Brookleigh Caring Services Limited

Brookleigh Caring Services

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

The inspection took place on 4 and 15 May and 8 June 2017. The inspection was announced. This means the registered manager was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available to support the inspection.

Brookleigh Caring Services is a domiciliary care agency registered to provide personal care to people in their own home. At the time of our visit there were 309 people receiving personal care calls.

The service had a registered manager in place. 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 service was previously inspected on 19 January 2016 and was not meeting one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment. We took action by requiring the registered provider to send us action plans telling us how they would improve this. When we returned for this inspection we found the issues identified had not been addressed.

The systems and processes in place to protect people from the risk of harm were still not sufficiently robust. We saw that some risks had been identified without any information on how staff could mitigate these risks. Other risks were apparent from information in people's care records but no risk assessment was in place.

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.

Clear and accurate records were not being kept of medicines administered by care workers. Gaps in the medicines administration records meant we could not be sure people were always given their prescribed medicines. Details of the strengths and dosages of some medicines were not recorded correctly. Care plans and risk assessments did not support the safe handling of people's medicines.

Complaints were not always being handled in line with the registered provider's complaints policy.

Records were not always comprehensive or up to date. Contact information we were given was not current. Some people's care plans lacked the level of detail required to be person centred. Person centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

A number of people we spoke with told us it was difficult to contact the office and calls were not always returned. People did not always receive rotas informing them which staff would be providing their care.

Although there were systems in place to monitor and improve the quality of the service provided these were

not being used effectively to make improvements. The results of a satisfaction survey was analysed but no action plan was produced and people's comments were not taken into consideration. Audits of care plans and medicines had not picked up the issues we identified.

Staff were able to tell us about different types of abuse and were aware of the action they should take if they suspected abuse was taking place. Staff were aware of whistle blowing procedures and all said they felt confident to report any concerns.

Appropriate environmental checks had been done on people's homes to ensure health and safety of staff and the people they cared for.

Staff had received appropriate training and had the skills and knowledge to provide support to the people they cared for. New staff had a comprehensive induction and shadowed a more experienced colleague until they were sufficiently confident and capable to work alone.

People who used the service were happy with the care provided by staff. Staff were knowledgeable about the people they provided care to; they promoted independence and respected people's privacy and dignity.

People were supported to maintain good health and to access health professionals when needed.

We found that safe recruitment and selection procedures were in place and appropriate checks had been undertaken prior to staff starting work.

Staff had been receiving regular supervision and annual appraisals to monitor their performance.

Staff had received training on the Mental Capacity Act (2005) and demonstrated an understanding of the requirements of the Act.

We saw that people were given support to ensure their nutritional needs were met.

Staff meetings were held regularly and staff who were unable to attend had access to the meeting minutes. The registered manager was described as approachable and staff told us they felt supported by management.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Individual risk assessments were not always in place and those that were did not always include sufficient detail on how to mitigate risk.

Medicines were administered safely but we saw that medicine records were not always correct.

Staff had received safeguarding training and had knowledge of how to look for signs of abuse and report concerns accordingly.

Is the service effective?

Good

The service was effective.

People were cared for by staff who had the right skills and knowledge to care for them. Staff had received the appropriate training.

Staff had received training on the Mental Capacity Act (2005) and demonstrated an understanding of how to apply this in practice.

People were supported to access healthcare and their nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring.

People were happy with the level of support they received and felt staff were kind and caring.

Staff knew how to treat people with respect and dignity.

People were encouraged to be independent where possible and given the right level of support when they needed it.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints were not always being handled in line with the registered provider's policy. Some complaints had not been correctly followed up.

People had care plans in place that addressed their support needs but these could be improved with the inclusion of more detail.

People were involved in decisions about their care and how they wished to be supported.

Is the service well-led?

Requires Improvement 

The service was not always well led.

Records were not always accurate or up to date and people told us they had difficulty contacting the office.

The registered manager carried out regular quality assurance checks but audits were not picking up issues we found. Survey data was not used to improve the service delivery.

Staff meetings were held regularly and staff spoke positively about the support they received from management.

Brookleigh Caring Services

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 4 and 15 May and 8 June 2017 and was announced. The registered manager was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available.

The inspection team consisted of two adult social care inspectors and one pharmacy inspector. Three experts by experience telephoned people in their own homes to gain their views of the service. These calls took place between 4 and 5 May 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a service, on this occasion a domiciliary care service.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are details of changes, events or incidents that the provider is legally obliged to send us within a specified timescale.

The provider completed a provider information return (PIR) and returned this to us on 5 February 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with one of the directors of Brookleigh Caring Services Ltd, the registered manager, a care co-ordinator, three care workers and one senior care worker. During and after the inspection visit we spoke on the phone with 32 people who used the service and 11 relatives of people that used the service. We emailed the registered manager a set of questions to be handed to all 70 care staff and we received 11 responses.

We reviewed the care records of six people that used the service, reviewed the records for six staff and also

records relating to the management of the service. We also looked at the medicine records of nine people who used the service and visited five people in their own home to make sure that appropriate arrangements were in place to manage medicines safely.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we had found the registered provider was in breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was because comprehensive, detailed risk assessments were not in place and the provider was therefore not effectively identifying or mitigating risk.

The registered provider completed an action plan which indicated that care plans would be completely reviewed, including risk assessments. They stated that where a risk was identified documents would detail how the risk would be mitigated and what control measures would be put in place to minimise the risk. We were told that the service would be compliant with this regulation by 1 August 2016.

At this inspection we found risk assessments were still not in place for every identified risk and those that were in place did not contain sufficient detail to enable staff to safely mitigate those risks.

We saw in two people's care plans they were identified as at risk of falls but there was insufficient information on how to mitigate this risk. People's care plans were completed using a standard template and the way questions were answered dictated whether or not a risk assessment was put in place. This system often led to risk assessments not being triggered. For example one person required a soft diet and thickened fluids. Their care plan stated that they often coughed when eating, however, the question on the care plan template 'Do you have any problem swallowing?' had been answered 'no' and therefore no risk assessment had been completed in respect of this person's potential choking risk. This person also had a medical condition which meant they were prone to uncontrollable movements. Pre-admission information stated that carers were to be aware of this but it was not referred to at all within their care plan and there was no risk assessment in place to protect the person or staff. Another person experienced hallucinations but as there was no specific question on the form relating to this no risk assessment was put in place. A third person's care records stated that a family member assisted staff with moving and handling but this had not been risk assessed to ensure the safety of the person, the family member and the staff. We discussed this with the registered manager who recognised that this standard formula meant potential risks not included on the form were being missed and this needed to be addressed.

We saw that environmental risk assessments were completed for each person's home. These included things like fire safety, access to premises and where the isolation points were for utilities such as water, gas and electricity. However, where people were using equipment such as wheelchairs or walking frames details of equipment checks and servicing were not recorded. Whilst the provider was not responsible for the upkeep of the equipment failure to ensure it was correctly maintained meant staff could not be sure the equipment they were using when supporting people was fit for purpose and safe to use.

During this inspection, we looked at the medicine records of nine people who used the service and visited five people in their own home to make sure that appropriate arrangements were in place to manage medicines safely. We spoke with staff about medication and reviewed the provider's medication records.

Staff had not accurately documented the level of support that individual people needed in their care plan. For one person whose care plan we looked at, the medication risk assessment was ticked to indicate they were both level 1(occasional prompt) and level 3 (full administration) for oral medication.

Care workers did not always ensure that the administration of people's prescribed medicines was accurately recorded. We saw that care workers signed medicine administration records (MAR) when people were given their medicines. The MARs we looked at did not always clearly demonstrate which medicines were administered on each occasion. We saw gaps in the records kept for all the people we looked at, these were also identified in the audits done by the provider. We also found that the medicines recorded on the MAR did not match the medicines that staff administered from the pharmacy supplied medicine compliance aid and we found that the process of updating the records when changes occurred was not robust. Medicine compliance aids are used to package medicines in a way that clearly identifies the time of day medicine doses are to be given and on which day. They group together those medicines that are to be given at the same time as each other. For one person we visited the medicine listed on the MAR was losartan 25mg tablets; however, the actual medicine administered by care staff from the medicine compliance aid was losartan 50mg tablets. For another person we visited the dose administered was unclear because care staff had changed the entry on the MAR. For one person prescribed short-term antibiotics, there was no record on the MAR to say which antibiotic had been administered. For the same person a note on the reverse of the MAR stated they were prescribed a cream that staff administered, however there was no record to say when or where it was administered. This meant we could not tell whether medicines had been given correctly. Where one or two tablets had been prescribed, staff did not record the number of tablets they had given which meant records did not accurately reflect the treatment people had received. Where the non-administration code 'O' was used on the MAR, care staff had not recorded the reason for this as detailed in the medication policy.

Several people were prescribed creams and ointments that were applied by care staff. There should be guidance for care staff in the care plan that described how these preparations should be applied. However, in the care plans we looked at this information was missing, or the guidance referred to several creams on the same chart. This meant there was a risk that staff did not have enough information about which creams were prescribed and how to apply them.

Care plans we reviewed contained lists of people's medicines and information about where people kept the medicines, how they should be administered and what time they should be taken. However, we found that the information on the current medication list was not always up to date and accurate.

People told us they received all their prescribed medication on time and when they needed it. We observed medication being administered to people safely.

For medicines that staff administered as a patch, a system was in place for recording the site of application for pain relief patches; however, they were not all fully completed. This is necessary because the application site needs to be rotated to prevent side effects and because this was the only record of administration as patches were not listed on the MAR.

Checks of the medicines administration records were completed when they were returned to the office however; these had not picked up all of the issues we identified at our visit.

These findings evidenced a continuing breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment.

People we spoke with told us they felt safe being cared for by staff from Brookleigh Caring Services. One person said, "Of course I feel safe with them, I couldn't do without them." Another person told us, "I get a little letter saying who is coming and they show their badges."

The provider had an up to date safeguarding policy in place which was reviewed on an annual basis and made available to all staff as part of their induction. The policy was also readily available for existing staff to view. The provider had a whistleblowing policy and information on this was displayed in the office. Whistleblowing is when a person tells someone they have concerns about the service they work for. One member of staff told us, "I know about the safeguarding and whistleblowing policies, they are kept in the manager's office and any revised policies are sent out to us in the post."

Records showed that all staff had received safeguarding training and this was updated every two years. Staff we spoke with had a good understanding of safeguarding, the types of abuse people may experience and the correct action to take if they had concerns about any of the people they supported or the actions of any colleagues. One member of staff told us, "I know how to report things and I would if I had to, definitely." Another said, "If I thought anyone was being abused I would report it to my co-ordinator or the manager."

We asked people if the same staff regularly provided their care. Some people responded positively. One person told us, "I have a regular carer, I can set my clock by them." However, 12 of the people we spoke with had concerns regarding staff changes and the receipt or accuracy of rotas. One person told us, "The bone of contention is that there are regular changes of staff, I don't know who is coming or what time." Another person said, "I've never had a rota, they haven't got it sorted out yet." A third person commented, "My young family do get stressed if a different carer arrives. I have two a day and all the office need to do is call me and let me know if someone is off sick. It helps me to feel safe and comfortable if I know who is coming." One of the relatives we spoke to told us, "The carers get changed with no notice and this disorientates my relative. I have asked to be informed but am still waiting for a call back. They feel worried and concerned when new faces appear." We discussed these issues with the registered manager and they told us that rotas are sent out with staff every week. They didn't know why people weren't receiving them and said they would look at alternative ways of delivering them.

We discussed staffing levels with the registered manager and director they told us there had been a high volume of sickness absence recently and they had done their best to cover this with existing staff. They acknowledged that this had at times impacted on calls being covered by the staff member who was on the rota but told us no calls were missed during this time.

Calls are monitored using an electronic system that logs calls in 'real time'. This meant that staff in the office were alerted if a call is late or missed. The system relied on staff logging in to a person's home electronically using their mobile phone or calling the office to confirm a call has been made. We were told that some records were not showing accurate times as some staff were without mobile phones due to a dispute with the mobile phone provider and they were looking to rectify this as a matter of urgency.

The reports we were shown included a number of 'missed calls' however the registered manager explained that a call would show as being missed once it was outside of the 15 minute tolerance allowed for a late call. They assured us that none of those listed as missed calls were actually missed.

Although we were told by the registered manager that there had been no missed calls some of the people we spoke to did mention times when calls had been missed. One person told us, "They (staff) turn up late a lot or sometimes very early and they have missed calls." Another person said, "They did miss a call about a fortnight ago." Because late calls were flagged up as missed once they were outside the tolerance it was not

possible to establish for certain from records whether any calls had actually been missed. We highlighted this to the registered manager who told us they would look at the way the computerised records were produced in an attempt to address this.

Recruitment and retention of staff remained a challenge for the provider. They explained that they had an ongoing recruitment programme with new staff being inducted every month. The director told us, "There is a recruitment cohort every month. We can't wait for the crisis we have to be ready for it."

We looked at the recruitment records of six staff. Pre-employment checks had been undertaken prior to staff starting work. Disclosure and Barring checks (DBS) had been carried out for all staff. The DBS carry out a criminal record and barring check on individuals who intend to work with children and/or vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

Good

Is the service effective?

Our findings

People we spoke with thought that staff had received relevant training to meet their needs. One person said, "They all seem to know what they are doing." Another person told us, "They seem to have enough training, my needs are met."

Staff received mandatory training that included areas such as safeguarding, first aid and manual handling. Mandatory training is training that the provider thinks is necessary to support people safely. Staff also received additional training in areas specific to the needs of people using the service. This included topics such as understanding and managing challenging behaviour, epilepsy and dementia.

Staff training was monitored via a training matrix that showed the date staff had completed training and the frequency the mandatory training was to be repeated to keep essential skills up to date. These records showed that all mandatory training was up to date.

We were told that staff were matched to care packages to ensure those with appropriate skills attended calls. The registered manager explained how they looked at care packages as they came in to ensure staff were appropriately trained and also assessed new staff during induction to establish their knowledge in specific areas. Any extra training is sourced as necessary. We were given a recent example of a person who was had a Percutaneous Endoscopic Gastrostomy (PEG) tube. A PEG tube passes through the abdominal wall into the stomach so that food, water and medication can be given without swallowing. Although family are responsible for this at present staff are being trained to ensure they are aware of any issues that may arise and so they are able to step in with extra support if this becomes necessary. We asked how this would be affected if staff were absent, giving recent sickness levels as an example. The registered manager explained that care coordinators with the appropriate knowledge had attended calls if staff with correct training were unavailable.

Staff we spoke with were happy with the training they received. One member of staff told us, "Your training is regularly updated. I get a call to say what I'm due to do. The last courses I did were first aid and health and safety." Another staff member said, "I have recently done online training in safeguarding and mental health. It gives you a greater knowledge and understanding of these subjects. All my mandatory training is up to date."

New staff had a five day induction that covered areas such as company values, policies and procedures, safeguarding and medicines. During this time an external training provider delivered mandatory training. As part of their induction process staff shadowed colleagues for between two and five days depending on the individual. The registered manager told us that new starters would not work independently until they were confident they could provide care safely.

Spot checks were undertaken by senior staff and management to monitor the standard of care being delivered and the competence of staff. The registered manager told us that they had recently begun to use their training provider to undertake regular observations of staff and report on their performance. If any

issues were identified during these observations a plan was put together to ensure extra training or support was put in place.

This meant the provider ensured staff had the knowledge and skills to effectively undertake their role.

Staff received regular supervision and annual appraisal. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. These meetings were scheduled to take place every three months with an appraisal once a year. We saw records of these meetings taking place in line with the provider's supervision policy. One member of staff told us, "I have regular supervision and daily contact with the management team." Another member of staff said, "I have supervisions. You can discuss any issues and raise any concerns at them. I do find them useful although I think they are too often."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. For those people receiving support in domestic settings applications are made to the Court of Protection for such authorisation.

Staff had received MCA training and were able to explain their understanding. One member of staff told us, "It protects vulnerable people who lack capacity. I understand that people have to be protected." Staff were also provided with a small pocket guide to MCA and its five key principles.

Nobody who used the service was subject to a Court of Protection order at the time of our inspection but the registered manager demonstrated a clear understanding of their responsibilities. They explained that all people using the service were assumed to have capacity and told us any concerns staff had were discussed with social services. We saw evidence of consent being appropriately obtained in most people's care files however one consent form was left blank and another had been signed by a relative without any evidence that they had authority to consent on this person's behalf.

Records showed that people were supported to access health professionals when needed.

Those people who required support with meals had food prepared or heated up by staff. The registered manager showed us a brochure for ready meals that staff gave to people to make them aware of a delivery service available in the area. The majority of people we spoke with were happy with the help they received in this area. One person told us, "They do my meals. These [staff] should be chef's not carers, they cook really well."

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the care they received from staff. One person told us, "They are all marvellous, I can't fault them at all, they are all a blessing." Another person said, "The [staff] are lovely and I couldn't do without them as I am in a bit of a bad way now. The [staff] are the best thing about it, there are three I am really friendly with and they are all really nice."

A letter of thanks received from a relative said, 'Thank you to the team of carers who looked after my [family member]. Their care for them and kindness to me was greatly appreciated. You were all brilliant, they couldn't have had better, so kind and thoughtful.'

Staff demonstrated a knowledge of the people they supported and confirmed that the majority of the time they visited the same people. One member of staff told us, "You get to know how people prefer their care by being part of their care plan process and reviews. I take time to understand personal preferences and choices. It's about getting to know the person." Another member of staff said, "They try to keep us in our own area so we get to know the clients."

Staff described how they supported people with privacy and dignity and promoted choice. One staff member told us, "I respect personal space. You have to be polite, considerate and courteous. Offer choice at all times and be respectful." Another member of staff told us, "I always knock on the door before I go into a room. Make sure blinds are closed if people are getting changed. It is important to ask what they want to eat and what they'd like to wear."

People we spoke with told us that staff were respectful of their dignity. One person we spoke with told us, "They are usually cheerful, it keeps me happy. They always draw the curtains in my bedroom when they are helping me get dressed." Another told us, "They always respect my privacy and it works for me."

Relatives confirmed that staff respected their loved one's privacy and dignity. One relative told us, "They are polite and treat [family member] with respect. They will wait outside when [family member] uses the commode, they are very good like that."

Staff told us the ways in which they promoted people's independence. One member of staff said "[Name] will prepare their own meal. I access the food from the freezer for them and help if they need it but they can do most of it and they always set the table themselves." Another member of staff said "[Name] has had a stroke but always washes the pot at the end of their meal. It makes them feel useful." Care plans also included information for staff on how to promote independence, for example one care plan stated that staff were to allow a person to wash themselves as far as they could manage to do so.

Staff spoke passionately about their work. One member of staff told us, "There is no better job. Making people happy, well fed, clean and tidy. There really is nothing better." Another said, "I take time to sit with people, listen to them, talk to them, support them. It gives them a sense of wellbeing and self-worth."

The registered manager confirmed that they had access to local advocacy services if anyone using the service required this type of support. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

The service delivered some specific end of life care packages. The registered manager discussed the challenges of ensuring all the relevant information was received promptly in order to put together a care plan, often at short notice. They were continuing to work alongside NHS Continuing Healthcare to find the most effective way to do this. Staff had received end of life training to enable them to deliver this care.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they knew how to complain. One person told us, "I know them all in the office, I've never had to complain but this is a new thing so we'll see but so far I have had no complaints." Another person said, "If I need to I ring the office and speak to the manager; I have no complaints."

We looked at the way that complaints were handled. We found that one complaint had been received on 24 August 2016 and although a letter of acknowledgement had been sent on 9 September 2016 there was no record of any investigation or outcome. We asked the registered manager about this and they confirmed that it had not yet been followed up. Another complaint we looked at had been investigated by the registered manager however we found inconsistencies in the investigation records and the action taken by the registered manager failed to adequately address all of the issues raised by the complainant.

The provider had a complaints policy and procedure in place that was reviewed annually. This stated that all complaints would be acknowledged in writing within two days, an investigation begun immediately and a full explanation provided to the complainant within 28 days. The records we saw showed that complaints had not always been handled in line with this policy.

This was a breach of Regulation 16 of the Health and Social Care Act (2008) Regulated Activities Regulations 2014: Receiving and acting on complaints.

At our last inspection we found that care plans were in the process of being transferred from one format to another. We found that the new style of plan lacked detail and fed back to the provider that the 'tick box' format of the new care plans made them less person centred. At this inspection we found that care plans were now all produced using the same standard format which was still mainly 'tick box' in nature.

The care plans we looked at contained varying degrees of detail. We saw some plans that were written in a very person centred way, describing exactly how care should be delivered to suit the individual. Other people's care plans contained only basic information relating to their practical care needs rather than personal preferences. Some care plans listed people's medical conditions but did not include any information relating to these conditions for staff to refer to. One person's care plan said they had 'bladder problems' but did not give any more information in relation to this or how it impacted on them and the care they required. We saw this was repeated in three other care plans we looked at with different medical conditions.

The people we spoke with did not raise any concerns regarding a lack of person centred care and the issue was more to do with the records rather than the delivery of care.

Where people had social calls we saw that in some care plans their preferred activities at this time were listed. Experienced staff we spoke with displayed a knowledge of the people they provided support to and their preferences so they were able to provide support in a person centred way. One member of staff told us, "I will sometimes ring the office and ask if [name] and I can go out for a little walk. I know they enjoy getting

out in the fresh air so it's nice to be able to go for a walk with them." The lack of detail in some care plans meant it would be more difficult for new staff to provide the same level of person centred care. The registered manager acknowledged that improvements were needed in care plan records and told us these would be worked on in the coming months.

Most of the people we spoke with said they were involved in making decisions about their care and support. One person we spoke with said, "Yes I am involved in my care as it does differ from day to day and the carers always respond. I just wish the office would. They adjust my times and then the carers have to try and merge my needs with the office schedule." Another person told us, "They did a care plan. I was asked about that, they do reviews but it is just whoever comes from the office, I don't know any names." A relative told us, "It's all in the file, what [family member] likes and doesn't like. We discuss changes and put them in the file."

The registered manager kept a spread sheet to oversee when people's care plan reviews were due. Reviews took place every two months and alternated between face to face and telephone reviews. We were told that care plans were also audited as part of these reviews but records we looked at showed that errors and omissions in care plans were not always being picked up.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection people told us they had difficulty contacting the office. At this inspection communication with the office or lack of a rota was again highlighted as a problem by 22 of the people and relatives we spoke with.

One person told us, "I call the office and advise them of changes and there is only voice mail and this is daytime. I never, never get a call back so I have to keep ringing." Another person told us, "The answer machine was on when I rang and they never got back to me." Another person said, "I call in the morning and say don't come at lunchtime. I have to leave a voice mail and what happens? They turn up!" Another said, "One of a few improvements – communication, communication, communication." A relative told us, "Communication with the office is hit and miss." The registered manager told us a new telephone system had been installed and they could not explain why calls were not being answered or returned. They told us they would look into this and ensure the telephone system was working correctly.

The registered manager told us that rotas were sent to everyone on a weekly basis. However people we spoke with were not receiving rotas consistently. Some people told us they received rotas, others did not. One person told us, "I've never had a rota, they haven't got it sorted out yet." Another person said, "I used to get a visit sheet (rota) at the beginning but not now."

The registered manager told us that customer surveys were sent out annually. We saw the results from the most recent survey which had been completed in February 2017. Although we were told a copy was sent to everyone who used the service only 21 completed surveys had been returned, this equates to less than a 7% return. Most of the people we spoke with told us that they had not received a survey to complete. We fed this back to the registered manager. We were told the surveys were delivered by care staff along with the rotas.The registered manager agreed this was an area that needed improvement as we also found that rotas were not being received on a regular basis by everyone using the service.

We found that the survey was a tick box assessment of satisfaction with no space for people to add additional comments. We saw that some people had chosen to write comments on the forms despite this but the analysis of data had not taken any of these comments into account. No action plan had been produced following the data analysis and therefore the information gathered was not being used to make improvements within the service.

We looked at the quality assurance and audit systems that were in place. We found that although regular audits were being carried out, we could not evidence their effectiveness as they had failed to proactively identify the issues we found during our inspection. For example, incomplete records, issues with safe management of medication and failure to appropriately capture risk and assess appropriately.

The above was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulated Activities Regulations 2014: Good governance.

The registered manager told us after taking over as manager they had not made all of the changes they had planned and they were aware that there were outstanding areas in need of improvement. Following the first and second day of our inspection we saw they were looking at ways to implement changes to care plan documentation. The registered manager acknowledged that there was significant work to be done but they were receptive to our feedback and keen to make the necessary improvements.

We saw that staff meetings were taking place three times a year. Topics discussed at these meetings included rotas, staff sickness, performance targets and training. Staff told us, "Meetings are three times a year and you have to attend at least one. I'm happy to speak up in them. There was one I couldn't attend and so I gave a colleague a list of things to ask. I have seen the minutes for meetings I couldn't attend."

Staff told us they felt well supported by the registered manager and the management team. One member of staff told us "I wanted to change my rota and that was accommodated. I go to my supervisor and then to [registered manager] they get the ball rolling." Another said, "I'm always supported I can raise any concerns I have and they do get dealt with."

Statutory notifications had been submitted to CQC in line with legal requirements. Notifications are changes, events or incidents that the provider is legally obliged to tell us about.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider was not ensuring that all complaints were being investigated. Necessary and proportionate action was not always taken in response to failures identified by investigation of complaints.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess and monitor the service. Audits were not identifying the issues found during inspection. Records relating to the care and treatment of people using the service were not always accurate or complete. Action plans were not put in place in response to feedback from surveys.