Altruistic (North Kent) Ltd

Expertise Homecare (Canterbury & Coastal)

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

Expertise Homecare (Canterbury and Coastal) is a domiciliary care service and is a franchise of the Expertise Homecare brand. It provides personal care to people living in their own homes in the community. The service is provided to mainly to older adults, some of whom have complex needs such as dementia or complex health conditions. The service supports people in Canterbury and surrounding rural areas. Not everyone using Expertise Homecare (Canterbury and Coastal) receives a 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. At the time of inspection 59 people were receiving the regulated activity of 'personal care'.

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

Staff were not always recruited safely. This was because the registered manager did not take all the necessary steps to ensure they knew the previous conduct of newly recruited staff. People did not always receive their medicines safely. We found staff were not following best practice guidelines when administering controlled drugs. We made a recommendation about this. The registered manager had not always taken steps to learn lessons when things went wrong to keep people safe. Some people and staff might be at risk because risks were not always being fully documented.

People's needs were assessed before the service began, but we found some needs were not fully recorded. Newly recruited staff were supported with an induction, but progress was not always tracked in accordance with the registered provider's guidelines. Staff were knowledgeable about the Mental Capacity Act, but records were not always accurate or up-to-date.

We found the registered provider had not always acted on complaints in a timely manner. This had a negative impact on the person making the complaint. People's care plans did not always contain detail about their needs or preferences. This included how they wished to be supported at the end of their lives. People did not receive information about their care in an accessible format. People and their relatives told us they had not seen all of their care records because they were on a computer system which they did not know how to access. We have made a recommendation about this.

Governance systems were not always effective in making sure that shortfalls in service delivery were identified and rectified. The registered manager was unaware of the shortfalls in, for example, the recruitment procedures or care plans which we identified during our inspection. Not all the staff we spoke with were clear about what was expected of them. This was because job descriptions were not always changed when staff's roles changed. Although staff were not supported with regular meetings or supervisions, they told us they felt supported by their manager and senior staff.

People were protected from abuse. Staff were knowledgeable about the types of abuse which could occur, and knew what action to take if they had concerns. People were protected by the prevention and control of infection. Staff had access to, and used, protective equipment, and received regular training which helped them keep people safe.

Staff received sufficient training in order to meet the needs of those being supported. Where people had specialist needs, additional training was provided. When required, people were supported to eat and drink enough to maintain a balanced diet. Staff worked across organisations to ensure people received joined up care and support. People were supported to live healthier lives. Senior staff ensured people had access to health professional support when needed.

Staff treated people with kindness and respect. People and their relatives told us that staff were compassionate and offered they emotional support when it was needed. People were supported to be independent. They were able to express their views and make decisions about their care. Staff took steps to make sure they treated people with dignity.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

We found additional shortfalls in the service in relation to which we have made recommendations.

This is the first time the service has been rated Requires Improvement.

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.

Staff were not always recruited safely.

Staff did not always take action to reduce the risks and keep people safe.

People did not always receive their medicines in a safe way.

Lessons were not always being learned when things went wrong.

People were protected from the risk of abuse.

There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were assessed but records did not always reflect people's needs accurately.

Staff were following the principles of the Mental Capacity Act but records were not always accurate.

Staff received training so they could carry out their roles effectively.

Staff worked together across organisations to help deliver effective care when people moved between services.

People were supported to live healthier lives and have access to healthcare services.

Is the service caring?

Good

The service was caring.

People were treated with respect.

Staff supported people to express their views and be actively

involved in making decisions about their care.

People's privacy, dignity and independence were promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People knew how to complain, but the registered provider did not always act on complaints in a timely manner.

People receive care that was personalised to their needs and preferences but they were not always recorded accurately. This included any needs or preferences they may have to enable them to have a dignified death.

Is the service well-led?

Requires Improvement

The service was not well-led.

Quality assurance processes did not identify shortfalls in the service.

Some staff were not clear about their roles and responsibilities.

Although staff were not receiving regular supervision or meetings, they told us they were supported by their managers.

Staff work were working with health and social care professionals to help people receive joined up care.

Expertise Homecare (Canterbury & Coastal)

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.

Our inspection was prompted by concerns raised by a member of the public about the standard of care and support provided by the service. The provider was given 24 hours' notice because the location is a domiciliary care agency and we needed to be sure that someone would be at the office. The provider was not asked to complete a 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 took this into account when we inspected the service and made the judgements in this report.

Inspection site visit activity started on 31 October and ended on 13 November 2018. It included visits to three people in their own homes where we also met relatives and/or friends. We spoke with an additional two people and five relatives via telephone. We visited the office location on 31 October and 1 November 2018 to meet the registered manager, other office staff and also the registered provider. The inspection was carried out by two inspectors.

We spoke with the provider, the registered manager, and a care co-ordinator for the service. We looked at ten people's care plans and the associated risk assessments and guidance. We looked at a range of other records including five staff recruitment files, staff induction records, training and supervision schedules, staff rotas and quality assurance surveys and audits.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they thought the service was safe. One person said, "We see a small group of staff, and they're always on time." A relative told us, "They always wear gloves and aprons when they're here." However, our findings at inspection showed that the service was not always safe.

Risks to people were not always being recorded, and detailed guidance was not always given to staff in order to help them reduce the risks. Senior staff received training on how to identify and reduce risks. They carried out assessments on people and their home environment before staff began to provide care to ensure it was safe to do so. Not all risks to staff and people, however, were adequately assessed. For example, an environmental home safety checklist completed for each new person at the time of assessment, did not consider the type and condition of equipment staff may have to use in their support of people's personal care needs and whether this was in safe working condition and serviced. No system was in place to monitor if equipment servicing was being maintained. Risk guidance lacked important detail to support staff's care practice, for example risk measures implemented to reduce the risk of pressure wounds for people confined to bed or who required repositioning were not well documented. Risks from dehydration and poor nutrition or falls were not assessed, although care plans indicated awareness and some support from staff in these areas. One person's care plan mentioned that they had seizures. Records included a vague description of 'unpredictable movements' when a seizure occurred. This gave staff little information about what they might see and how they should deal with this if it occurred during the course of delivering personal care. This placed staff and people at risk of unsafe care and support.

The registered manager had not always taken steps to learn lessons when things went wrong to keep people safe. Eleven incidents had been reported by staff during 2018. However, the information reported by staff was not always used to keep people safe or prevent concerns reoccurring. For example, one person was found by a member of staff to have fallen out of bed. Paramedics were called and identified the person had an infection commonly associated with being dehydrated. Although a review of the person's care was scheduled for the following week, the resulting care plan did not include any information for staff to follow to help ensure the person was hydrated enough in the future. Another person had been found on the floor by a staff member. The person had declined medical attention but there was no record that any investigation was carried out to determine how the person fell, and steps to be taken to reduce the chance of them falling in the future.

The failure to effectively assess or take action to mitigate against risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Staff were not always recruited safely. Records showed the registered manager had not carried out all the checks needed to make sure newly recruited staff were suitable to carry out their role. In one person's recruitment file we saw that the registered manager had requested two references from one new staff member's previous employers. Neither organisation had replied, and neither were followed up by senior staff. In three other staff member's records we saw references had been provided as part of the application process, but not sought independently by senior staff during recruitment. Another staff member's reference

was sought, but was not received until seven weeks after their first shift. These oversights meant the registered manager did not have all the assurances they needed regarding applicants previous conduct.

The registered provider had a robust procedure which was to be used to help ensure new staff had the skills to carry out their role. This included various review points, with at least two weeks of shadowing more experienced staff, an office based supervision session in week three, shifts being assigned on week six and a probation period at six months which needed to be passed before employment was confirmed. However, one person's records indicated they started their first shift in their second week of employment, and did not have their first supervision session until five months into employment. There was no record that this person had passed their probation period. Other staff member's records were incomplete and the registered manager was unable to confirm if or when the review points had taken place.

The failure to operate effective recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Staff who used their car to get to visits were required to have business insurance and an up-to-date MOT. We saw records for one staff member who had car insurance only for personal use, and another staff member's vehicle records were out-of-date. Other background checks were being carried out on prospective staff members. For example, gaps in candidate's employment history were investigated and recorded. A Disclosure and Barring Service (DBS) check was carried out before staff started to work with people. A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with vulnerable people.

People did not always receive their medicines safely. Records indicated one person had a pain patch administered each week by care staff. The registered manager told us that care staff would write on the patch to indicate when it had been given, but there was no guidance on which part of the body the patch had been placed previously, so staff could make sure they did not put in in the same part of the body for two weeks in a row in line with manufacturer's instructions. There was no guidance for staff to follow if, for example, if the patch was to fall off. The care plan did not require staff, for example, to check the patch was still in place on the days of the week it did not need to be changed.

We recommend the registered manager seek guidance from a reputable source relating to the safe management of people's medicines.

Other people's medicines were managed in line with recognised guidelines. Senior staff assessed the person's ability to manage their own medicines independently, and only provided support when it was needed. Staff used an electronic system to record the medicines the person required and the type of support needed. If a person had a new medicine prescribed, staff would take a photograph of the label and send to the registered manager so it would be added to the electronic medication administration record (MAR). The system held information on side effects of medicines so staff knew which signs and symptoms to look out for to help keep people safe. Staff told us they found the system was simple and effective to use.

Other incidents were managed more robustly. For example, when staff identified medicine errors, these were recorded as incidents and investigated by senior staff. We saw three occasions where people had been given medicines at the wrong time of day, each had been reported by staff. Senior staff had contacted the person's GP for advice and this advice was followed. Where it was seen that one staff member was making individual errors, they registered manager held supervision with them, and arranged for additional training. Other accidents and incidents, such as people when people fell, were reported by staff and followed up by managers.

There were examples of good practice regarding risk. During one assessment the registered manager identified that the area outside one person's house might be poorly lit at night. They arranged for another visit when it was dark, and this assessment resulted in staff being supplied with torches to help ensure they got to the property safely. Once they were providing care, staff were encouraged to identify and report any changes to risks whilst providing care, with one telling us, "It's an ongoing process. We have access to information on the tablet but things can change." In another example staff identified a person was at risk of taking medicines incorrectly and safer administration strategies were put in place as a result. The registered manager and a staff member had also worked proactively with one person who raised regular concerns around threats to self-harm, since this input the numbers of such calls had reduced significantly.

There were enough staff to meet the needs of people using the service. The registered manager worked with health and social care staff to determine the needs of people before the service began, and used this information to calculate the number of hours required each day. Although the registered provider had previously had some difficulty recruiting staff, the registered manager had started to use local social media websites in the recruitment process. They told us this had improved recruitment and retention numbers, meaning they now had enough staff to meet existing needs and had additional staff to be able to support future demand. Staff were organised into teams which covered areas in Canterbury and Herne Bay. For those who needed two staff members at each visit, it was arranged for them to travel with each other so they could arrive together at the same time. People were supported by a small group of staff and the registered manager tried to make sure they supported the same people as much as possible. The registered manager said, "Continuity is really important to people so we organise ourselves with this being at the top of our mind." People and relatives, we spoke with confirmed this was the case, with one relative telling us, "My wife needs two carers at each visit, but I only see about five in total. It means they know her well, which is important as she has dementia and cannot communicate easily." The registered provider had identified that as the service was taking on additional referrals, there was a need for an additional senior member of staff to support the registered manager and care coordinator and was in the process of recruiting an existing member of the care staff to this role. Both staff and relatives told us senior staff were available outside normal working hours if they needed support.

People were protected from the risk of abuse. Staff had received training on how to identify safeguarding issues as part of their induction into the service. Training plans showed other staff received refresher training each year which helped them keep up-to-date with changes to legislation. Staff were knowledgeable about the different types of abuse, knew how to report concerns and were confident that any concerns would be taken seriously by the registered manager. One staff member told us, "I would report anything to the manager, or the owner if I needed to." Staff also knew they could report concerns to external organisations such as the police if required. The registered manager told us there had been one safeguarding concern since the last inspection, and records showed this was raised with the local authority and CQC as required. Records confirmed the registered manager also had discussions about safeguarding with staff during supervision, giving them an opportunity to voice any concerns.

People were protected by the prevention and control of infection. Staff received training on infection control as part of their induction, and established staff received refresher training. Staff told us they had easy access to personal protective equipment such as gloves and aprons. People and their relatives confirmed to us that they saw staff using the equipment when providing care and support to them. The registered manager also checked staff were using them during regular spot checks in people's homes.

Requires Improvement

Is the service effective?

Our findings

People's relatives told us they thought staff were skilled in carrying out their roles and could meet their needs effectively. A relative told us "They know what they are doing, and I have learnt so much from them, like how to move him."

People referred to the service were assessed prior to a care package being offered. Any protected characteristics a person had in relation to their disability, sexual orientation, race, culture and religion that were important in the delivery of support were recorded at the time of assessment. Staff had received training in equality and diversity and a policy was provided for them to read. Assessment helped to inform the registered manager and senior staff as to whether they could meet the needs of the person. Records showed reassessment of needs took place after six months or sooner if needs changed significantly. People and their relatives told us that staff provided the care and support they needed and wanted. However, we found that information gathered for assessment and care planning failed to incorporate important information that could impact on risk and how care was delivered. For example, an assessment for someone confined to bed who was entirely dependent on others for their nutrition, hydration and personal care, and who was also at risk of choking, stated that there were 'no risks'. Our checks showed that the person was receiving appropriate support from carers with ongoing oversight from a relative but assessment documentation was an area for improvement.

The Mental Capacity Act 2005 (MCA 2005) 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.

The service was following the principles of the MCA, however documentation did not always support practice. For example, staff were observed seeking consent to carry out tasks during visits, and asking if there was anything else they could do. Formal consent to the provision of care was sought at initial assessment. Consent forms were completed by office staff on behalf of people and relatives, but not signed by those they were relevant to, in order to demonstrate their agreement. Staff liaised with relatives of people that lacked capacity but staff lacked knowledge of which relatives had legal authority to make decisions on the behalf of people without capacity. Some records indicated that relatives may have power of attorney or lasting power of attorney but this was not made clear within the records and there was no indication authorisations had been seen by staff. A system for recording legal authorisations was not in place. This was an area for improvement.

We found supervision was not carried out in a systematic manner, with some staff not receiving it for many months. Staff did not have a yearly appraisal of their work. The coordinator informed us that they themselves had not been supervised by the registered manager for over a year. This meant the registered manager had not had the opportunity to identify any learning or development needs of the care coordinator which might have helped them carry out their role more effectively .This was an area of improvement.

Staff were aware of people who needed additional support with their nutrition and hydration. A record was kept of drinks offered to people at visits if this required monitoring, and care plans made staff aware of the need to leave drinks and snacks accessible to people at the end of each call. The need to record these risks as part of the risk assessment process was not developed well enough to reflect the actions staff took to reduce the level of risk to people from not eating or drinking enough and this was an area for improvement. People who were able were supported to make their own meals, staff cooked for others consulting with them about what they wanted to eat. Food supplements were given to people if these had been prescribed.

Staff had the skills, experience and knowledge to deliver effective care and support. Newly recruited staff took part in a four-day induction programme which was completed before they started working with people. This included courses on subjects important to their role, such as moving and positioning techniques, first aid, food safety and medication. Established members of staff were supported with ongoing training, which was monitored by the registered manager to ensure they kept up-to-date. Staff completed a range of training that helped and informed their safe support of people, this included for example infection control, food hygiene, medicine administration, first aid and safeguarding. Where people had specialist needs such as dementia, training was sought to ensure staff could meet their needs. When one person needed specialist support for their nutrition to be provided via a percutaneous endoscopic gastronomy (PEG) (a tube that carries medicines and liquid nutrition for people who cannot swallow), the registered manager arranged for training specific to the person and the equipment before they started to provide support.

The registered manager advised us that they had started to develop networks and good working relationships with organisations and agencies they worked most closely with, such as a carers support organisation, continuing health care professionals and the mental health team in regard to specific referrals and cases.

Peoples health needs were monitored and supported by staff. Staff alerted relatives or other reliant people if they were concerned about a person's state of health to ensure that action was taken to seek treatment or advice. One relative told us, "There was a time when we needed to call an ambulance. I've not done that before. The carers were so calm in what was a stressful time for me." Staff showed commitment and care towards the people they supported. For example, the registered manager informed us about a call received from the lifeline team in respect of someone who used the agency service and had fallen and called the lifeline team. The person had already received their daily visit from agency staff but a call went out to all staff for anyone in the vicinity to go and sit with the person until the ambulance came. A staff member responded and provided comfort to the person until they could be assessed by paramedics.

Good

Is the service caring?

Our findings

People and their relatives told us that staff treated them with compassion, dignity and respect. One relative said, "They are really gentle with her, they take their time and don't rush her." Another said, "It's nice that they take the time to speak to her, especially as she's unable to speak back."

Staff were observed to be respectful of their surroundings when in people's homes, calling out on arrival so as not to surprise people. Staff attitudes were kind and friendly. They made enquiries as to the persons wellbeing either with the person themselves or with their relatives or representative. Staff showed that they understood people's individual needs well. One relative told us, "My wife cannot speak anymore, but the carers always talk to her as if she could. They explain what they are going to go and ask if she wants a drink or something to eat. It's lovely to hear that." When conducting personal care, they did so discreetly shutting curtains and closing doors. Staff confirmed they took steps to respect the person's dignity when providing care to them. One staff member said, "I'll make sure the door is closed, close the curtains and cover the lower part of their body when drying their top." They understood the security arrangements for entering and leaving people's property and the actions to take to leave them safely with drinks and snacks provided. Staff understood how to deliver personal care in a person-centred way and had received training in personal care giving.

Staff delivered care to people in an unrushed manner, the provision of travel time between calls gave staff the flexibility they needed to arrive at calls within the given timeframe and spend time with the person they were supporting. They provided a level of social interaction and reduced isolation whilst undertaking their support tasks. People were encouraged to do as much for themselves as they could but in the knowledge that if they found it too much, staff were there to provide support. Staff only departed once they had confirmed there was nothing more for them to do.

People said they thought staff did what they were meant to do and stayed the right amount of time. People felt that they could ask staff to do other things for them if they needed to. Through the assessment process staff had a good understanding of people's individual preferences and beliefs and respected these. People and their relatives were involved in reviews, with one relative telling us, "[Registered manager] has encouraged me to ask for additional hours from [the commissioners]. They are coming to do a review and [registered manager] said she'd support me at the review." People also appreciated the continuity many of them enjoyed in the staff that supported them, there was a computerised rota and some people had made the choice to have a paper copy of the rota for their own use.

Staff demonstrated a good understanding of confidentiality, people were not aware of staff ever talking about other people they visited when they were offering support to them. Staff were provided with tablets that enabled access to people's computerised records to record tasks undertaken and record how people were at each visit. They, office staff and people and relatives had their own login to access parts of the computer system. This protected the security of records and ensured only those authorised to do so had access. Care records and staff files were locked away when they were not being used by senior staff. Tablets used by care staff were password protected.

Requires Improvement

Is the service responsive?

Our findings

The registered provider had not always taken timely steps to respond when failures were identified through complaints. We saw records showing one relative had made a formal complaint in January 2018. They expressed some serious concerns about the poor standard of care provided by staff, and the manner by which senior staff had responded to those concerns when they had been raised informally. We were concerned to find that although there had been some communication between the registered provider and the complainant in the meantime, the complaint had remained unresolved almost ten months later. This had caused the complainant and the person receiving support significant distress. It also meant the registered provider was unable to take action on any shortfalls identified by the complaint to help improve the service for others.

The failure to take action to respond to failures identified by a complainant was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Each person had their own care plan. These provided basic information to enable staff to meet the everyday basic care needs of the people they supported, information about tasks to be conducted at each call was clearly detailed. A review of daily notes against the tasks performed by staff we observed at visits showed them to be carrying out tasks in accordance with the care plans. People and their relatives said that staff did everything for them that was needed. The content of care records including care plans and risk information however, was an area for improvement. This was because important information about people's needs was not always documented to fully inform staff support. For example, one person we visited could become agitated, this was mentioned in the care plan but no strategy recorded as to how to divert the person's attention. At the visit staff were able to tell us about why and when the person became agitated and the strategy they had developed to help divert the behaviour; this was not recorded or shared so that other staff could be made aware and use the same strategies.

The registered provider was not meeting people's communication needs because they were not meeting the Accessible Information Standard. The Standard was introduced on 1 August 2016 and sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss. It also includes people who live with dementia and who need to have information presented to them in an accessible manner using techniques such as large print and graphics. Staff had access to an electronic version of people's care records, but this information was not readily available to people or their relatives.

The organisation promoted itself as operating a paperless service, people and their relatives knew this when they joined the agency. They were provided with an initial folder of information about the service and a computer login to access their own or their relatives care plan, medicines administration record and the daily reports staff completed for each visit. However, this did not meet the needs of those not comfortable with new technology, and therefore unable to access their own care plan and daily reports to check they were an accurate reflection of care needed and delivered.

In a recent survey carried out shortly before our inspection, most people said that they did not know how to view their care plan and other information on the online system. Relatives knew about the online system but had not arranged to get access. One person told us, "I don't see the carers providing care, but I know they make notes on the tablet about what is happening. I know I can get access to them somehow if I contact someone in the organisation. It'd be easier if there were notes left in the house as the last agency did."

We recommend the registered provider seek guidance from a reputable source regarding providing information to people in a way they understand.

The service did support people with complex needs and life limiting conditions. The registered manager spoke of being committed to offering people a service for however long they needed it and their needs could be met safely. End of life training for care staff had been identified and was to be included in the staff training programme. However, people's end of life wishes were not routinely gathered to give staff an awareness of what people wanted to happen at the time of and following their death, such as a religious observance or specific people who should be contacted first. This was an area for improvement.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and staff told us they thought the service was well led. One relative said, "I think it is well managed. They're' always in contact if anything is changing, or if carers are running late." A member of staff said, "[Registered manager] is always at the end of the phone. I needed to call at 10pm one night so I didn't forget something, and she answered straight away." However, we did not always find the service to be well-led.

Governance systems were not always effective in making sure that shortfalls in service delivery were identified and rectified. The registered provider had not carried out overarching quality audits on records such as staff files. This meant they were unaware of the shortfalls in, for example, the recruitment procedures we identified during our inspection. Additionally, although the registered manager carried out some checks on staff, such as spot checks, these had not been organised in a systematic manner, meaning some staff were checked whilst others were not. At the time of the inspection these checks were carried out by the registered manager. However, the registered provider had identified the need for an additional staff member to support this work, and had recently recruited an existing staff member into the post. They told us part of the new role would be to carry out regular and planned spot checks.

Online systems were not being used effectively to monitor or gain good oversight of the service. Care staff used an online logging in system on a tablet, which identified the time the visit started and ended. However, we found if staff were running late they could change the time recorded on the tablet to reflect the expected rather than actual time they visited. This meant senior staff were not able to be confident about the time the staff visited a person's home, which made investigating any complaints of timekeeping difficult. Additionally, the registered manager had not activated all the functions of the system to monitor time keeping. For example, we found they system was not being used to alert senior staff if a staff member was running late, even though it had the functionality to alert staff in real time. Instead the registered manager told us they had waited outside people's houses in an unplanned manner, to check the time care staff arrived. On one day this took place they identified six out of nine visits being later than expected. Although they spoke to staff involved, they had not acted to implement a more effective, regular way of checking staff punctuality.

There were shortfalls in the quality of record keeping as previously described in this report. Assessments of people's needs were carried out, but they did not record all the needs we identified during our inspection. People's care plans did always record all the information needed in order to fully inform staff of people's needs and preferences. The registered provider did not always keep accurate records relating to people's capacity and how people were supported to make decisions in line with the MCA.

The registered provider had not ensured that effective systems were in operation to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not all staff were clear about what was expected of them. We found the care coordinator had originally been

employed as an office administrator. They told us how their role in the organisation had changed, meaning they now had line management responsibilities for care staff. However, their job description had not been changed, and they had had minimal training in how to carry out their new management role, such as the recording of supervision or managing complaints. Staff meetings had not been held since the registered manager had taken up post although two were planned for December 2018. Staff one to one sessions providing staff with a forum to express their views had also become infrequent. However, staff said they felt well supported by the registered manger and co-ordinator, and indicated that there was an open culture that enabled them to raise issues when they arose.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was aware of their responsibility to comply with our registration requirements. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support.

The registered manager and senior staff were caring of the well being of their staff and took steps to ensure their work life balance met their specific needs. The provider promoted a paperless service and the use of new technology was key in achieving this. There was recognition however that some staff were less comfortable with computers and so an exception had been made for two staff who visited a specific service user to administer medicines and a paper copy of the medicine administration record has been made available for them. These were returned to the office at monthly intervals.

Customer surveys were sent out and staff were also surveyed for their views. The registered manager was in the process of analysing the findings at the time of the inspection. Policies and procedures to guide staff practice were in place. These were produced by the franchiser head office and took account of current best practice. These were kept updated and staff were notified electronically when updates had been provided that they needed to read.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager was not doing all that was reasonably practical to assess and mitigate against risks. Regulation 12 (1) (2)(b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider had not ensured all complaints were investigated without delay. Regulation 16 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager did not use systems and processes to effectively monitor the quality and safety of the service being delivered. Regulation 17 (1) (2)(a)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered manager did not request all the information necessary to be assured of the suitability of newly recruited staff.

Regulation 19 (2)