Mach Care Solutions Limited

Mach Care Solutions (Birmingham)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 March 2018 and was unannounced. At the last inspection in December 2016 the provider was found to be requiring improvement in three out of the five areas we looked at; safe, responsive and well-led. At this inspection we found that some improvements had been made. However further improvements were required as people were still not consistently receiving care that was safe, responsive or well led. We found that the provider was in breach of one Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the end of our report.

Mach Care Solutions (Birmingham) is a Domiciliary Care Service which is registered to provide personal care and nursing care services to people living in their own homes. It provides a service to people of all ages including children, adults and older adults living with physical, learning and/or mental health conditions, such as dementia. At the time of our inspection Mach Care Solutions (Birmingham) was providing care to 122 people, including two children. They were not providing any nursing care to people at this time.

Mach Care Solutions (Birmingham) is required to have 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager was in post at the time of our inspection.

Some people continued to raise concerns about late, rushed or short care calls particularly when their regular carer [staff] was absent from work. This meant that some people did not always receive the care and support they required when they required it. The provider's quality assurance practices had not always identified or addressed these issues in a timely manner. They had also failed to recognise or address other shortfalls that we identified during our inspection, including the lack of robust recruitment practices and poor information governance systems. We continued to experience a delay in receiving the information we requested as part of our inspection and some of the records we received could not always be relied upon for their validity. This meant that this inspection was the fourth consecutive inspection whereby improvements were required to the governance of the service and therefore the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. You can see what action we have taken at the end of our report.

People were supported by sufficient numbers of staff who had the skills, knowledge and competencies to keep people safe and to meet their needs. People were protected from the risk of abuse because staff understood their responsibilities and knew how to raise concerns if needed. People were supported to have their prescribed medication safely.
Most people were pleased with the consistency of the staff that provided their care and reported staff to be kind and caring. People were treated with dignity and respect and received their care with consent. People were also encouraged to be as independent as possible and staff were mindful of the need to involve people

in making choices and decisions about their day to day needs.

People knew how to make a complaint if they were unhappy and felt that any complaints or issues raised were dealt with efficiently. However, further improvements to the management of complaints was required. The management team were compliant with the Duty of Candour regulation and were receptive to the feedback we provided at the time of our inspection.

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 always safe.

People did not always receive the support they required when they needed because staff did not always stay for the full duration of the care call, visits were rushed or care calls were late.

The provider did not always ensure staff had access to information that was specific to people's care needs and any associated risks.

The provider had failed to ensure robust recruitment practices were followed to ensure people received support from staff that were suitably qualitied and safe to provide it.

People were supported by sufficient numbers of staff and were pleased with the consistency of care they received.

People were protected from the risk of abuse because staff understood their responsibilities and knew how to raise concerns if needed.

People were supported to have their prescribed medication safely.

Is the service effective?

Good

The service was effective.

People were supported by staff that understood their responsibilities to protect people's rights and the provider had taken the appropriate measures to ensure that care was provided to people lawfully.

People were supported by staff who had received the training they needed to do their job effectively.

People received enough food and drink and were supported to have food that they enjoyed.

People were supported to maintain good health and to have

access to other health and social care agencies when required.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect by staff that knew them well.

People were encouraged to maintain their independence as far as reasonably possible.

People were encouraged to express their own views, preferences and opinions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in the planning of their care and the provider sought feedback on the service they received. However, people could not always recall having had a care review and had requested to have face to face meetings with the provider.

People knew how to make a complaint if they were unhappy and were confident that their concerns would be acted upon responsively. However, the recording and management of complaints continued to require improvement.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We saw some improvements had been made to monitor the quality and safety of the service since our last inspection. However, further improvements were still required. This is the fourth consecutive inspection where improvements in this area have been required.

We found a clear leadership structure within the service.

The management team were receptive to the feedback we provided at the time of our inspection.

Mach Care Solutions (Birmingham)

Detailed findings

Background to this inspection

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

This inspection took place on 15 March 2018 and was unannounced. The inspection team comprised of two inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at the information we held about the service. This included statutory notifications from the provider that they are required to send to us by law about events that occur within the service, such as deaths, accidents/incidents and safeguarding alerts. We contacted the local authority and commissioning services to request their views about the service provided to people, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection we spoke to eight people who used the service, three relatives of people who used the service, the registered manager, the operations manager, the quality assurance manager, six care staff, and an administrator.

We looked at the care records of six people in detail to see how their care was planned and reviewed. We also reviewed the records of seven members of staff to check the provider's recruitment practices and looked at records maintained by the provider about the quality of the service. These included audits of medication administration, care records and daily reports, as well as training records, feedback surveys and telephone reviews, staff meetings and spot checks.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found the service required improvement, in relation to their call monitoring systems, their risk assessment and management plans as well as their recruitment records and processes. At this inspection people we spoke with and records we looked at confirmed that some improvements had been made; however, further improvements were still required.

Most of the people we spoken with told us that there had been an improvement to the reliability and timeless of their care calls as well as to the consistency of the care staff who visited them. One person said, "Oh it is much better now, they used to turn up late all the time, but there are no problems at the moment and I get a regular carer [staff] now". Another person told us, "They [staff] are always on time but if they are running late, the office will let us know". A third person said, "I have complained in the past because they [staff] were never on time, but it's much better now". However, some people we spoke with continued to raise their concerns in these areas, especially when their regular carers were absent from work. One person said, "My regular carer is great; she is reliable and always on time. But when she is not at work, it is terrible. They can be two to three hours late. I'll call the office and they will apologise and get someone [staff] out to me but that's no good if I have appointments I need to get to". Another person told us, "They [staff] are usually on time in the morning but tend to be late in the afternoon but it depends on the carer [staff]; some are better than others". A third person said, "They [staff] come at the wrong times and they are always late. I get up at 08.20 and they come anything up to 10am and even after that". A relative we spoke with commented, "They [provider] is okay but I wouldn't recommend them because you can't rely on regular times of calls". Many of the people we spoke with also consistently stated that staff were not always staying for the full duration of their allocated care call. This meant that people were not always receiving the care and support they required and/or as planned. One person told us, "They [staff] have one foot in the door and are quick to leave; it's very rushed. Sometimes they rush me so much, some things don't get done, like one time I didn't brush my teeth, I know it's only small but it's important to me and other times they haven't had time to prepare my meals so I have had to ask my daughter or a friend to come and help me or they bring me a take-away". Another person said, "It's rushed and things don't always get done and I end up having to try and do it myself". A relative we spoke with stated, "My only concern at present is that sometimes carers [staff] are eager to rush off early from the job". This meant people felt rushed or did not always receive the care and support they required.

This was an on-going issue within the service and was noted as an area that required improvement at our previous inspections. At our last inspection, we were told that the provider had started to implement a new electronic call monitoring system to enable them to detect late or missed calls. However, at this inspection the provider explained that this system had not been as effective as they would have hoped. As a result, they were currently in the process of changing over to a new system which had been recommended to them by the local authority. The provider told us, "This system will be much better as it will be implemented for all our service users (the previous system had only been installed for people who were considered to be the most vulnerable and who would be unable to alert someone if their care call had been missed, such as those living with dementia) and it has been tried and tested for its effectiveness and reliability". They assured us that this system would allow them to monitor the timeliness and duration of staff attendance to

care calls as staff would be required to log in and out of each call they do. We were also shown how the system could be used to alert office staff of any late or missed calls as well as any overlaps in scheduling times. We were told by the management team that this will allow them to ensure staff have sufficient travel time between visits and visits were not 'double-booked'. People we spoken with appeared to be reassured by this new system and were hopeful that improvements will be made in this area. We will monitor the effectiveness of this system at our next inspection.

At our last two inspections we found that the provider had assessed and identified potential risks to people's health and well-being and that these had been formalised in risk assessments which were recorded in people's care files. However, we found that some of these were standardised and lacked personalisation. For example, we saw that where the risk management plans made reference to a clinical condition; the information provided was presented generically with a list of potential symptoms, which were not always specific to the symptoms experienced by that individual. At this inspection, we saw that some improvements had been made to the personalisation of records, but we found that some care files continued to have generic information. For example, one person's risk assessment noted that they had diagnoses of epilepsy and were at risk of seizures. The management plan stated that staff should inform the person of the risks associated with taking drugs and alcohol as some of these, such as cocaine can cause seizures. However, there was no indication within this person's care file or personal history to show that they were at risk of taking drugs or alcohol, or that they would have access to these substances. The provider told us that they were still in the process of reviewing all of the care plans and risk assessments as part of their improvement action plan and assured us that further improvements will be made in these areas. Feedback we had received from the local authority also noted that improvements had been made with input from the commissioners but further developments were still required. They informed us that risk assessments had improved but, in places, contained a lot of clinical information instead of mitigating actions which required further development. We will continue to monitor the improvements in this area at our next inspection.

People we spoke with told us that they felt safe receiving care from Mach Care Solutions. One person said, "I feel very safe with [staff]; she is very good and I would recommend her to anyone". Another person told us, "I have never had any problems, I am happy for them to come in to my home". Staff we spoke with were able to explain to us how they promoted people's safety and what they would do in an emergency situation, for example, if a person experienced a fall or a seizure. They were also able to tell us about their understanding of safeguarding people from the risk of abuse. Staff spoken with were aware of their roles and responsibilities in these areas, including what the reporting procedures were, in order to keep people safe. Records we looked at showed that staff received training on how to keep people safe from the risk of avoidable harm, as well as basic life support and these were regular agenda items for their team meetings and staff supervision.

Information we hold and records we looked at showed that a number of safeguarding concerns had been raised since our last inspection. We found that the provider had taken appropriate action and had liaised and worked collaboratively with the appropriate investigating bodies in order to assess and address the issues being raised. Action points from the provider's internal investigations also showed an appetite to learn lessons in order to drive improvements within the service.

Staff we spoke with told us that the provider followed safe recruitment processes. One member of staff said, "A friend told me about Mach Care Solutions, so I applied for a job, had an interview and then provided the necessary documents like proof of my identification and details of references; I also had a Disclosure and Barring Service (DBS) check". Another staff member said, "I had all the checks and training I needed before they [provider] let me start work". Most of the staff files we looked at confirmed this and showed that the provider's recruitment processes included a formal interview, and obtaining references and a DBS check.

The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care. However, not all of the staff files we looked at evidenced that the provider had reliably checked the validity and authenticity of staff references. Other records we looked at showed that the provider remained in the process of auditing and updating staff recruitment files and they assured us that this would be addressed.

Some of the people we spoke with and records we looked at showed staff supported people to take their medicines. One person told us, "I have to take medicines, so they [staff] do all that for me". Another person said, "I know what medicines I need to take but I often forget so [staff] check I have taken it". A third person said, "They [staff] help me with my medicines and write it all down". Care plans and risk assessments we looked at confirmed that staff were required to support some people to take their medicines either by prompting or administering their medicines to them to take. We found that both the care plans and risk assessments provided step by step instructions to staff to promote safe medicine management. The provider stated that information about side effects was provided by the dispensing pharmacist in the blister pack. Staff we spoke to and training records we looked at showed us that staff had received training in medication management and that medication management was one of the topics included in the team briefings as a refresher session. This showed us that arrangements were in place to support people with their medication if this was identified as a support need.

People we spoke with confirmed that staff wore uniforms and protective clothing when they supported them with their personal care. Staff we spoke with and records we looked at, including staff 'spot checks' confirmed that staff were provided with protective clothing and uniforms in order to promote infection control practices.

Good

Is the service effective?

Our findings

People we spoke with told us that the staff who visited them seemed to have the knowledge and skills they needed to meet their needs. One person said, "Yes, they [staff] know what they are doing". A relative we spoke with told us that they had had concerns in the past about the level of training the staff received but they were confident that the staff were well trained now. They said, "I wasn't happy with the way they [staff] were in the past but they [staff] are very gentle with him [person] now and properly trained". Staff we spoke with told us they felt confident in doing their jobs and confirmed that they received training. One member of staff told us, "The training is good; we have training every month". Another member of staff said, "We [staff] do a lot of training; it's good". Another member of staff told us, "When I first started I did all of my training and I shadowed another carer to make sure I was confident". Records we looked at confirmed that staff had engaged in face to face training sessions and were required to complete question papers to demonstrate their learning from each of the training sessions. New staff were also required to complete observed practices to be 'signed off' as competent within their roles. This meant that staff were supported by the provider to be effective in their roles.

Staff we spoke with told us that they attended regular staff meetings which often incorporated training and these, together with regular supervision and easy access to the management team, meant that they felt supported within their roles. One member of staff told us, "I feel very supported, I can call the office any time and they [management] will help me". Another member of staff said, "If I need anything at all, they [management] will help me, they are very good". We heard how effective communication systems within the service supported staff to ensure they were well informed with any updates or changes within the service or in relation to their specific duties. One member of staff explained, "We have office staff who we can contact. We get emails, text messages and there is an 'on-call' system we can use too, so help and advice is always available as well as team meetings and supervision".

People we spoke with told us that care was provided to them with their consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At our last inspection we found that improvements had been made to the provider's processes to ensure they supported people who lacked the mental capacity to consent to the care they received, in accordance with the MCA. At this inspection, we found that these improvements had been sustained. Staff we spoke with were aware of the need to sought consent, to ensure people were offered choices and to respect the decisions that people made. One member of staff said, "We always give people choices about what they want to eat or wear, some people may refuse a wash one day and we will respect that but record it". Another member of staff told us, "If a person refused [personal care], I would leave them alone and try again later; we can't make people do anything". The provider was able to articulate their knowledge and understanding of the MCA and had processes in place to fulfil their roles and responsibilities in complying with this legislation. We saw the provider had contacted the appropriate agencies for a formal mental capacity assessment and for an application to be made to the court of protection, where required.

People we spoke with told us that they felt their rights were protected and staff offered them choice. One person told us, "They [carers] are very good; it [care] is always my choice". Another person said, "They [staff] are very respectful and polite, they always ask what I need". Staff we spoke with understood the need for consent and were able to give examples of how they offered choices and protected people's rights. For example, one member of staff explained that some people weren't always able to understand verbal communication, so they would show them items of clothing or different food options, to enable them to make a choice.

We found that most people were supported to have sufficient to eat and drink and were given choices. One person told us, "She [carer] is very good, anything I ask for [food] they will do it". Another person said, "I have no problems at all, they do everything in need […] including my meals". Staff we spoke with confirmed that they supported people with meal preparation and eating if they required assistance in this area. One member of staff said, "I don't support anyone with this [meal preparation/feeding assistance] at the moment but I have done in the past. I make sure they have a choice from what is available and they have enough". Another staff member told us, "I prepare whatever they ask for, if they can't tell me, I will look at what they have had previously and what family have left for them so they get a bit of variety; I will feed them too if they need me to". This member of staff told us how important it was to take their time with people and be aware of any risks of choking and allergies when supporting a person to eat and drink. Records we looked at also showed that guidance was provided to staff on ensuring people had sufficient food and fluids available to them in between calls, where required.

People we spoke with told us that staff supported them if they were feeling physically unwell. One person told us that their main carer had been very observant in the care they had provided and said, "She [carer] found something on my back, it was a sebaceous cyst. She took a photo of it for me to help me to monitor if it gets worse and to show the GP". Another person told us, "I have had several chest infections recently; thank goodness [staff] was there to help me in the shower the other day because my knee gave way and I collapsed; but she was excellent she took over straight away and was able to help me out and sat me on the commode". They explained that they were not injured in any way but recognised that it was a 'near miss' and was grateful for the support of the staff member. The person said, "I am so lucky to have her [staff], she makes me feel safe". Staff spoken with were clear about the signs and symptoms people may present with to indicate that they were physically unwell and knew what action to take. Records we looked at showed that staff were advised to report any physical or mental health changes to the management team and to seek medical treatment as required. We also saw that the provider liaised with and made referrals to external health and social care professionals as required, to promote people's health and well-being.

Good

Is the service caring?

Our findings

Most of the people we spoke with were happy with the staff and the consistency of the staff who visited them. One person told us, "I feel so lucky to have my carer [staff] and she works seven days a week; anything I need help with, she does; nothing is too much bother; I'm really fond of her and treat her like family now". This person explained to us how their regular carer took the time to sit and have a chat with them and how valuable this was to them as it made them feel cared for and appreciated the company. Another person said, "She [staff] is great; I'd recommend the carer I have to anybody, she is lovely". A relative we spoke with stated, "The carers are really helpful". Staff we spoke with told us how having regular care calls meant they could develop good relationships with the people they cared for. One member of staff told us, "I see the same people every day so we get to know each other really well and it's good for them because it takes some of the embarrassment away". This member of staff also explained the benefits it had for people living with dementia. They said, "Even those living with dementia get used to you; for one lady, I'm the last person she sees at night, and the first person she sees in the morning, so she recognises me know and it has helped us form a good bond".

We found that people were supported to be independent. One person told us, "I can do a lot for myself and they [staff] respect that". Another person said, "I try my best but they [staff] help me when I need them to". A third person told us how they were keen to remain as independent as possible and that the staff understood this. They said, "She [staff] is very good, she will let me go on with what I can for myself and will assist me when I need it, like I'll take the lead in preparing my lunch but she is there to help me; she makes sure I am safe". We saw care plans reflected people's level of independence and informed staff of ways to promote independence as far as possible. For example, one care plan we looked at read, "I will take my medication myself but please check that this has been taken as I sometimes forget". Another care plan stated, "I am able to use the toilet independently but some days I may need more assistance than others". Staff we spoke with told us how they encouraged people to remain as independent as possible in order to enable them to retain their daily skills as much as possible.

We found that people were encouraged to express their own views, preferences and opinions. For example, one person we spoke with told us that they had been involved in the initial assessment to ensure the care they received met their needs and was delivered in a way that they required it. All of the people we spoke with said that the staff treated them with dignity and respect. We found that staff involved people in making day to day decisions in relation to the care they received, offered people choices and respected them as individuals. One person said, "They [staff] don't do anything without asking and will do anything I ask for". Another person said, "They [staff] are very respectful and I wouldn't have it any other way". Records we looked at showed that people were given choices about their care, such as the times staff visited, whether they preferred male or female staff and what they needed help with. For example, one care file we read stated, "I have full capacity and can make my own choices. I prefer my personal care to be carried out by a female carer". People we spoke with confirmed that these preferences were upheld.

Staff we spoke with were able to explain to us the importance of promoting people's privacy and dignity and gave examples of how they delivered care in this way. For example, staff told us that they always ensured

doors and curtains were closed when they provided personal care to people and that they respected people's privacy by turning their backs, covering people up as much as possible and only assisting when required. One member of staff said, "We always ask what people are comfortable with and I think because we see the same people, they get used to us which takes some of the embarrassment away. But we still have to mindful. Sometimes we have to ask family members to step outside to protect people's privacy because some people are too polite to ask and family don't think it's a problem but I'll check with them and ask on their behalf if they want me to".

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they were involved in and contributed to the planning of their care but many could not recall having had a care review or being asked for their feedback. One person told us, "I remember them [provider] coming for the initial assessment, but I haven't seen them since". Another person said, "Sometimes they call to see how things are but I would appreciate a face to face meeting with them". Records we looked at showed that care reviews were facilitated 28 days after the care package was initiated to ensure that the care being provided met the needs of people. We were then told that thereafter, care reviews were facilitated annually or sooner, as required. Other records confirmed that satisfaction surveys had been sent out to people and monitoring calls were made to people to ensure they were pleased with the service they were receiving. However, we fed back to the provider that people would prefer face to face reviews and any improvements in this area would be monitored at our next inspection.

We found that the care plans we looked at were detailed and in the most part, were person-centred, providing information about people's preferences, which corroborated with what people had told us. Staff we spoke with us told us that they found the care plans and risk assessments useful and informative. However we found that care staff were not always reading people's care plans to find out what their support needs were and were reliant on people telling them what they required assistance with. This meant that when staff were rushing, some people felt uncomfortable to ask them to do all that was required. For example, this person told us that their priority was to receive support with washing and dressing and 'didn't like to ask' the staff about meal preparation if they were in a rush, despite this being recorded as a requirement in their care plan. We fed this back to the provider for further exploration at the time of our inspection. .

People we spoke with told us that they knew how to complain. They consistently told us that if they were unhappy or dissatisfied in anyway, they would either speak to the carer [staff] directly or contact the office. Everyone we spoke with confirmed that they had the number to the main office and most people were confident that their concerns would be dealt with. One said, "I am happy with the service and haven't had to complain but I do have the number if I need it". A relative we spoke with told us, "We made a complaint about a year ago when it [care package] first started, but it was dealt with and the problem resolved". The operations manager told us that they had not received any formal complaints recently and any constructive feedback (concerns that had been raised that required action or follow-up, but were not raised as formal complaints) they had received had been acted upon to improve the service.

Information we hold showed that where deficiencies within the service had been raised, the provider had complied a full investigation report which recognised their responsibilities under the Duty of Candour and also proposed where lessons have been learned. Records held by the provider also showed that they kept a record of the complaints and constructive feedback that they had received from people, which also detailed what action they had taken. However, information we received from people and relatives we spoke with was not always reflective of the records we looked at. For example, one relative told us that they had made a complaint a couple of weeks prior to our inspection about the attitude and conduct of one of the care staff. They informed us that they had contacted the office to complain and were told that the issue would be dealt

with and received an apology over the phone. However, records we looked at did not detail this complaint. This indicated that not all complaints were recorded as such and therefore it could not be assured that they had been investigated in accordance with the provider's complaints policy. This was an on-going issue since our last inspection. We fed this back to the provider and also noted that it would be useful for the complaints log to record reasons why certain complaints had been made to enable the provider to demonstrate or follow up any improvements made. The provider acknowledged our feedback and we will continue to monitor any improvements in this area at our next inspection.

We asked the provider how they ensured that people's diverse care needs were met in accordance with the Equality Act 2010. The provider told us that they had a diverse staffing team and where possible tried to ensure people were supported by staff that could speak their preferred language and had an enhanced understanding of their cultural and religious needs. We also found that the provider used gender neutral terminology when referring to people's partner's and that this in part showed their understanding and awareness of diversity and inclusivity for respecting and acknowledging differences in relation to sexuality. We saw care plans acknowledged people's cultural needs and preferences and people were referred to by their preferred name. At our last inspection we found that some people reported to have difficulty communicating with staff due to 'language barriers' and that this also impacted upon record keeping. At this inspection we found that the provider had enrolled some staff on to English speaking, reading and writing courses as an additional training opportunity. However, two of the staff we spoke with and some records we looked at continued to present with similar issues. Whilst we recognised the value of having a multilingual staffing team to provide care to people from a range of diverse backgrounds, staff should be able to communicate with people they are caring for and undertake effective record keeping as a part of their role. The provider advised that this was something that they would continue to work on with staff in order to sustain and develop further improvements in this area.

We were not informed of anyone receiving end of life care at the time of our inspection. The provider advised that they offered this service when required and staff received training in end of life care.

Requires Improvement

Is the service well-led?

Our findings

At the time of our last inspection, the service was found to be requiring improvement in this area. The provider was required to make improvements to the quality assurance systems and record keeping within the service. Whilst we found that some improvements had been made, further improvements were still required in these areas. This meant that this inspection was the fourth consecutive inspection whereby improvements have been required in this area.

Whilst we noted that improvements have been made, some of these had not been implemented within a timely manner, given the time frame since our last inspection. For example, we continued to experience a considerable time delay between us requesting information from the provider and the information being made available to us. This was an on-going issue and was noted at the last two inspections at the service. We also received feedback from the commissioning authorities which advised that they too had similar issues when visiting or contacting the service for information. We informed the registered manager at the time of our inspection that this could be considered an obstruction to the inspection process and was a potential offence. We asked for the outstanding information to be sent to us electronically within a given time frame; of which was, in the most part, met.

However, when we received the information we requested, we also received additional quality assurance documents which we had initially requested at the time of our site visit, but were told that these were not available. The 'file properties' of these documents indicated that they had been 'created' and 'edited' after our inspection site visit and therefore suggested that these had been produced and back dated to satisfy the requirements of the inspection. However, the provider informed us that this was not the case, and that a document made 10 years ago can be copied and pasted today and show that it was created and edited today. We were unable to verify if this was the case. This meant that some of the requirements and actions included within the provider's action plan had not reliably been met prior to our site visit. For example, during our site visit, we asked the provider how they had analysed the feedback they had received from people following the submission of feedback surveys, care reviews or complaint to identify any trends or themes. We also asked how they used this information to drive improvements or to address any issues identified. The operations manager informed us at our site visit that any matters arising from these feedback forums, were addressed with staff during meetings and this was captured within the records for these meetings. We asked if there was any other analysis of this data or actions plans from these quality assurance practises and we were told, 'no'. We asked to look at the records of the team meetings and found that these lacked detail about the specific issues raised within some of the feedback they had received. However, when we received the electronic information from the provider following our site visit on, we received a document titled 'Thematic complaints analysis' which stated it had been created on 19 March 2018; and 'Thematic Survey Analysis 1' had been created and edited on 16 March 2018. This meant that we could not be assured that the provider's quality assurance practices had improved to the standards suggested within their action plan because we could not always rely on the validity of the information presented to us.

The providers quality assurance practices had also failed to recognise or address some of the other shortfalls that we had found as part of our inspection. These included the issues raised with us about late,

short or rushed care calls, the on-going issue with generic information presented within people's care plans and/or risk assessments, as well as the continued deficits with their recruitment checks and the recording of people's metal capacity required clarity. For example, the provider kept a record of the people they cared for who had been assessed by them as lacking the capacity to consent to the care package they were receiving. However, it also stated that 'capacity was assumed but needs assessment' followed by a note to state that the provider had informed the local authority and was awaiting a reply. We fed back to the provider how this information could be seen as contradictory and therefore confusing without any guidance to ensure care was being delivered in accordance with the MCA. The action plan we received for the projected year also reflected many of the actions required at our last inspection, which showed the slow rate of progression in order to evidence the improvement.

Therefore the on-going shortfalls noted within the governance and record keeping within the service meant that the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We will ask the provider to submit a detailed action plan, informing us of what actions they propose to take, specifically in relation to the issues identified, who will be responsible for fulfilling these action and by when. We will then request evidence from the provider to demonstrate that these actions have been completed and will continue to monitor the service.

We found that people's and staffs experiences of the service had improved since our last inspection and therefore recognised that improvements had been made. The provider had also deployed the support of a consultancy agent to assist them in making the improvements required. The provider is unable to confirm at this time that they will continue to work with the consultant to further support their improvement journey.

The service was required to have a registered manager in place as part of the conditions of registration. There was a registered manager in post at the time of our inspection. Information we hold about the service showed us that the provider was meeting the registration requirements of CQC.

Staff we spoke with confirmed that they felt supported within their work and told us that someone was always available to speak with them should they require any assistance or support. Staff we spoke with confirmed that they received open communication with the management team through supervision, team meetings, regular text message alerts and on call support systems. They also told us they felt comfortable and confident in raising concerns with the registered manager and were aware of the whistle-blowing procedures. Whistle-blowing is a term used when a member of staff raises a concern about wrong-doing or illegality that may be occurring within the organisation in which they work. Whistle-blowers are protected by law to ensure that they are protected as far as reasonably possible, against the risk of reprisal. Staff we spoke with confirmed that they were aware of the whistle-blowing policy and processes within the organisation and felt confident raising concerns both internally and externally (with CQC for example), if they felt that this was required. Information we hold showed that we had received contact from whistle-blowers and that any areas of concern raised were investigated and, where necessary addressed with the provider.

We found that the provider was receptive to our feedback and made plans to follow up any of the issues or concerns that we had identified as part of our inspection process.

The provider worked collaboratively with external agencies to support the needs of the people they cared for. For example, we saw examples of how the provider liaised with other health and social care agencies to ensure referrals were made and followed up where necessary.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This inspection is the fourth consecutive inspection whereby the provider has required improvement. The provider's quality assurance practices had failed to proactively identify and address the shortfalls found during this inspection.