Bell View Help at Home Limited

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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

This inspection was announced and took place on 19, 20 and 27 October 2016. The service was last inspected in January 2015 and at that time was in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. In response to our findings the provider had submitted an improvement action plan, which stated they would have met the breach by February 2015.

The service provides personal care and support for people living in their own homes in the North Northumberland area. At the time of our inspection, the service provided care and support to approximately 50 people. Their office is located in a purpose built resource centre in Belford. The service had close links with Bell View Care Ltd which provides day care; meals; home support; assisted shopping trips and a transport service. Bell View Care Ltd is not regulated by CQC as its services are out of scope of the Health and Social Care Act 2008 Regulations.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in January 2015 we found some concerns with medicines management regarding certain administration and recording procedures. Whilst we saw some improvement measures had been taken, shortfalls remained in the management of medicines. Risks related to medicines had not always been assessed, and information had not been provided to staff about how to mitigate risks. Records showed medicines had not always been administered in line with prescribed instructions.

Staff had been trained in safeguarding people from abuse and staff we spoke with were clear on their responsibility. However procedures to reduce the risk of financial abuse and to maintain the security of people's homes were not robust.

Contingency plans were in place to ensure the provider could maintain the service in the event of poor weather, and risks within people's homes had been assessed.

Safe recruitment procedures had been followed and there were enough staff to deliver the service. People told us staff were sufficiently skilled to care for them and meet their needs. Staff training was monitored and kept up to date. Staff were given opportunities to further develop their skills and knowledge. Records we looked at showed staff met regularly with their manager in supervisions sessions to discuss their practice; however two staff told us they had not yet attended these meetings. Appraisals had not been carried out. The registered manager acknowledged improvements should be introduced by forward planning meetings with staff to ensure they were able to discuss their roles.

Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. The registered manager advised us all of the people who used the service had capacity to make their own decisions, he was aware of the process which should be followed if this was not the case.

People were supported to access healthcare services such as GPs.
People and relatives told us the staff were very warm and caring. Staff told us they enjoyed their jobs, and described to us occasions where they felt they had 'gone the extra mile' for people.

People had been involved in planning their care, and staff were very knowledgeable about people's preferences and care needs.

Staff had received training to help them support people at the end of their lives, and a community matron we spoke with praised staff who provided this care.

Care plans and assessments of needs were varied in detail. We saw some records were very person-centred with specific information describing how the person should be cared for. However, we saw other examples which were simply descriptions of a task to carry out. One person's records did not contain any information which showed how their needs had been assessed.

People described the service as 'consistent' and 'reliable' and told us their care was delivered by a small team of staff who knew their needs well. People told us they knew how to complain, but had no cause to.

The system to monitor the quality of the service provided was not robust. Audits had not been carried out by the registered manager. The provider had carried out some quality assurance checks, and taken steps to improve the service, however issues identified by the provider in June 2016 still remained at the time of this inspection.

We were unable to access some records as the registered manager told us he could not find them. Records we did view were sometimes incomplete or out of date.
The service had a strong community focus which aimed to improve the lives of people living in rural areas, and helped to signpost people towards other services and events to address social isolation.

We found two breaches of the Health and Social Care Act 2008. These related to Regulation 12: Safe care and treatment and Regulation 17: Good governance. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines had not been managed safely.

The safeguarding policy was followed, but policies relating to finances and security of people's homes were not robust.

Safe recruitment procedures had been followed, and there were enough staff to deliver the service.

Is the service effective?

Requires Improvement

The service was not always effective.

The induction process was not robust and annual appraisal meetings had not taken place.

Staff training was up to date and staff had opportunities to meet with their manager.

The service was operating within the principles of the Mental Capacity Act.

People were supported to access health professionals when required.

Is the service caring?

Good

The service was caring.

People and their relatives described staff as friendly and warm.

Staff knew people and their needs well.

Staff had received training supporting people at their end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessments and care plans were varied in detail. Some people's records provided little or outdated information about how to support people.

People were supported to pursue their hobbies and take part in activities.

A complaints procedure was in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

An effective system was not in place to monitor the quality and safety of the service. Records relating to the delivery of care were not always available, up to date or complete.

Policies and procedures were not always in place to support the delivery of the service, where they were, they were not always followed.

Bell View Help at Home 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 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 19, 20 and 27 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure staff would be available in the office to assist us. The inspection was carried out by two inspectors. One inspector visited the office base for the service, and another inspector visited people in their homes. We also conferred with a pharmacy inspector following our inspection.

We spoke with the local authority safeguarding team and contracting team. We also spoke with a community matron. We used the information they shared with us in the planning of our inspection. We did not ask the provider to complete a PIR before this inspection. A PIR 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 looked at the care and support records of six people who used the service, including their medicine administration records. We looked at records relating to the management of the service, such as audits, and five staff files and recruitment records. We also reviewed information we held about the service including any statutory notifications that the provider had sent us. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

During our inspection we spoke with six people who used the service, visiting three of those people at their homes. We spoke with the registered manager, the deputy manager, and six staff members. After the inspection we also spoke with the two directors of the service. Following the inspection we were sent information to support us with our enquiries.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection in January 2015 a breach of legal requirements was found in Regulation 12 relating to safe care, as the provider had not ensured the proper and safe management of medication. Following the inspection the provider had written to us, detailing in an action plan, the steps they would take to ensure the proper and safe management of medication. The provider told us they would be compliant with the regulations by February 2015. During this inspection we saw some steps had been taken to address the previous breach, such as introducing regular audits of medicines records. However insufficient improvements had been made in this area in order to meet the requirement notice.

Risks related to medicines had not always been considered. One person was prescribed, a medicine which has risks of unpleasant side effects if it isn't taken properly. These risks had not been assessed and specific instructions about how staff should minimise risks had not been detailed within the person's care record. The medicine should be taken 30 minutes before other medicines, however Medicine Administration Records (MAR) showed it had been recorded as administered at same time as the person's other medicines. This meant the effectiveness of the medicine could have been compromised. We spoke with two staff members who were able to explain to us how they mitigated the risks relating to the administration of this medicine.

One person was prescribed a pain relief medicine. There was no information within the person's care records which detailed what the minimum time interval between doses should be. The British National Formulary (BNF) stated it should be administered, "every 4 hours when necessary." The MAR showed this person had received this medicine with an interval of less than four hours three times in the course of one week. This meant important information had not always been provided to staff about how to administer medicines safely.

Care staff had not always ensured that the administration of people's prescribed medication was accurately recorded. We saw gaps on MAR where staff had not recorded whether people had taken their medicines. We saw codes had been used at times to show medicines had not been administered. However further information about why the medicine had not been taken had not been recorded anywhere on the MAR or within care records. This meant it was difficult to tell from records whether people were receiving their medicines as prescribed.

Staff prepared one person's medicine for them, and left it for them to take at a later time. Staff had signed the MAR to show this prepared medicine had been administered, however as it had not been witnessed by staff there would be no way to tell if this was an accurate recording. There was no medicines risk assessment in place for this person so that staff could be sure that the individual knew when and how to take this 'left out' medication and that they could manage it safely.

Where people were prescribed short courses of medications, such as antibiotics, the date the medicine had commenced had not been recorded on the MAR. We saw some gaps on the MAR within these short courses of antibiotics, and were unable to tell if these were recording mistakes, or if the medicine had not been given

as prescribed, because we were unable to tell when the medicines should have started and finished.

When prescribed medicines had changed during the MAR cycle, for example an increase in dose from once a day to twice a day, MAR entries had been annotated with the new instructions, as opposed to re-written. The annotations had not been dated. This meant the MAR was not an accurate record of medicines which had been administered.

Staff we spoke with were knowledgeable about medicines and could respond to our questions about how specific medicines should be administered and how to reduce risk related to medicines. However one member of staff did tell us they found medicines records 'confusing' and 'unorganised'.

We considered that the service was failing to protect people using the service against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe with staff. One person said, "Am I safe? Definitely. Never doubted it. There has never been any nastiness or abuse." There were policies and procedures in place related to the safeguarding of vulnerable adults. Staff had received training in recognising and responding to potential abuse. Staff we spoke with were aware of their responsibilities and described to us how they would respond to any such concerns. The registered manager told us there had been no safeguarding incidents in the previous 12 months, but that he had worked with the local authority safeguarding team in the past and would not hesitate to contact them if necessary.

Whilst arrangements were in place to protect people from potential financial abuse, they were not robust. When staff supported people by making purchases on their behalf, such as groceries, the purchase and receipt was recorded on a finance record which people were asked to sign to show their consent, where they were able to. These purchases were monitored by the registered manager when they were returned to the office. However there was no formal process for returning records to the office. The registered manager was unable to locate records when asked, and could not confirm whether records had been archived or were still within people's homes. This meant we could not be sure if checks on staff purchases had been carried out.

The service held information about how to access some people's homes, where they had a key code entry in operation. This is where a key is left within a small safe outside of the person's home, which requires staff to input a code to access the key. These codes were sometimes texted to staff's personal mobile telephones so they had this information to gain access when they visited people. We discussed with the registered manager issues around the security of personal telephones and how they could be sure staff deleted this information once it was no longer required. The registered manager told us they would update their policy on the use of personal mobile phones to ensure staff were aware of expectations when holding this kind of information.

Risks in people's home environment had been assessed. Assessments had been carried out when people began using the service which included reviewing any environmental risks such as whether people had working smoke alarms, adequate ventilation and the mobility aids which they required.

Some people who were supported by the service lived in very rural areas. There were plans in place to deal with the risks of flooding, snowing or staff shortage.

There were enough staff to carry out the planned visits to people's homes. The registered manager told us there had never been any missed calls whilst the service was in operation. People we spoke with confirmed

that staff had always visited their home when they were expecting them to.

The registered manager was supported by a full time deputy and a part-time administrator. Time sheets showed the registered manager and deputy frequently provided care to ensure people's planned calls were delivered. This meant there was a considerable amount of time when they were not working on managerial tasks. The registered manager told us they had recently employed five new members of care staff, and therefore should be required to cover these calls less frequently.

Safe recruitment procedures had been followed. We saw prospective employees had submitted application forms, attended an interview and two references had been sought. Records showed that checks had been undertaken with the Disclosure and Barring Service (DBS) as to whether applicants had a criminal record or were barred from working with vulnerable people, before they had commenced employment. These checks were carried out to ensure only suitable people were employed by the service.

Requires Improvement

Is the service effective?

Our findings

Newly employed staff received induction training and shadowed experienced workers. Staff and the registered manager told us this shadowing arrangement was flexible to the needs of the staff and their understanding. Training modules completed within the induction included knowledge tests. However, the registered manager acknowledged there was further work to be carried out on the induction framework before it met the criteria for the Care Certificate. The Care Certificate was introduced in April 2015 and details the training, assessments and reflections which care staff should undertake to equip them with the skills required to deliver care. The registered manager told us he was working on introducing, formal supervisions and competency assessments to the current induction. He was able to evidence with staff rotas, that both the registered manager and deputy had worked alongside new staff during their induction and told us they had informally discussed new staff's progress and monitored their performance. He advised us he would introduce new paperwork to capture these conversations and assessments of performance.

We checked five staff records, and saw these staff had met regularly with the registered manager on a one to one basis in supervision sessions. Records showed supervision sessions included opportunities for staff to discuss the care they provided and the needs of people they supported. However, during our discussions with staff, two staff told us they had not received any individual supervisions. When we asked the registered manager how supervision sessions were scheduled to ensure all staff attended, he acknowledged improvements were required in this area as all records were stored within individual staff files, and he did not have an overview which showed when staff required supervision sessions.

The registered manager told us he had not carried out formal appraisals with staff, but was in the process of planning these meetings. He told us that he was very open with staff, and discussed staff professional development informally when they were in the office, or when he worked alongside them delivering care. Two staff we spoke with told us they were working towards a diploma in Health and Social Care.

People who used the service told us they were very satisfied with how staff met their needs. One person told us staff were, "Competent and certainly seemed to know what they were doing." Staff had received a range of face to face training and E-learning, including moving and handling, safe handling of medicines, health and safety, food hygiene and infection control. Staff we spoke with told us they felt they had been given appropriate training to be able to carry out their roles.

Some staff had also undertaken specialist training in relation to the individual needs of people they supported, for example staff supporting one person had attended training delivered by nursing staff about renal medicines administration. All the staff who supported this person had been signed off as 'competent' by nursing staff to deliver this aspect of their care.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least

restrictive possible.

We checked whether the service was working within the principles of the MCA. The registered manager told us at the time of the inspection everyone who used the service had capacity to make their own decisions. He was able to describe appropriate steps he would take and the assessments he would carry out, if he had concerns over anyone's capacity. The manager told us no one who used the service required constant support to keep them safe, and was aware that if this was the case then applications would need to be made to the Court of Protection to grant authorisation. The Court of Protection make decisions on financial or welfare matters for people who are unable to do so for themselves.

As part of the assessment process people's food, hydration and nutrition needs had been assessed, and information was detailed for staff about the support people needed in these areas. Where people were supported with meals, their nutritional needs had been assessed to determine what level of support they needed from staff. Care records included details of people's meal preferences and any allergies. For example one record said, "Make or serve a nourishing lunch, [Relative] often leaves adequate nourishing cold platter, leave small snacks like nuts, fruit, and a cold drink to graze on in the afternoon." People told us they were happy with the support they received with their food. One person said, "The girls keep me right. They make me my breakfast. They know what to give me. I like to have the same thing every day, always have."

People were supported to access healthcare services. Records showed that staff arranged appointments with GPs when they had concerns over people's health. People we spoke with confirmed that staff supported them with their healthcare needs. One person said, "They [staff] come with me to the hospital once a month." Another person said, "The carers look out for hazards on a daily basis. They would report any faults with my equipment like the hoist or profiling bed."

The service worked closely with the district nursing team to ensure people's healthcare needs were met. Following discussions with the district nursing team, staff had been proactive in implementing changes to one person's plan of care, which resulted in a positive outcome on their healthcare needs.
We spoke with a community matron who told us they had delivered bespoke training to staff for the service related to one person's needs. The community matron told us, "We've done some joined up learning, staff have always been eager to learn and they meet people's needs as best as they can."

Good

Is the service caring?

Our findings

All of the people we spoke with, and their relatives, told us they were very happy with the service. People's comments included; "I couldn't wish for nicer people [staff]. They are all very nice girls"; "We have some good laughs"; "I'm very lucky"; "I couldn't ask for more" and "They are very good to me."

Staff we spoke with told us they enjoyed their roles and felt they provided a very good, caring service. One member of staff said, "I love my job. I wish I'd done it years ago." Another staff member said, "We're all tight knit and we get on well with the clients and their families."

People and staff spoke about examples where they felt the service had 'gone the extra mile'. One person told us staff would always pop to the shop for them if they ever ran out of anything. Staff told us about times they had hung people's washing out during their care visits, and then returned when their shift had ended to bring it back into their home. Another staff member told us they bought one person their favourite marmalade whilst they were doing their own groceries, as it was only sold in one supermarket, which the person could not visit.

Staff and relatives described a close relationship between people who used the service and staff. One staff member told us that relatives had contacted the office on a Sunday because their family member had changed their mind about going into respite care, the family were described as 'distraught' and contacted the service because they knew staff had a positive relationship with the person. The registered manager had been able to talk to the person and calm the situation.

People had been provided with information about the service. Records were kept in people's homes. Care files contained information about the service including the telephone numbers for the office and what they should expect from the service. Information had also been provided to people about how they could make a complaint if they needed to.

People told us staff treated them and their home with respect. One person said, "I'm spoken to nicely. They treat me with dignity." Another person said, "They are all very nice, respectful people."

People were included in planning their care. We saw care plans varied in the level of detail recorded, however most included information about people's preferences. We saw some care plans had lots of specific information to support staff in meeting people's social needs. Some care plans included details about people's jobs, families and the names of their pets. Whilst other people's care records were less detailed, all of the staff we spoke with had a good knowledge and understanding about people's preferences and life histories.

The registered manager informed us that no one who used the service was currently using an advocate. He told us they would refer people to advocacy services if they felt they needed support to make decisions. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

The service had close links with Bell View Care Ltd, a social enterprise which provided a range of events and activities to enable people to live independently and to facilitate social inclusion. The registered manager told us he had introduced people who used their services to Bell View Care Ltd. He said, "We are so lucky to be able to provide so much for people. They come to us because they need support at home. But we can bring them into the resource centre, get them signed up for the lunch club to meet other people, and then they can go on the shopping trips so they don't have to go themselves. It's fantastic and we've had some real success stories."

The service had plans in place to support people as they approached the end of their lives. Staff had received training in end of life care, and the registered manager told us that he and the deputy provided additional support to staff who cared for people at the end of their lives. We spoke with a community matron who praised the care the service delivered, they said, "They are very professional. Staff all seem to be happy within their jobs, and they are very approachable. Patients and their families have always seemed very happy with the care provided."

Requires Improvement

Is the service responsive?

Our findings

People told us that the care they received was responsive and met their needs. One person said, "I wouldn't want to go elsewhere, I know these carers very well, they know my routine." Another person said, "I couldn't do without them." People told us that staff usually arrived on time and they did not feel rushed. One person said, "They always get done what's needed. They are good girls."

Care records were varied in the level of completion and detail. We looked at six people's care records. We saw five people's needs had been assessed to determine what level of staff support they needed. For example, to transfer from bed or to bathe. However, we found one person's records contained blank assessment forms. The registered manager was unable to say if an assessment of this person's needs had been carried out. We looked at this person's care plan and saw it was very brief, and consisted of one sentence which simply stated, 'personal care', 'lunch' and 'bed' as the extent of information provided to staff about the care they should provide to this person. This meant staff had not been given information about this person's care preferences or needs to enable them to deliver personalised and appropriate care.

We saw other care records were more personalised and they contained specific information about how to support the person. One person had very complex needs. We saw their care records contained detailed information which described clearly to staff how to deliver this person's care. For example, we saw their moving and handling care plan had been set out in bullet point steps, which included images for staff about how to correctly position the person and the equipment which they used.

Other people's care records included specific details about the way they wanted their care to be delivered. For example, they stated whether people preferred male or female staff support. However, personalised information was sometimes out of date. One person's care record included information about the person's home, stated it was very important to them to stay there. However, we saw from other records that this person no longer lived at that address. We spoke with staff about the support they provided, they were able to tell us about people's up to date needs, and how they met them. Staff told us if they started to provide care to a person they had never supported before, they were able to shadow other staff who knew that person and their needs well, to ensure they were able to properly support the person.

We noted care plan review documents were contained within all of the care files we reviewed. They detailed conversations between the registered manager, person who used the service and their relatives, about whether their care needs were being met and if they were happy with the service. However all of these reviews had taken place over a year ago. One person we asked said they had not received a review of their care 'for a while'. The registered manager acknowledged that he had not completed any care reviews for some time, and told us that this was an area he needed to focus on so people had an opportunity to review and discuss their care.

People were supported by a small team of staff who visited them regularly. One person said, "It's always the same carers. Very occasionally it might be someone I don't know. If someone has called in sick, but I can count on one hand how often that has happened." People were given a rota in advance so they knew which

staff would be supporting them. People described the service as 'reliable' and 'consistent'.

People who used the service had different packages of care, determined by their needs. Some people received only short visits for a specific task, whilst other received more care hours and had been identified as requiring staff support to access the community and take part in activities. Records showed people accessed activities based on their interests. We saw one person was supported by staff to go to the gym, swimming pool and the shops. This person told us the activities they took part in were their choice.

People we spoke with told us they would know how to make a complaint if they needed to, but they told us they were satisfied with their care. The registered manager told us no formal complaints had been made in the previous 12 months, but that a complaints procedure had been provided to all of the people who used their service which explained how any complaints would be investigated and responded to. He told us that minor issues were dealt with as and when they arose. For example, he told us if people did not 'gel' with their care workers that new staff would be assigned to deliver their care, as soon as it was practicable. He acknowledged he had not made any record of these minor issues.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Care Quality Commission since December 2013. The registered manager was present during our inspection and assisted us with our enquiries.

After our previous inspection the provider wrote to us to advise us of the steps they were taking to address the issues we found, which included completing regular medicines audits. However, during this inspection we found further shortfalls in the management of medicines, as well as poor record keeping in relation to the management of the service and care records. We found the provider had failed to ensure there was adequate governance and oversight.

We found evidence that medicines were not managed safely. Risks had not been assessed, important information about how to safely administer medicines had not been made available to staff, there were omissions in the recording of medicines, and proper processes had not been followed when adding short courses of medicines to records. Medicines audits had been completed on a monthly basis; however these audits had only identified gaps in the recording of medicines. They had not highlighted the other shortfalls in medicine management.

Care records were not accessible, complete and up to date. During our inspection we requested to see people's daily monitoring records. These are records which staff completed after each visit to a person's home, detailing the care they have received. We asked to see six people's records for the three months before our visit. The registered manager informed us he was unable to provide more than half of these records as he was unable find them. He explained this was because the service had recently relocated their archived records, and that records had not been stored in any kind of order.

We saw from the records which were available to us, that assessments and care plans were not always an accurate reflection of people's needs and planned care. Staff we spoke with told us there was not enough information available to them about people's needs when they first began to use the service. Staff told us it took some time for care records to be put in place, and they had previously had to telephone the office to find out when care records would be available. Staff told us they often needed to ask each other about people's needs as there was not enough information contained within care records.

We found a range of documents within people's care records, and records related to the management of the service were undated. This meant we were unable to determine when they had been produced, and if they were still relevant.

We saw within people's care files some uncompleted care plan audit documentation. However, we found no evidence that any care records had been audited by the registered manager. He was unable to tell us, when asked, when he had last audited any care records.

Accidents and incidents were not monitored. The manager told us that records related to any accidents

involving people who used the service would be recorded in their care records. There was no specific documentation, which meant in the event of an accident or incident staff would not have any prompts about the type of information they should record. There was no records where the manager would compile any accidents or incidents which occurred within the service to determine if there were any trends, or if any steps could be taken to reduce the likelihood of accident reoccurring. The manager told us that there had not been any accidents or incidents within the service within the previous 12 months.

Amendments had not been made to induction training to incorporate the care certificate standards. There was no overview of supervision sessions to monitor which staff had attended these one to one meetings with their manager. Two staff we spoke with told us they could not remember when they had last had a supervision session. No appraisals had been carried out. There was no evidence that staff competency in delivering care had been assessed or monitored as there had been no spot checks or assessment of staff practice for over a year. The registered manager advised us he monitored staff performance and provided feedback informally, but acknowledged there was no record of this.

People had not been asked their views on their care or the service which was provided. No satisfaction surveys had been sent out, and reviews of people's care had not been carried out for over a year.

A relative we spoke with told us they worked within the care sector, they said they thought the service was, "Okay, better than some, but lacked quality assurance." They told us they felt staff should receive spot checks as there were aspects of staff practice which would be improved with regular monitoring. For example, they said that their relative's bin was not always emptied, and considered that if staff were checked more closely, minor issues would be picked up by senior staff.

Company policies and procedures had not been followed. Within the provider's medicines policy it stated newly trained staff would have their competency in delivering medicines assessed three months after their training, and then annually to ensure their knowledge and skills were appropriate. We found these competency assessments had not been carried out. This meant the provider had not assured themselves that staff who administered medicines were competent to do so.

Policies and Processes were not in place to ensure electronic records were kept secure. Information containing service user's names and key codes to gain access to their homes had been occasionally sent via text message to staffs' personal mobile phones. This had not been detailed in policies or procedures, and had not been risk assessed. Staff had not been provided with information which detailed expectations about security settings on their personal phones or when they should delete this information.

Whilst we found no audits had been carried out by the registered manager/nominated individual, we noted many of the shortfalls highlighted during our inspection had been identified when the provider had carried out an ad-hoc review of management records and care files in June 2016. Records showed these shortfalls in care delivery and management of the service had been fed back to the registered manager. Directors meeting minutes showed an action plan had been created to address these issues, including employing additional administration staff. The registered manager had been asked to feedback on progress towards the action plan on a monthly basis. The directors also told us they had provided support and checked progress of improvement actions on a more frequent basis when they visited the office base. However we found the same issues remained at our inspection four months after the records review. This meant the provider's assurance system had failed to drive improvements in the quality and safety of the services provided.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014, good governance.

After our inspection we spoke with the directors, they provided us with further information about the immediate steps they had taken to improve the quality and safety of the service, including pulling together a team to check each person's medicines records to highlight and address any risks in relation to the management of their medicine.

People and their relatives told us that they thought a good service was provided. One person said, "I wouldn't go with anyone else. I'd recommend them to anyone in my situation." Another person said, "I'd say they were good. Possibly very good. I would happily recommend them."

The company had a strong community focus. We spoke with the Services Development Manager who told us their mission was, "To support and enable older people to live independently by working in partnership to develop innovative services that respond creatively to the needs of individuals and local communities in rural North Northumberland." The registered manager told us about the steps they had taken to provide joined up care within the rural area, and gave examples of when people who used the service had been signposted towards the social opportunities available through Bell View Care Ltd who the provider had close links with.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 always provided safely. Systems were not in place to ensure the proper and safe management of medicines. Regulation 12 (f).

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not in place to monitor the quality and safety of the service and mitigate the risks relating to the health, safety and welfare of people and others. Records relating to people, staff and the management of the service were not always accurate, complete or securely maintained. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

The enforcement action we took:

We issued a warning notice.