure placed on staff.

When we looked at the rotas we saw some staff were working very long hours, 50 to 60 hours a week. The registered manager told us his was down to personal choice; however, some of the staff we spoke with said they felt under pressure to work additional hours. One person who used the service told us they had the same care workers every night, seven nights a week. They were concerned that the staff never seemed to have a night off.

Other people who used the service echoed the concerns expressed by staff about the lack of provision for unplanned absence. People expressed concerns about staff being repeatedly late and about a high turnover of staff. One person we spoke with said they had stopped using the service in November 2015 after having 13 different care workers in three days. Another person said, "The carers are very good and very kind but it's not like it used to be, there have been a lot of changes and there are a lot of different staff." People told us they were not informed about possible delays or missed calls or if there was going to be a change of carers at short notice.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured enough staff were deployed to meet people's care and treatment needs.

Safe recruitment procedures were in place. Candidates were required to complete an application form and attend an interview. Checks on their identity, health and character were undertaken, such as ensuring a Disclosure and Baring Service (DBS) check, and two references were obtained prior to commencing work. This was managed by a computer system which would not allow shifts to be allocated until these checks had been completed. Staff we spoke with confirmed all these checks were completed before they started work.

People's care records showed that potential risks to their health and welfare had been assessed. This included the environment and people's specific needs such as moving and handling, falls and the risk of developing pressure sores.

Procedures were in place to help ensure care workers responded appropriately in emergencies for example if there was no response on arriving at a person's house. Staff we spoke with understood these procedures and how to respond to help keep people safe.

Requires improvement

Is the service effective?

Our findings

Staff received comprehensive classroom based induction training when they started working for the service. This included core care skills, medicines management, safeguarding, supporting people to eat and drink and dementia. Competency assessments were undertaken to ensure staff had gained the required skills and knowledge. New staff without previous care experience were required to complete the Care Certificate. The Care Certificate provides a national recognised set of training standards. New staff worked with an experienced care worker and read the service's policies and procedures before working alone.

Existing staff were required to complete refresher training in mandatory subjects on a regular basis. We saw all training was up-to-date. The computerised management system would not allow staff to be allocated care shifts without training being completely up-to-date demonstrating the provider acknowledged the importance of ensuring staff were appropriately trained.

Specialist training was also provided to some staff by registered nurses for example in percutaneous endoscopic gastrostomy (PEG feeds), epilepsy rescue medication and ventilation equipment to support people with more complex needs.

Staff were provided with a range of support which included regular meetings and reviews after induction and a plan of supervision and appraisal. Staff we spoke with told us they felt well supported by the service and said training had been useful in giving them the skills required to deliver care effectively. However, some said they did not think there were enough staff trained in the specialist skills required to support people who had continuing health care packages. The impact of this was that existing staff felt under pressure to work additional hours because no provision had been made for covering unplanned staff absence.

Most of the people we spoke with were satisfied the staff were adequately trained to meet their needs. However, one person told us that while their regular staff were very good some of the newer staff did not know how to use the moving and handling equipment, they said, "Some don't have a clue."

The provider told us in their provider information return (PIR) the majority of staff had received training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. However, when we spoke with one of the senior care supervisors they told us they had not received any training on the MCA despite the fact that part of the their role was assessing people's needs and developing care plans. The provider subsequently told us the senior care supervisor had actually completed the training in 2013.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care applications must be made to the Court of Protection. The service had not needed to make any applications to the Court of Protection. We found the service was working within the principles of the MCA.

Where people were making decisions on behalf of others it was acknowledged these were best interest decisions. In some cases we saw care plans were missing signatures from people who used the service, we raised this with the registered manager who told us they would ensure they consistently asked people to sign their care plans in the future. We saw evidence in daily records of care that people were asked for their choices with regards to how they wanted their care and support tasks to be delivered. All people and relatives we spoke with confirmed staff asked for permission before assistance or care was provided.

Most people were supported with meals by their families. When the agency was providing support to people we found there was information in the care plans to guide staff. For example, one person's care plan stated they must not have salt added to their food and needed time and encouragement to eat. Some people who used the service had difficulty eating and drinking and received all their nutrition via PEG (Percutaneous endoscopic gastrostomy) tubes. This aspect of people's care was overseen by registered nurses and there were clear care plans in place for staff to follow.

Requires improvement

Is the service effective?

People told us they were supported appropriately with food and drink and the daily records of care provided evidence people received appropriate support with food and drink. There was information about people's likes and dislikes in the care records.

We saw evidence the service liaised with external health professionals such as GP's, district nurses and community mental health care teams to help ensure people's healthcare needs were met.

Requires improvement

Is the service caring?

Our findings

People we spoke with were very complimentary about the care workers and said they were kind and caring. One person said, “The carers are very nice.” Another person described them as “Lovely,” and another person said, “They (care workers) are absolutely wonderful.”

The provider told us staff attitude, dignity and respect was monitored through regular contact with people who used the service and staff including spot checks of staff practice, customer reviews and annual satisfaction surveys. The spot checks, satisfaction surveys and review records we reviewed showed there were no issues with dignity and respect with people reporting staff were kind and caring. Spot check records showed staff consistently displayed appropriate dignity and respect towards people they were caring for.

People’s experience of the quality of care they received was influenced by the variance in call times. People told us they were rarely informed when staff were running late; if they were informed it was because the care workers, rather than the office, who let them know. People also said they did not always know who was going to turn up.

For example, one person told us they had no problems with their regular team of care workers. However, they said other staff often arrived and they had no idea who they were. They said they did not get introduced to new staff before they started providing care and support.

Another person said, “The girls are very nice but I never know who is going to turn up, there are that many different ones.” A further person said there were often delays when two staff were needed because they did not arrive at the same time. They said valuable time was wasted waiting for the second care worker. They said this was compounded by the fact that the first care worker did not know who the second was and therefore could not contact them to find out how long they were going to be.

The provider told us they tried to ensure care workers car share on double up calls which would in most cases alleviate the issue.

Two people told us they had, on more than one occasion, cancelled the visit because staff had been so late.

Most people said that although the care staff were very busy this did not have an impact on the care they received. However, one person said they sometimes felt rushed at bedtime. Two other people said that although the staff were very good at providing their care and support they often did not clean up after themselves and this was left for family members to do.

In the PIR we asked the provider if they had received any recognition of good practice and they told us Allied Healthcare won the Domiciliary Provider of the year in the Health Investor Awards 2015. Allied Keighley workers had received a 'Shining Stars ‘award for the outstanding care they had delivered and the registered manager and 50% of care staff had recently been certified as 'Dementia Friends'.

Requires improvement

Is the service responsive?

Our findings

One person who used the service told us they were "quite satisfied" with the two regular care workers who visited them. They said they liked to have an early start and whenever possible their regular carers made them the first call of the day.

The documentation reviewed showed people were not allocated specific call times although this was listed on the staff rotas. This was confirmed by the care co-ordinator. This could lead to uncertainty or worry and we found this was the case for some people who used the service. For example, two people we spoke with told us they felt they had to make compromises to suit the service rather than the service being flexible enough to meet their needs.

Another person told us the time of their bedtime call had been changed from 9.30pm to 10.30pm without consultation. They said they were not happy with this change as it was too late. The records showed the person had been received their bedtime call between 9.30pm and 10pm in September and October 2015 but in December 2015 it was scheduled for 10.30pm. There was no evidence of consultation with the person in the records.

We saw some variations in call times, for example one person received their morning call between 08.30am and 10.30 in early October 2015 and another person had received their morning call between 07.00 and 9.50 at the end of August 2015. We saw a third person had received their morning call between 05.00am and 07.30am and there teatime call between 16.30 and 19.00 in December 2015.

We identified that for one person who had been using the service for a week, there was insufficient information recorded within their care plan as to the nature of the care and support required with many sections blank. This meant care workers had no clear plan to follow as to how this person's needs were to be met.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not done everything reasonably practicable to make sure people received care and treatment which was appropriate, met their needs and reflected their preferences.

The registered manager told us they were currently working their way through care reviews with people who used the service. We looked at documentation which confirmed this was the case. However, we identified one person who had not yet received a care review or been asked for their feedback on the service since they started using the service in May 2014. In addition, their daily records of care had not been brought back to the office or reviewed. We spoke with this person who told us they felt safe with their care workers and trusted them but said they did not think the provider, Allied Healthcare, was interested in them. They said they had received one visit from office staff when they started to use the service about 18 months ago and had not had any contact from the office staff by phone or in person since then.

Another person said it had been nearly a year since they started using the service and they had never had a review and no spot checks had been carried out on the staff providing their care in their home. A further person who had been using the service for several years said they had one or two reviews when the service started but nothing recently. They also said no spot checks had been carried out on staff working in their home.

This was a breach of Regulation 9(3)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not enabled or supported people to make or participate in decision making about their care and treatment.

The registered manager told us there had been 15 complaints and 25 compliments in the last 12 months.

The registered manager said 15 complaints had been resolved within 28 days. They told us the complaints had been analysed and inconsistent call times and missed calls had been identified as a trend. They told us they were working with the provider's recruitment team to improve recruitment of staff and the Human Resources department to improve the management of staff absence.

The majority of people we spoke with told us they knew how to make a complaint if they needed to. Most people said they could ring the office if they had any concerns. However, they went on to say that although the staff in the office were very nice when they rang nothing ever really changed. Five people told us they had little or no confidence in the provider's complaints procedures and felt their concerns had not been taken seriously. Two people

Requires improvement

Is the service responsive?

told us it was only when they had involved other agencies that action was taken to resolve their concerns. One person said if they had any concerns they would speak directly to the care workers because that was more effective than contacting the office.

This was a breach of Regulation 17(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to act on feedback from people who used the service.

Requires improvement

Is the service well-led?

Our findings

We asked people who used the service if they would recommend it. The majority of people we spoke with were happy with the service and were happy to recommend it to others. However, four people said they would not recommend the agency and two people said they did not feel they had a choice. The reasons given for not recommending the agency were related to a lack of organisation and planning. For example, one person said if they had to choose an agency again they would keep the same workers but not the agency. Another person said, "The care workers are very good but it is not very well run."

The service had a well-defined structure with four care co-ordinators managing and co-ordinating the various geographic areas and people being supported to have their continuing healthcare needs met.

Staff we spoke with said morale was generally good and for the most part they found the management team supportive. However, some staff expressed concerns about feeling under pressure to work additional hours to cover absence or vacancies.

Systems were in place to obtain people's views on the quality of the service, although it was not always clear what action had been taken to respond to information received. Annual customer satisfaction surveys were completed to obtain people's views on the quality of the service. We looked at the most recent from March 2015. The responses were mainly positive, for example 71% of the people would recommend, and only 6% rated the service as poor. There were some negative comments received, for example, about care workers not informing people if they were going to be late, staff not always showing ID badges and staff not always having the right skills. However, the action plan had not been filled out to demonstrate a robust plan was in place to implement and embed improvements and improve overall satisfaction. The registered manager told us that they should have filled this out.

People were also regularly asked for their feedback through a "customer review" where they were either telephoned or visited in person to ask for their feedback on the quality of the care and if any changes were needed. We saw a number of these had been completed and although most people stated they were very happy, negative comments were also noted on some forms. We saw where this was the case actions had been filled out demonstrating how the service was going to address these concerns. However, when we spoke with people who used the service they told us nothing really changed. We concluded these reviews did not affect any positive change for people using the service.

Systems were in place to assess and monitor the quality of the service although it was not always clear what action had been taken to improve the service.

The provider's head office also undertook an annual audit of the quality of the service assessing against CQC standards. This included speaking with staff, people, reviewing paperwork and systems and processes. The most recent audit completed in September 2015 was mainly positive, with the service achieving a score of 92%. There were a number of actions that needed to be completed, for example, the audit found issues with risk assessment documents and log books not always being promptly returned to the office and reviewed. However, the action plan had not been completed and returned to the provider within the agreed timescale, the registered manager agreed they should have done this. We were therefore unable to confirm what action had been taken.

Staff practice was monitored through field supervisions. These were 'spot checks' when one of the management team goes to the home of someone using the service to observe a care workers practice. These looked at areas which included timeliness, dignity, documentation and whether the care worker undertook the required tasks in a competent and complete way. Where issues were identified, we saw plans were in place to address these with staff. Staff also received office based supervisions, where their performance and developmental needs was assessed as well as clinical based supervisions.

The provider told us they were planning to introduce an electronic call monitoring system, but this was not yet in place. This meant at the present time the service relied on complaints from people or staff to ascertain whether calls had been missed and late. This meant there was a risk poor or unsafe service would not be identified particularly given the size of the organisation and for those who did not have the capacity to realise calls were late or missed.

Audits of paperwork such as MAR charts and daily records of care were periodically undertaken to monitor call times and documentation quality. We saw some evidence these were identifying and rectifying issues. However, this

Requires improvement

Is the service well-led?

process was not consistent. For example, one person had been using the service since May 2014 but there were no daily records of care to review in their file which had been checked or reviewed.

Where daily records had been reviewed, we found issued had not always been picked up. For example, we looked at one person's records, this showed that no lunchtime call was recorded on 7 September 2015, and no early evening or late evening call recorded on14 September 2015. We looked on the electronic system with the care co-ordinator and could find no evidence these calls were cancelled. We were concerned that these discrepancies were not picked up during the care plan review to identify whether calls were missed or documentation was not completed.

Incidents including medication errors, complaints, safeguarding's, missed calls and any accident were documented on a computerised recording system. We saw evidence that actions and lessons learnt sections were filled out detailing the individual measures taken to prevent a re-occurrence. The service submitted all incidents to head office which were monitored to ensure they were actioned and closed within a 28 day timeframe.

However, there was no separation of analysis of these types of incidents into different categories to analyse the number of each type of incident, for example, per month, quarter or annually as a tool to monitor performance. For example, we identified between October and December 2015 there had been a number of missed calls due to rota mix ups or carers "forgetting about calls." Overall analysis could have recognised this was a broad problem and ensured an overarching strategy was in place to address rather than simply addressing matters with the individual staff members.

This was a breach of Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not done everything reasonably practicable to make sure people received care and treatment which was appropriate, met their needs and reflected their preferences. Regulation 9(1) The provider had not enabled or supported people to make or participate in decision making about their care and treatment. Regulation 9(3)(d)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided. Regulation 17(1)(2)(a) The provider had failed to act on feedback from people who used the service. Regulation 17(2)(e)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured enough staff were deployed to meet people's care and treatment needs. Regulation 18(1)