

Smithfield Health & Social Care Ltd

# Smithfield Health & Social Care Limited t/a Verilife

## 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 18 and 19 October 2018 and was announced. Smithfield Health & Social Care Limited t/a Verilife, is a domiciliary care agency. It provides personal care to people living in their own houses and flats. At the time of the inspection 171 people were using the service, of which 151 people received regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had 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.

We inspected Smithfield Health & Social Care Limited t/a Verilife, in January 2017 and found significant shortfalls. We found two breaches of the fundamental standards and regulations. Staff were not always deployed in a way that met people's needs. Effective systems were not in place to monitor and address late visits and the provider was not taking sufficient action to improve the service.

We took enforcement action and issued a warning notice relating to 'Good Governance' and told the provider to meet the fundamental standards by 12 April 2017. We followed up on the warning notice and we inspected the service on 15, 16 and 21 August 2017. We found that the provider had made improvements to the systems used to assess and monitor the quality of the service; however further improvement was required in specific areas of quality assurance and call monitoring. The service was rated overall requires improvement at June 2017 and in August 2017 inspections.

At this inspection we received a mixed response from people, their relatives and staff about the management of the service. We found the provider had not always monitored and analysed short, early or late calls, to identify patterns and improve on the service. The provider had not acted to make sure that risk assessments included appropriate guidance for staff on how identified risks should be managed. Care plans we reviewed did not always reflect people's current needs and had not been updated when their needs had changed. The provider had identified communication needs for people but had no guidance in their care plan for staff about how to meet them.

You can see what action we told the provider to take at the back of the full version of the report.

People and their relatives told us they felt safe. The provider had clear procedures to recognise and respond to abuse. All staff had completed safeguarding training. The service had a system to manage accidents and incidents and to reduce recurrences. People were protected from the risk of infection.

The service had enough staff to support people's needs and had carried out satisfactory background checks

for staff before they started working at the service. The service had an on-call system to make sure staff had support outside of office working hours.

Staff supported people to take their medicines safely. The provider had a policy and procedure which gave guidance to staff on their role in supporting people to manage their medicines safely.

The service provided an induction and training, and supported staff through regular supervision and spot checks to help them undertake their role.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People consented to their care before it was delivered. The provider and staff understood their responsibilities within the Mental Capacity Act 2005. Some people lacked capacity to make important decisions about their care and the provider had documented best interest decisions, when decisions had been made on their behalf.

Staff supported people to eat and drink enough to meet their needs. People's relatives coordinated their health care appointments and health care needs, and staff were available to support people to access healthcare appointments if needed. People's personal information about their healthcare needs was recorded in their care records.

People and their relatives said staff were caring. People were supported to be as independent as possible. Staff involved people and their relatives where appropriate, in the assessment, planning and review of their care needs. People's care records showed that they were involved in planning and subsequent reviews of their care. Staff showed an understanding of equality and diversity.

The service had a complaint policy and procedure in place. People knew how to make a complaint and told us they would do so if necessary. Each person had a care plan which contained information about people's personal life and social history, their health and social care needs, allergies, family and friends, and contact details of health and social care professionals. The provider had systems and processes in place to support people with end of life care, in line with their wishes.

The registered manager held staff meetings, where staff shared learning and good practice so they understood what was expected of them at all levels. We observed staff were comfortable approaching the registered manager and their conversations were friendly and open.

People's views were sought to improve on the quality of the service. The service had a positive culture, where people felt listened to and included in making decisions. The service worked effectively with health and social care professionals and commissioners. Feedback from a social care professional stated that the provider made improvements since the previous inspection in August 2017.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Some aspects of the service were not safe.

Senior staff completed risk assessments and risk management plans to reduce identified risks to people. However, there was no risk assessment and management plan for people identified with risk of falls.

Medicines were managed safely.

The provider had raised safeguarding alerts as required.

We confirmed through our discussions with people using the service there had been no missed calls to them.

The service had a system to manage accidents and incidents to reduce reoccurrence.

The provider had enough staff to support people. Staff had undergone satisfactory background checks before they started working.

Staff followed infection control procedures.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

Staff carried out an initial assessment of each person to see if the service was suitable to meet their assessed needs.

Staff were supported through induction, training, regular supervision, appraisal and spot checks to help them undertake their role.

Staff sought consent from people when offering them support. The provider had maintained a record of best interest decisions in accordance with the requirements of the Mental Capacity Act 2005.

Staff supported people to eat and drink enough to meet their needs. People's relatives coordinated health care appointments

**Good** ●

and staff were available to support people to access health care appointments if needed.

The provider had procedures in place to work with other services to ensure effective joint working.

### **Is the service caring?**

**Good** ●

The service was caring.

Staff respected people's privacy and treated them with dignity.

Staff told us they kept people's personal information confidential.

People and their relatives told us they were consulted about their care and support needs.

Staff treated people with respect and kindness, and encouraged them to maintain their independence.

### **Is the service responsive?**

**Requires Improvement** ●

Some aspects of the service were not responsive.

Some people's care plans did not reflect their current needs.

People knew how to complain and told us they would do so if necessary. The service had a clear policy and procedure for managing complaints.

The provider had systems and processes in place to support people with end of life care in line with their wishes.

### **Is the service well-led?**

**Requires Improvement** ●

Some aspects of the service were not well-led.

We received a mixed response from people, their relatives, and staff about the management of the service.

The provider did not have effective systems and processes to assess and monitor the quality of the care people received.

There was a registered manager in post. They kept staff updated about any changes to people's needs and the service.

The registered manager held regular staff meetings, where staff shared learning and good practice so they understood what was

expected of them at all levels.

The provider worked in partnership with health and social care professionals.

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# Smithfield Health & Social Care Limited t/a Verilife

## **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 site visit took place on 18 and 19 October 2018 and was announced. The provider was given 48 hours' notice because the service is a domiciliary care service and we needed to be sure that the provider would be in. We visited the office location to see the registered manager and office staff; and to review care records and policies and procedures.

One inspector and one specialist advisor visited the service on the 18 October 2018. Two inspectors returned on 19 October 2018 to complete the inspection. One inspector made phone calls to field staff and two experts by experience made phone calls to people to seek their views about the service. 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 all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the commissioners and the local authority safeguarding team for their feedback about the service. We used this information to help inform our inspection planning.

During the inspection, we spoke with 16 people and seven relatives, 14 members of staff, the registered manager and the director. We looked at 13 people's care records, 10 people's medicines records and 14 staff records. We also looked at records related to the management of the service, such as the complaints,

accidents and incidents, safeguarding, health and safety, and policies and procedures.

# Is the service safe?

## Our findings

People and their relatives gave us positive feedback about their safety and told us that staff treated them well. One person told us, "Of course I feel safe." Another person said, "Yes, I feel safe. I have two carers who are regular. Always the same two. They are very good." A third person commented, "Safe? Absolutely. The girls are so nice and friendly." A relative said, "Oh, yes, [My loved one] feels very safe. [Staff] really care and look after them well." Another relative commented, "Yes, [My loved one] feels very safe with them."

However, we found that risk assessments did not include appropriate guidance for staff on how identified risks should be managed. There was no risk assessment and management plan for people identified with the risk of falls. For example, five of 13 people's records showed that they had a fall recently, and one person had three falls within the past six weeks. However, there were no falls risk assessments and management plan to provide staff with guidance on how to reduce the risk of falls. Staff were working independently, in people's homes, without direct supervision and without clear guidance there was a risk people may receive inconsistent or unsafe care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some good practice with regards to risk assessment and management. Staff completed a risk assessment for each person when they started using the service. Risk assessments covered areas including medicines management, the home environment and moving and handling. Risk assessments for these areas included appropriate guidance for staff on how to reduce identified risks. For example, where someone had been identified with a risk regarding their mobility, a risk management plan had been put in place which identified the use of equipment and the level of support the person needed to reduce the risk. The registered manager told us that risk assessments were reviewed periodically and as and when people's needs changed.

The provider had a system to manage accidents and incidents and to reduce the likelihood of them happening again. Staff completed accidents and incidents records. These included action staff took to respond and minimise future risks, and who they notified, such as a relative or healthcare professional. The coordinator reviewed each incident and the registered manager monitored them to identify possible learning.

At our comprehensive inspection of 15, 16 and 21 August 2017, we found the provider had not always allowed enough time for all staff to travel between calls. At this inspection we found that the provider had made improvements. People and their relatives told us there were no missed visits. For example, one person told us, "They [staff] are on time, and no missed calls, and they let us know if they're running late."

People were supported by sufficient numbers of effectively deployed staff. The service had enough staff to support people safely. The registered manager told us they organised staffing levels according to people's needs. Staff rostering records showed that they were allowed enough time to travel between calls. The

service had an on-call system to make sure staff had support outside office working hours and staff we spoke with confirmed this. The care coordinator explained that when staff were running late for more than 15 minutes they followed up by calling people using the service and if required they arranged replacement staff. There was a communication record to show that the office staff had informed people when staff were running late to their scheduled home visits. The registered manager and the care coordinator confirmed through our discussions that there had been no missed calls since the previous inspection in August 2017.

Medicines were managed safely. People told us they were happy with the support they received with their medicines. One person told us, ", [Staff] puts it in my hand and watches me take them (medicine) and they log it in the book." A relative said, "Staff prompt [my loved one] to take their medicine, and they record it on the medicine administration record (MAR)."

Where people were supported to take their medicines, this information was recorded in the MAR and these were up to date. The MARs we reviewed showed that people had received their medicines as prescribed. There were also protocols for dealing with medicines incidents and staff had a clear understanding of these protocols. The provider had a policy and procedures which gave guidance to staff on their role in supporting people to manage their medicines safely. The service trained and assessed the competency of staff authorised to administer medicines. Staff confirmed they felt equipped with skills to ensure that they dispensed medicines safely. For example, staff told us, "I mostly prompt people, but I did the training. I was trained to give medicines to clients, but most of my clients I only prompt them or I have to put medicine in a pot and [people] do take them, and some people are supported by their families. I have received medicines training and I feel confident to give people medicine because, I have been giving medicines for 10 years now, but I will contact the office if I am not sure of anything." The provider conducted regular audits of management of medicines and shared any learning outcomes with staff to ensure people received their medicine safely.

The service had a policy and procedure for safeguarding adults from abuse. The registered manager and staff understood what abuse was, the types of abuse, and the signs to look out for. Staff knew what to do if they suspected abuse. This included reporting their concerns to the registered manager, the local authority safeguarding team, and the Care Quality Commission (CQC). Staff told us they completed safeguarding training and their training records confirmed this. The service maintained records of safeguarding alerts and monitored their progress to enable learning from the outcomes of investigations. The provider worked in cooperation with the local authority in relation to safeguarding investigations. Staff from the local authority confirmed that there were no statutory safeguarding investigation against the provider in 2018. Staff told us there was a whistle-blowing procedure available and they said they would use it if they needed to. One member of staff told us, "I will be very shocked if they [office staff] don't take any action, because I am confident they would take action, and if they don't I will inform social services." Another staff member said, "If they [office staff] don't take any action, I will escalate to the regional managers and directors, social services and CQC."

The provider carried out satisfactory background checks of all staff before they started working. These included checks on staff member's qualifications and relevant experiences, their employment history and consideration of any gaps in employment, references, and criminal records checks, a health declaration and proof of identification. This reduced the risk of unsuitable staff working with people who used the service.

People were protected from the risk of infection. Staff understood the importance of effective hand washing, using personal protective equipment (PPE) such as aprons and gloves and disposing waste appropriately to protect people and themselves from infection and cross-contamination. One member of staff told us, "I use aprons and gloves and antibacterial gels and I do change my gloves when I finish personal care before doing

their tea." The service had an infection control policy and procedures in place and records showed that staff had completed infection control training to ensure they knew how to prevent the spread of diseases.

## Is the service effective?

### Our findings

People and their relatives told us they were satisfied with the way staff looked after them and that staff were knowledgeable about their roles. One person told us, "They [staff] are very good. They do a proper job. They understand my needs because they are well trained. They do it very well." Another person said, "Staff understand my needs well. All the things that need to be done, are done. Staff know exactly what I need. Consistency of staff is good." A third person commented, "They [staff] understand my needs. They are excellently trained. They do anything I need. Can't fault them at all." A relative told us, "They [staff] seem to understand. They are fully conversant with what they have to do." Another relative said, "Yes, [staff] are very good. To be honest we are pleased with them."

At our comprehensive inspection of 15, 16 and 21 August 2017, we found the provider had not maintained a record of best interest decisions in line with the Mental Capacity Act (MCA) 2005. At this inspection we found that the provider had made improvements.

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 with appropriate legal authority. If the service wished to restrict the liberty of any person an application would have to be made to the Court of Protection. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

The service had systems to assess and record whether people had the capacity to consent to care. Staff understood the importance of asking for consent before they supported people. One member of staff told us, "I will always ask and give people choices and for them to make their own decisions. I will ask them what they want to wear, if they want trousers or shorts, if they want salad or sandwiches, I always ask them." Another member of staff confirmed they sought verbal consent from people whenever they offered them support. Staff also recorded people's choices and preferences about their care and support needs. At the time of the inspection, the registered manager told us that most people using the service had capacity to make decisions about their own care and treatment.

Where people lacked the capacity to make important decisions for themselves the provider worked with them, their relatives, if appropriate, and relevant health and social care professionals in making decisions in their best interest and a record of decisions was maintained. For example, these decisions were in relation to consent to care and support by the provider in the community.

The provider supported staff through regular supervision, annual appraisal and spot checks. One member of

staff told us, "I had supervision, spot checks and appraisal. I am given enough support and if I am not sure of anything I call the office." Records showed the service supported staff through regular supervision, appraisal and onsite observation visits. Areas discussed during supervision meetings included staff wellbeing and leave, their roles and responsibilities, and their training and development plans. Staff told us they felt supported and able to approach the registered manager and the care coordinator at any time for support.

Staff told us they completed comprehensive induction training when they started work, and a period of shadowing an experienced member of staff. Records showed induction training was completed in line with the Care Certificate which is a nationally recognised way of training staff new to social care. The registered manager told us all staff completed mandatory training specific to their roles and responsibilities. The training covered areas such as basic food hygiene, safeguarding, health and safety in people's homes, moving and handling, administration of medicine, and the MCA 2005 and training records confirmed this. Staff told us the training programmes enabled them to deliver the care and support people needed. One member of staff told us, "We are given different trainings at different times of the year. I can also request a refresher training and I have just had a first aid training." Another member of staff said, "Induction was very good but I have done care before. I did shadowing and various trainings."

People's needs were assessed to ensure these could be met by the service. Staff carried out an initial assessment of each person's needs to see if the service was suitable to meet them. Where appropriate, staff involved relatives in this assessment. Staff used this information as a basis for developing personalised care plans to meet each person's needs. The assessment covered people's medical conditions, physical and mental health, mobility, nutrition and social activities. Other healthcare professionals including occupational therapists were involved in assessing people's needs and ensuring they had appropriate mobility equipment in place. The provider trained and supported staff to adhere to best practice when delivering care.

Staff supported people to eat and drink enough to meet their nutritional needs. One relative commented, "They [staff] support my [loved one] with food." One member of staff told us, "I support people with breakfast according to their choice. At lunch, I show them three things from the freezer and I microwave it for them and they choose a dessert. I give them hot drinks, coffee or tea, and cold drinks including water. I also leave them a drink during the day time before I go back for the next visit." Another member of staff said, "I supported one person in the past to blend their food and feed them in bed and be patient with them, without rushing them. You have to make sure they sit in the right position when feeding them. Currently, it is all heating up ready meals and giving them hot or cold drinks." People's care plans included a section on their diet and nutritional needs.

People were supported to have access to healthcare services where required. People's relatives coordinated their healthcare appointments and healthcare needs, and staff were available to support people to access healthcare appointments if needed. People's personal information about their healthcare needs was recorded in their care records. Contact details of external healthcare professionals including GPs were in every person's care record. Staff told us they would notify the office if people's needs changed or they required the input of a healthcare professional such as a GP or a hospital appointment. For example, one staff member told us, "I sometimes call the GP or pharmacist to let them know when people's medicine is running low and then let the office know. I have also called the district nurse to come and check on one person."

The service had links and worked with local healthcare professionals. Staff completed health action plans for people when required and monitored their healthcare appointments.

## Is the service caring?

### Our findings

People and their relatives told us staff were caring. One person told us, "They [staff] are very respectful, very kind." Another person said, "They [staff] are like a friend, and I asked them to call me by my first name. I look forward to them coming. We can chat. It is lovely to have the same person." A third person commented, "[My carer] is very nice, and calls me Mum which I like." One relative commented "They [staff] are kind and considerate. [My loved one] is quite happy with them."

People were supported to be as independent in their care as possible. One person told us, "[My carer] gives me the flannel to wash my face. They chat and encourage me to do things." A relative commented, "They [staff] don't rush [my loved one] and they do encourage them to wash their own face and brush their teeth." Staff told us that they would encourage people to complete tasks for themselves as much as they were able to. One member of staff told us, "I will give the person a flannel. I will always promote their independence to wash their face and arm and I will do the rest of their body. I will always let them do what they are capable of doing."

Staff involved people and their relatives, where appropriate, in the assessment, planning and review of their care. One relative commented, "I have had to reschedule care and they've been flexible with my needs." People's care records showed that they were involved in planning and subsequent reviews of their care.

People and their relatives told us their privacy was respected and staff acted in accordance with people's wishes. One person told us, "They [staff] respect my privacy." One relative commented, "Yes, staff always cover [my loved one] and I'm not in the room when they are changing." Staff told us they did this by ensuring people were properly covered, and curtains and doors were closed when they provided care. One staff member told us, "We always talk them [people] through what we are doing, which is very important. Ask their families to leave, if they are in the room. Be as quick as you can, cover them with a towel, shut the door, window and curtains and make sure no one is looking at them."

Staff told us they kept people's information confidential. They said they would share people's information with their line manager or the relevant health and social care professionals. Staff completed training in maintaining confidentiality as part of their induction, and this was refreshed as required.

Staff showed an understanding of equality and diversity. For example, staff completed care records for every person who used the service, which included details about their ethnicity, preferred faith, culture and spiritual needs. Staff we spoke with told us that the service was non-discriminatory and that they would always seek to support people with any needs they had with regards to their disability, religion, and gender.

## Is the service responsive?

### Our findings

The provider completed care plans for each person and they contained information about people's personal life and social history, their health and social care needs, allergies, family and friends, communication, mobility and contact details of health and social care professionals. They also included the level of support people needed and what they could do for themselves. Staff told us that they read people's care plans to ensure they had the appropriate information to support the person. One member of staff told us, "There is a care plan in each house and I have read the care plan and I always follow the care plan and if there is any change with the person I have to report to the office for them to come and assess again."

However, care plans we reviewed did not always reflect people's current needs and had not been updated when people's needs changed. For example, in one person's care plan, it was highlighted that they had a stair lift in place, however, it was currently not working and therefore they had to sleep downstairs and were not able to go upstairs as they could not manage the stairs safely. The assessment had been carried out in July 2018, yet, when staff were asked whether it was still broken, they said that they thought it had been repaired. It was documented in the person's daily notes that they had been supported to have a shower. However, the care plan said they were to be supported to have a wash in the kitchen as they were unable to go upstairs, which meant that people's care plans did not reflect their current abilities and needs and that care being delivered was not in line with the care plan.

Another person's care log it was recorded that they had sustained some pressure areas and a district nurse had advised how they should be monitored and treated; however, their care plan had not been updated accordingly. This meant the care plans were not accurate and up to date, regarding how to support people to ensure people received consistent care. There was a risk without this guidance that staff may support people in an unsafe manner, or not in line with their preferences.

The provider identified communication needs for people but had no guidance for staff about how to meet them. For example, in one person's initial assessment it was documented that they had a hearing impairment. However, there was no information in the person's care plan about how to communicate effectively with them. Without guidance for staff to gain consent from people with communication needs, prior to providing care in line with their preferences was a risk. This meant that they were not meeting the accessible information standards.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought this to the attention of the registered manager and the care coordinator, they told us that all outstanding care plans would be updated immediately. We will continue to monitor and will check the improvements at our next inspection.

People told us they knew how to complain and would do so if necessary. One person told us, "I had lodged a complaint, and it had been resolved quickly." One relative commented, "I feel they [office staff] listen to me

and deal with concerns very well."

The provider had managed complaints in line with their policy and procedure. The service had a complaints procedure which clearly outlined the process and timescales for dealing with complaints and how to escalate if they remained unhappy with the outcome. Information was available for people and their relatives about how they could complain if they were unhappy or had any concerns. The service had maintained a complaints log, which showed when concerns had been raised. Senior staff had investigated and responded in a timely manner to the complainant and where necessary they held meetings with them to resolve the matter. The complaints we reviewed were mostly about staff behaviour and general care issues. The registered manager told us they had not received any complaints after these concerns had been resolved.

The provider had systems and processes in place to support people with end of life care in line with their wishes. However, at the time of the inspection no one was receiving end of life care support from the provider, but received support from other providers. For example, one relative told us, "We have an end-of-life care plan for my [loved one]. Not to do with this agency, but we discuss these things amongst ourselves as a family." Another relative said, "Yes, we do have an end-of-life care plan but it has nothing to do with this agency." Staff told us that the end-of-life was being provided by the local hospice nurses.

## Is the service well-led?

### Our findings

The service was not consistently well-managed. We received a mixed response from people and their relatives about the management of the service. Some people and their relatives were positive saying, for example, "They [office] do a good job and when there's sickness, they send covers." Another person said, "The staff are on time. It's a good service." One relative commented, "The co-ordinator is very well organised, and rings me if the carer is going to be late."

However, other people and their relatives said the service was not well managed. For example, one person told us, "They [office] are not well-managed. They have good people on the whole who are capable of providing good care but they are not well-managed." One relative commented, "Staff seem to come and go, and the person doing the rotas does not seem to be familiar with local geography, so carers have to travel miles between care visits."

At our last comprehensive inspection on 15, 16 and 21 August 2017 we found that effective systems were not in place to monitor and improve the quality and safety of the service provided to people. Some people either received late calls or early calls instead of their scheduled call time. Also, on some occasions staff had not spent the full, allocated time at people's home. The provider told us they would make improvements by 31 October 2017.

At this inspection we found that the provider was still not effectively monitoring people's calls.

People were not always supported in line with the care and support that had been planned for them. The provider had not always monitored and analysed short calls, early or late visits, so patterns could be identified and improvement made. Call records showed that on some occasions staff had not spent the full allocated time at people's home. For example, one person had a scheduled call visit for 45 minutes but they were visited for 19 minutes, another person was visited for 25 minutes instead of a full 45 minutes. For a third person, staff visited for 32 minutes, instead of a full 60 minutes. There was no record to show people had asked staff to leave earlier than their scheduled visit times. As a result, it was not clear whether people had requested staff leave early or if staff were in a rush to complete their allocated tasks.

Staff did not always arrive at their allocated time. For example, on 20 September 2018, one person had a 34 minutes late call, another person had 44 minutes late call and a third person had 30 minutes late call. There was no record to show that people had requested them to come late.

Staff told us that they were not always given enough time to travel between people which impacted on their ability to arrive promptly or stay the full time with people. One staff member told us. "Sometimes they [management] are good and sometimes they are not organised at all." Another member of staff said, "Sometimes, the time they [management] give you to go from one client to another client is too short especially if you are on the bus."

We brought this to the attention of the provider and explained that completing the previous action plan was

mandatory. The provider told us that they had experienced technical issues when monitoring people's calls. They had tried to manually complete this analysis, however, had been unable to do so in a timely manner. Following the inspection, the provider carried out a manual analysis for a one-week period from Monday 22 October 2018 to Sunday 28 October 2018 each day, which showed there were in the range from 2.84 percentage to 6.3 percentage early calls, and from 2.36 percentage to 4.11 percentage late calls. The provider told us they planned to make further improvements, including introducing a new online system in December 2018, to monitor the calls and take immediate action, to ensure people received home visits in line with their care plan. We will continue to monitor and will check the improvements at our next inspection.

The provider's quality assurance systems were not effective. Although they completed checks and audits on care plans, accidents and incidents, complaints, medicines management but had not identified the issues we found at our inspection. This included concerns relating to the oversight of the service, risk management, reflecting current needs of the people their care plans, and monitoring visits to people's homes.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had 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. The registered manager demonstrated an understanding of the requirements of the role and their responsibilities under the Health and Social Care Act 2008. We observed the manager interacting with staff in a positive and supportive manner throughout the time of our inspection.

People's views were sought to improve the quality of the service. People who used the service completed satisfaction surveys in September 2018; we found that the service had made improvements in comparison to 2017 survey results. For example, people said that staff's time keeping was good and had improved from 81 percentage to 93 percentage, length of time from 85 percentage to 94 percentage, regular care worker from 82 percentage to 90 percentage. However, the aspect of meeting needs had deteriorated from 90 percentage to 89 percentage. The provider developed an action plan in response to the feedback from the survey to show how the identified concerns were addressed.

Staff meetings were held to share learning, and good practice so staff understood what was expected of them at all levels. Records of the meetings included discussions of any changes in people's needs and guidance to staff about the day to day management of the service, coordination with health care professionals, and any changes or developments within the service.

The last inspection rating of the service was displayed correctly on their website.

The provider used staff induction and training to explain their values to staff. The service had a positive culture, where staff understood the organisational values and applied in their day to day work. One member of staff told us the vision of the service was, "To give good care and promoting independence of people." Another member of staff said, "Yes, to provide choice and respect people, working as a team."

The service worked effectively with health and social care professionals and commissioners. Feedback from a social care professional stated that the provider had made improvements since our last inspection in

August 2017.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>Care plans did not always reflect people's current needs and had not been updated when their needs changed. The provider identified communication needs for people but had no guidance in their care plan for staff about how to meet them.</p>
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not taken action to make sure risk assessments included appropriate guidance for staff on how the identified risks should be managed.</p>
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not always ensured that they monitored and analysed short calls, early or late calls, so patterns could be identified and improvement made.</p>