

Northern Community Care Line Limited

Northern Community Careline Services

Inspection report

Community Care Line Services
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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

The inspection of Northern Community Careline Services took place between 11 October and 7 November 2018. We previously inspected the service in January 2018, at that time we found the registered provider was not meeting the regulations relating to safe care and treatment, complaints, staffing and good governance. The registered provider had also failed to display their previous Care Quality Commission inspection rating, clearly and conspicuously on their website.

We rated them as inadequate and placed the service in special measures. The purpose of this inspection was to see if significant improvements had been made and to review the quality of the service currently being provided for people.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. On the day of our inspection 45 people were receiving care and support from Northern Community Careline Services.

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.

People told us they felt safe. Risk assessments were now in place and there was a system in place to ensure equipment was routinely checked for safety.

There was a system in place to reduce the risk of people receiving late or missed calls. Improvements had been made to recruitment procedures to make it safe.

Risks associated with the management of people's medicines were not always identified which meant appropriate measures were not always in place to ensure safety. Records relating to the management of people's prescribed topical creams needed to be improved.

New staff received an induction. Since the last inspection staff had received supervisions and checks on their performance. A significant amount of training had been undertaken by staff although some staff had not received training in all the topics recorded on the training matrix.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People had signed their consent to the care and support they received although where people lacked capacity to manage their own medicines, a formal assessment of capacity had not been completed.

People told us staff were caring and kind. Staff respected people's privacy, confidentiality and maintained

their dignity.

Since the last inspection people's records had been reviewed and updated. Records were person centred and provided sufficient information for staff to ensure people's needs were met. Although further work was needed to ensure all aspects of people's care and support included enough detail.

Staff spoke positively about the management of the service. Changes to the systems of governance had been made including the implementation of audits. However, they were not yet sufficiently robust to ensure they would drive the improvements required for all people to receive a consistently high level of service.

At this inspection we found sufficient improvement had been made to meet the regulation relating to complaints and staffing. The service is no longer in Special Measures. This is the first time the service has been rated Requires Improvement. Further improvements were needed to safe care and treatment and good governance to ensure the regulations were fully met.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

The management of people's medicines needed further improvement to ensure it was safe.

Risk assessments were in place where people needed staff and equipment to support them to transfer.

People received their calls on time. Staff recruitment was robust.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff had completed training in a range of topics since the last inspection, although some further training was still required.

Staff had begun to receive regular supervision and performance checks.

Where staff were required to record people's fluid intake, improvement was needed to ensure these records were accurate.

Further work was needed to ensure the requirements of the Mental Capacity Act were being met.

Is the service caring?

Good ●

The service was caring.

People were treated with kindness and respect.

People's privacy, dignity and independence were respected.

People were invited to be involved in the care planning process.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Peoples care records were persons centred and provided sufficient information to enable staff to provide their support. Although we identified one person's records which did not provide sufficient information regarding their communication needs.

There was a system in place to address complaints.

Staff had spoken to people using the service about their end of life wishes.

Is the service well-led?

The service was not always well-led.

Systems of governance were not yet sufficiently robust to ensure people received a consistently high level of service.

There was a registered manager in post.

Feedback was routinely gained from people who used the service.

Requires Improvement ●

Northern Community Careline 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.

The inspection was carried out between 11 October and 8 November 2018. We gave the service short notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure they would be available. Inspection activity started on 11 October 2018 when we visited the provider's office and spoke with the registered manager, deputy manager, care co-ordinator and a care worker. On 25 October 2018 an inspector spoke on the telephone with three people who used the service and six relatives. Between 24 and 25 October 2018 the inspector carried out telephone interviews with a senior care worker and four care workers. We also visited the provider's office on 8 November 2018.

During the inspection we looked in detail at the care records of seven people who used the service. We also looked at eight staff recruitment files. We reviewed other records including medication records, risk assessments, meeting notes and audits.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Is the service safe?

Our findings

Our inspection in January 2018 found the registered provider was not meeting the regulations regarding safe care and treatment, record keeping, and fit and proper persons employed. The management of some medicines needed to be improved, risk assessments were not always updated and recruitment practices were not sufficiently robust. At this inspection we found improvements had been made to the management of risk and staff recruitment. Further work was required to ensure the management of people's medicines was safe.

People told us they felt safe. We asked one relative if they thought their family member was safe, they responded, "Without doubt."

Each of the staff we spoke with was aware of the action to take in the event they thought a person was at risk of harm. Staff also knew how to contact other organisations, for example, the local authority safeguarding team if they wished to raise a concern external to Northern Community Care Line.

At our previous inspection we found the risk management was not robust. At this inspection we found improvements had been made. Care files included a generic environmental risk assessment as well assessments relating to moving and handling, falls and skin integrity.

Where people required the use of a hoist to transfer them their risk assessment provided sufficient detail to enable this to be done safely. The care records we reviewed for people who were identified as being at risk of falls, included information for staff about how to support the person to get up, once assessed as safe to do so.

At the last inspection there was no system in place to ensure all moving and handling equipment had been regularly checked to ensure it was safe to use. A senior care worker told us, "We routinely check equipment. We are in the process of sorting out a matrix to log equipment re service dates. We need the equipment to be safe." When we spoke with the registered manager they showed us the system which was now in place, equipment was logged into an online management system which raised an alert to inform staff when equipment was due to be checked for safety.

Staff were aware of the action they should take in the event a person was not home, or they could not gain access for a scheduled call. One of the staff we spoke with told us, "I would speak to the office, they would get in touch with them or their family. I wouldn't leave unless told by office."

At our last inspection we found recruitment practices were not thorough. At this inspection we checked eight recruitment files and found improvements had been made. We saw evidence of previous employment history, references and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions. At the time of the inspection DBS checks were not routinely renewed but the registered manager told us this was to be implemented in the coming weeks.

People told us staff never missed their calls and were normally on time. One person said, "Overall yes they arrive at the time I like. There has to be a bit of compromise, they are usually within half an hour of my preferred time". A relative told us, "Times can vary a bit, they have set backs with people. They have never missed and if they are late, someone rings me."

Two of the relatives we spoke with were concerned that their family members' calls were sometimes too close together. Although one of the relatives told us they had already spoken to the registered manager about this and the matter had been addressed. When we re-visited the office, we spoke with the registered manager and the deputy manager about this. They confirmed this had been identified as an issue and steps had been taken to rectify the timings.

The service had implemented an electronic call monitoring system (ECMS) to manage staff's rota's in April 2018. The system also provided real time feedback as to the location of staff and enabled office based staff to ensure staff were running to time and scheduled calls were not missed. The registered manager also completed a monthly audit to monitor for any incidences of late or missed calls. Where shortfalls were identified we saw the registered manager investigated the reason, for example a late call cancellation or staff failing to log in as they entered a person's home.

The service had a stable workforce with many staff having been employed for several years. The deputy manager told us agency staff were never used and shortfalls were covered by the staff team, including the office based staff. Staff told us they received their rota in a timely manner and they were provided with sufficient times to travel between their allocated calls.

At our previous inspection we identified a number of concerns regarding the management of people's medicines. At this inspection we identified further work was needed to ensure the management of people's medicines was consistently safe.

The management of risks associated with people's medicines was not always recognised or assessed. For example, the care plan for one person recorded at the tea call 'put the tea time medication on the table in the room and put the bedtime medication at the side of [person's] bed'. This was because the person took their bedtime medicines later when the care workers were no longer present. A document from the local authority noted the person had memory problems and confusion. However, records made by some care workers recorded the person had no memory impairment. Despite this conflicting information, a formal assessment of their mental capacity in relation to this decision had not been made. We also noted neither their risk assessment or their medication profile provided sufficient detail of the actions being taken by the service to reduce the risk of the person not receiving their medicines as prescribed. Another person's generic risk assessment identified 'no risk' in relation to the management of medicines despite these being dispensed from a dosette box and staff being responsible for their administration.

Medicine administration records (MAR) did not always record sufficient information. We reviewed the MAR for one person dated 1 to 30 September 2018. We noted a handwritten entry, 'ferrous sulphate 200mg' had been transcribed onto the MAR commencing 27 September 2018. There was nothing to indicate who had written it or why the medicine had been prescribed. We asked the registered manager about this. They showed us a copy of a letter from the prescribing doctor regarding this medicine, however, this was not evident from the MAR or daily records.

Records relating to the application of creams needed further improvement. The care file for two people recorded they administered their own medicines and there was no risk assessment regarding this aspect of their care. Yet their daily records included frequent references to staff applying their creams.

When staff applied a cream this was recorded on a topical medicines administration record (TMAR) but they were not always fully completed. We reviewed two TMARs for one person, the sections on the form about how to apply the cream and the date the cream was opened were blank and there were no instructions regarding the frequency of application for either cream.

These examples evidence a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the management of people's medicines was not always robust.

People received their medicines from suitably trained staff. Staff told us they had received training in medicines, this was confirmed when we reviewed the registered manager's training matrix. An assessment of their competency had also been completed. When we returned to the office on 8 November 2018 we saw evidence this staff member had received a recent assessment of their competency.

Staff had received training in infection prevention and control. Personal protective equipment (PPE) such as gloves and aprons were available from the office. One person we spoke with said, "Yes, they always wear gloves when they are washing me."

Staff understood the need to report accidents and incidents to the office. We saw accident reporting had been discussed at a staff meeting in February 2018 and the registered manager told us the accident and incident policy had been updated following the last inspection. It was clear from speaking with staff they were confident any reported concerns would be acted upon.

Is the service effective?

Our findings

Our inspection in January 2018 found the registered provider was not meeting the regulations regarding staffing and record keeping. Not all staff supervision, training and appraisals were up to date and staff did not understand how to determine if people had capacity to consent to their care and support.

Since the last inspection the registered manager and office based team had worked closely with the local authority contracting team. This work had included updating policies to reflect current good practice and legislation. Within the policy file we saw copies of good practice guidance from the local authority and the National Institute for Health and Care Excellence. This showed the registered manager now recognised the importance of ensuring people's care and support was delivered in line with current good practice guidelines.

People and their relatives told us staff were skilled and knowledgeable. A person who used the service told us staff knew what they were doing and new staff were always supported by an experienced care worker. A relative said, "The carers they are good, they know what they are doing." Although another relative felt some staff lacked the skills to persuade their relative to attend to their personal hygiene.

New staff were supported. The deputy manager said, "Everyone gets two weeks shadowing, we will offer more if they don't feel ready but it's usually two weeks." We spoke with two staff who had been employed at the service for less than a year, one of them said, "I got a full induction, I was told about the company and what we have to do. I shadowed for about four or five days and they checked me and made sure I was ok before I worked alone."

Since the last inspection staff had completed and refreshed their training in a variety of topics. The deputy manager told us, "I've seen a big improvement on the staff training side from the beginning of the year, we've done four mini qualifications, they are a booklet staff can work at their own pace, there is a tutor to discuss things with, on different subjects. I've done nutrition and health, infection control, and done mental capacity and first aid training. I'm doing a short course on care planning next week." One of the staff we talked with said, "We're always training, we do online courses, also people come to the office and do some training."

The registered manager's training matrix recorded the training individual staff had completed and where future training was booked. It was evident a significant amount of training had been completed since the last inspection, however, the matrix still contained a number of gaps where training was still to be completed. For example, of the 24 staff listed 15 staff had not yet received first aid training and ten staff had not received training in dementia care. The matrix did not record how often staff should refresh their training. For example, 13 of the 24 staff listed had completed health and safety training. The most recent training date recorded was April 2014, the registered manager had not refreshed this training since 2005.

Since the last inspection, staff had received regular supervision and community based checks on their performance. We saw evidence of this in the staff files we reviewed and this was further corroborated when

we spoke with staff. The registered manager told us they planned to ensure staff received supervision every three months, and an annual appraisal interspaced with community based spot checks on performance. One of the staff we spoke with said, "They come and spot check at any time. If there's anything we're unsure of, everyone is approachable, I feel safe to ask a 'daft' question." Another staff member said, "Yes we get supervision, my last one was about a month ago. My last spot check was July, I don't know when they are coming."

Community based performance checks were kept in a separate file. We saw the document used to record the check included a scoring system but there was no information to say what the final score meant. For example, was a high or low score good, or did it mean action was needed to improve performance.

The registered manager had a matrix in place to record when staff had received or were due their next supervision, appraisal and spot check. This is important as it gives the registered manager oversight and ensures all staff receive regular management support and performance checks.

People told us they received appropriate support to eat and drink. One person told us staff always offered them a choice of meal, they also said, "They leave me a flask of tea or coffee and a beaker of water." Another person said, "I tell them what I want, they make it as I like and always leave the kitchen clean."

The care plans we reviewed noted people's dietary preferences, cultural requirements and included details of the support people needed to prepare meals, eat and drink.

Staff told us information was effectively communicated throughout the staff team. The care co-ordinator told us information was shared within the team by way of staff meetings, memos and text messaging sent via the electronic call monitoring system accessed through staffs' mobile phones. Effective communication ensures people receive consistent, timely, coordinated, person-centred care and support.

We saw evidence the advice and input of other health care professionals had been requested, where appropriate. This included GPs, district nurses and the local authority moving and handling team. Staff told us if they were concerned about a person's wellbeing, they would speak with their family and the registered manager. A relative we spoke with told us, "They [care workers] waited here once until the ambulance arrived when [person] wasn't very well."

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. In the case of Domiciliary Care applications must be made to the Court of Protection. The service had not needed to make any applications to the Court of Protection.

At our previous inspection in January 2018 we found staff lacked knowledge and understanding about the MCA and there was no evidence of capacity assessments of best interest's decision making in peoples care records.

Each of the staff we spoke with expressed an understanding of people's right to make their own decisions; "Not everyone has the capacity [to make a] decision. But they have family and professionals to help them,

everyone has the right to make their own decision's", "Capacity, it's about their mental state. What information they can retain or not. If there are any issues, they have an assessment, if they don't have capacity" and "It's about whether they can make their own decisions."

The training matrix recorded 20 of the 24 staff listed had completed mental capacity training, the remaining four staff were scheduled to complete the training shortly.

It was clear from speaking with staff they offered people choices. One of the staff told us, "If they can't verbalise, I show them two or three options, they can point to which they want. Tea or coffee, I bring them both in and they can decide which they want to drink. They can all make simple choices."

The registered manager told us a lot work had been undertaken since the last inspection, with support from the local authority, to improve documentation relating to capacity and best interests.

Each of the care records we reviewed contained a consent form which had been signed by either the service user or their representative. The registered manager told us the people who used the service had capacity to consent to the care and support they received. The registered manager understood the principles relating to powers of attorney. This is a legal document that lets a person appoint one or more people (known as 'attorneys') to help make decisions or to make decisions on a person's behalf.

However, during discussions with the office based staff regarding how some people's medicines were stored in their home, it was clear some people lacked capacity regarding this aspect of their care. The registered manager acknowledged this had not been considered when they were assessing people's ability to make decisions about their care and support, they told us they would take action to address this.

Is the service caring?

Our findings

Our inspection in January 2018 identified care plans lacked information to enable staff to provide person centred care including those with communication needs, we were also made aware that on some occasions not all staff had been kind to people when providing care.

At this inspection everyone we spoke with told us staff were caring and kind. Comments included; "They are all friendly, willing to help and do what needs to be done. They are very pleasant girls. They are just like friends popping in", "Respectful, oh yes. I hear them, they have a laugh and a joke with [person]", "Great, they are all lovely, I want them to move in" and "The carers, they are good, they know what they are doing. They are respectful to my [relative], they listen to [relative] and chat with them." Although one relative we spoke with told us the experienced staff demonstrated more empathy with their relative than the more inexperienced care workers.

We saw an email received by the service in September 2018 from a paramedic who had attended a person receiving support from Northern Community Care Line, which said, "Two of your employees were present on the scene, [names of two care workers] Both [names of care workers] demonstrated a great deal of care, compassion and teamwork. Their conduct was commendable, please pass on our thanks to them".

We asked staff to explain what good care meant to them; "I want what I do for me, that is what I want for my service users. If someone wasn't doing job properly I would tell the manager", "Good care, it's understanding the client, being caring, understanding their needs", "It is care that revolves around them, individual to them" and "Treat people how you want to be treated, talk through everything you do, even if they can't communicate, talk and explain."

From our conversations with the registered manager and staff, it was clear they knew the people they were supporting very well. Staff told us they had regular runs and therefore people generally received continuity of care. This was confirmed when we spoke people and their relatives.

People told us staff respected their dignity and right to privacy. One person told us, "They help me shower, they always close the curtains, they are very particular about things like that. I never feel uncomfortable. They make you feel very comfy with them."

Staff were clear about the importance of treating people with respect and maintain their privacy and dignity. The deputy manager said, "We treat people how you'd want to be treated, or how you'd want us to treat your family. Like if you're washing someone, cover them with a towel. Staff get trained to ask before doing things. Staff talk the client through what they're doing, like 'I'm just about to wash your back'." A care worker said, "We knock before we go in, we are 'softly softly' until we get used to what they're comfortable with, for example, keeping the curtain around when showering as much as possible, using flannel and towels to respect their privacy."

At the previous inspection we not able to clearly establish if staff had received training in equality and

diversity as information did not tally correctly. At this inspection the training matrix recorded 11 of the 24 listed staff had completed this training during 2017 and 2018. A senior care worker who had recently completed this training told us, "I did a long course and e-learning. Someone did a talk from [name of local authority]. Everyone has got a right to be treated as an individual, not to be discriminated against, to be treated equally."

It was clear from talking with people, their relatives and staff, care and support was delivered in a person centred, non-discriminatory way. However, it is important to ensure staff receive training and updates in this topic to ensure the principles of equality non-discriminatory practice are embedded.

Care records included details about people's religious and cultural preferences. For example, staff had recorded one person's feedback, 'I used to go to church years ago, but I'm not bothered anymore'. Another care record noted the person's religious beliefs and how that influenced their care. For example, the food they ate or how they wished to be treated in the event of their death. This is important as it helps staff understand people's values and beliefs.

We saw evidence people had been involved in their care plans. We saw a document in one care record '[name of staff] visited [name of person] to ensure they were happy, all the details we hold are correct and the plan is person centred'. A relative we spoke with told us they had received a copy of their family member's care plan for them to review and provide feedback regarding the content.

At the time of the inspection no-one required the support of an advocate, although the registered manager was aware of how to access this service if required. An advocate is a person who can speak on a person's behalf, when they may not be able to do so for themselves.

Is the service responsive?

Our findings

Our inspection in January 2018 found the registered provider was not meeting the regulations regarding records and complaints. People's care plans did not fully reflect people's needs and lacked information about their personal history, likes and dislikes. Daily records were not always legible and complaints were not always recorded.

The registered manager told us a lot of time and work had been put into updating and improving people's care records. Staff told us people had care plans which were reflective of their care and support needs and were updated in the event a person's needs changed. One staff member said, "Yes, there's enough information for me to do the job, also if I notice things have changed for example there's a new piece of new equipment, then I would ask for a review."

Dates on each of the care records we reviewed evidenced they had been reviewed and updated in recent months.

The care co-ordinator told us when a new person requested to use the service, they would complete an initial assessment which enabled them to develop their care plan. They said they would then telephone the person or their family a week after the care package had begun to ensure they were satisfied and to check if there were any issues which needed to be resolved.

The deputy manager told us, "We have person-centred care plans, there are questions in there about how they'd like to be cared for, we ask them about their social history and what times they want (for their care call). We get background (information) from the social worker but as a new client also do a home visit."

Each of the care plans we reviewed contained a call summary. This provided a synopsis of the care and support needed at each scheduled call. Another document recorded information about the person, key contacts, their GP and what was important to them, such as family, friends, hobbies and interests. This document also provided more detail of the support needed and what people could do without the care workers support.

We found care records provided sufficient detail to enable staff to provide safe and effective care. Records were person centred, one person's care record noted, 'The tea carer then arrives and take off my stockings. Once I'm ready I then get myself ready for bed. I like to read and watch the soaps on tv'.

A relative we spoke with told us staff were supposed to record their relative's intake on a fluid chart. They said staff routinely recorded what they had left for the person to drink but did not consistently record the volume they had drunk. When we returned to the office we spoke with the registered manager about this. They told us they had been made aware of this and showed us how they had amended the chart to encourage more accurate recording.

At the last inspection the registered manager had not been aware of the Accessible Communication

Standard. This requires them to ask record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. We recommended they took steps to ensure a recording of an individual's information or communication support needs was 'highly visible' to relevant staff and professionals.

At this inspection we found information regarding people's communication needs was provided within their care records, although further work was needed where people's communication skills were more complex. For example, a member of staff told us, "We have one person, they can understand what you're saying but they can't talk back, but points and giggles and smiles, this will be captured in their care plan." When we looked in their care plan this information was not recorded. We discussed with the registered manager and the deputy manager how improvements could be made to information about people's communication needs.

Since the last inspection the registered manager told us staff had received training and support to improve their record keeping. We saw staff meeting minutes recorded where staff had been prompted and reminded about maintaining accurate records. The daily records we reviewed were legible, signed and dated. Although we saw staff had recorded one person's care and support on post-it notes and stuck them to the back of a person's log book when they had run out of blank records.

We noted some of the new documents in people's care records did not always prompt staff to record the date of implementation. We spoke with the registered manager at the time of the inspection, they told us this would be rectified.

There was a system in place to manage complaints.

One person told us, "If I had a problem, I would tell them, I wouldn't wait to be asked. A relative said, "I have raised a few things, not formally, but they seem to take things on board." Another relative told us they had recently raised a complaint with the registered manager and a meeting had been arranged to discuss their concerns. When we returned to the office, we saw this complaint had been recorded and included information about the complaint, how the registered manager had investigated it and the outcome.

The complaints policy had been updated since the previous inspection and now included details of other agencies people could contact in the event they were dissatisfied with the response from Northern Community Care Line. However, we noted the policy wrongly advised people that CQC would investigate their complaints. We brought this to the attention of the registered manager following the inspection.

At the time of the inspection the service was not supporting anyone who required end of life care. However, we saw staff had spoken to people using the service about their wishes and their comments had been recorded in their care plan. For example, staff had recorded one person had responded 'I don't want to think about that.

If a person had a Do Not Attempt Resuscitation (DNAR) instruction in place, this was recorded in their care plan.

Is the service well-led?

Our findings

Our inspection in January 2018 found the registered provider was not meeting the regulations regarding good governance. There was a lack of robust and regular audits or systems to assess the quality of their service, not all notifications had been sent to CQC as required by law. The registered provider had also failed to display their latest rating on their website to ensure people could see how CQC had rated the service.

Staff were positive about the registered manager and provider. Comments included; "I've seen an improvement anyway, I've seen three managers, [name of registered manager] has been one of the best to work for", "Brilliant. A good bunch of people that work there. The management are really helpful and supportive. Any problems, they deal with it," and, "I feel supported and listened to."

People and their relatives were generally happy with the organisation. We asked one person if they thought Northern Community Care Line were a good organisation, they responded, "Yes I do." A relative told us they had recently needed to increase the care package for their family member, they said, "They have really stepped up to the mark, one call and they sorted it. They are at the other end of the phone, we get consistent carers. If I message them about anything, they turn it around. The communication is really good."

The deputy manager told us the registered provider was a regular visitor to the service, "'I know provider well, I see him regularly, [person] tries to come once a week, if not every fortnight, I also have their phone number and email address.'" We saw a record of the registered provider's visits to the service had been completed in May and August 2018.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met. They had been employed at the service since 2007.

The registered manager told us a lot of changes had been made since the last inspection. They said this included updating policies and paperwork, updating staff training and implementing audits. They also said an external consultant, along with the local authority contracting team, had provided additional support.

We asked a senior care worker if there had been any changes since the last inspection. They said, "We have improved, we were getting lapsadacial. Since the last inspection we have altered all the care plans, they are more person centred. We have been going out and reviewing existing people, involving people and their families in this. [Name of local authority] have been involved and have helped us. We didn't have risk assessments, we've got those now."

An action plan detailing the issues highlighted at our previous inspection, including the action taken to address them had been implemented. We saw this had been periodically updated and evidenced the progress being made in addressing the shortfalls.

A significant number of policies had been updated since the previous inspection. The registered manager

showed us a file where staff had signed to confirm they had read individual policies. There was no log of all the staff which meant we could not establish if all employed staff had signed the record.

A number of systems and processes had been implemented since the last inspection. For example, the registered manager told us the ECMS was being used to alert the office based staff when care reviews were due and staff training needed to be refreshed. There was no system in place yet to audit people's care records as most records had been updated since the previous inspection. The registered manager told us this would be implemented in due course.

A senior carer was responsible for the auditing of MARs and daily logs. The instructions directed the staff member to audit ten comment sheets and five MARs per week. This target was not being met. For example, in August 2018 no MARs had been audited but 14 comments logs had been audited. The registered manager told us they met with the senior carer monthly to review the findings. They told us as a result, staff had received further record keeping training in September 2018. The audits had not identified the shortfalls we had identified regarding medicines. There was no system in place to ensure the records for each person who used the service were audited at regular intervals. We discussed this with the registered manager at the time of the inspection.

The registered manager showed us the audits they had completed in May, August and September 2018. They recorded generic information about how the service was meeting their regulatory requirements but they did not evidence a detailed inspection of aspects of the business had taken place. We spoke with the registered manager at the time of the inspection about how these could be improved.

Feedback was obtained from people and their relatives on a monthly basis. Thirteen surveys had been completed during September. Each respondent had marked the service excellent, very good or good, but it was not always clear if the form had been completed by a person using the service or by a member of staff gaining feedback over the telephone. The registered manager told us a survey was posted to everyone who used the service each December. The most recent had been completed in December 2017.

A survey had also been completed by staff in April and September 2018. The feedback was positive although the form did not contain a section for staff to include feedback about any other issues.

Team meetings were held at regular intervals. The staff confirmed this when we spoke with them and when we reviewed meeting minutes. A copy of all the recent memos issued to staff had also been retained, evidencing staff had received reminders about training and record keeping. There was also a memo thanking staff for their hard work during the snowy conditions earlier in 2018.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. When we reviewed the records for one person we saw staff had recorded a near miss. This is an unplanned event which does not result in injury or damage. This had not been reported to CQC. From our discussions with the registered manager we were satisfied they were clear about the type of incidents they had to report and this had been a misunderstanding of the wording within the regulations.

Prior to this inspection we checked the registered providers website. We saw the rating from their previous inspection was conspicuously displayed on the home page.

During this inspection we found many improvements had been made since our last inspection. However, as evidenced within this report there were still many areas where improvements were needed, for example,

medicines, training, capacity and governance. This demonstrates systems of governance were not yet sufficiently robust. These findings demonstrate a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 management of people's medicines was not always robust.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems of governance were not yet effective.