

Evolving Care Limited

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Inspection report

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Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

This inspection took place 3 August 2017 and 10 August 2017. The inspection on 3 August 2017 was unannounced. We returned to the service on 10 August 2017. This was announced.

Evolving Care Limited provides personal care for people in their own home. There were 111 people receiving services for which CQC registration was required at the time we inspected.

A registered manager who was also the provider was in post at the time of our inspection. 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 was run.

We found improvements evidenced at the last inspection had not been sustained.

Plans were in place to manage people's safety but people did not benefit from receiving care based on their assessed needs which was managed in ways that reduced risks to their safety. This was because people did not always receive the care they needed at the time they needed it for the duration required. Some people did not have regular carer staff who knew their safety risks well. Risks to some people were increased because staff did not consistently provide the care they needed to have their medicines as assessed.

Other people did benefit from being regularly supported by the same carer staff. Staff had received training in how to administer people's medicines. People were comfortable with the staff that regularly supported them and staff understood what actions to take to protect people from the risk of potential abuse.

People did not always benefit from receiving a service where the systems and procedures needed to support their care worked effectively. This included how people's care calls were managed. The systems used to monitor people's care had not driven through improvements needed in the care people received in a timely way. The registered manager had not notified us of some important things they are required to do, in law. Staff understood how the registered manager and senior staff expected people's care to be given, and some of the systems used to monitor the quality of the care people received were working effectively.

People and their relatives let staff know how they wanted their care to be planned, however, people did not always receive their care as it had been agreed. Other people did receive the care they wanted in the ways they preferred. People had been given information on how to raise any concerns or complaints. Processes for managing complaints were in place, but we found there were instances such as missed calls where improvements required were not always sustained.

Staff had not always been given the support required in order to care for some people, including information about people's needs and regular meetings with their line manager. Other people did receive

care from staff with the knowledge and skills they needed to care for them. Further training and one to one meetings with their managers were being planned, immediately after our inspection so staff would be supported to provide good care.

Staff checked people were in agreement for care to be provided and the actions they needed to take to promote people's rights. Where people received the care that had been planned for them people were encouraged to have enough to drink and eat by staff who respected their preferences and dietary needs. There was a risk some people would not have the care they needed to maintain their health because there care was not always provided as agreed. Staff who cared for people regularly understood risks to people's health and well-being and worked with people and health professionals to support people to maintain their health.

Some people had not been able to develop meaningful relationships with staff as they were not always supported by the same staff members. Other people had built caring relationships with staff that regularly cared for them. Staff who regularly cared for people listened to them and took action to make sure people were receiving their daily care in the ways they wanted. People were supported by staff who took their need for dignity and privacy into account.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

The service was not safe.

Improvements are required to reduce the risks to people as their care was not always provided as assessed and planned in order to reduce risks. This included in relation to people's medicines. People were not always supported by staff who knew their safety needs well. Staff understood what action to take so people were protected from the risk of abuse

Inadequate ●

Is the service effective?

The service was not always effective.

People were not always cared for by staff that had received the supported they needed to provide good care. Staff had not always received the training they needed promptly to care for people. Other people were being supported by staff who knew their needs and used their skills and knowledge to care for them. This included staff checking people agreed to the care provided. Some people did not always receive their care as planned and assessed so risks to their health, including people not having enough to eat and drink, were increased. Where people were supported as planned risks from people not having enough to eat and drink and to their health were reduced, and staff worked with other professionals when required so people's health needs were met.

Requires Improvement ●

Is the service caring?

The service was not always caring.

People were not always supported by a consistent staff team, and this sometimes meant people were not able to develop bonds with staff. Other people were positive about the staff that cared for them and staff supported people to make their own decisions about their day-to-day care. Staff worked in ways which promoted people's dignity and privacy.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Requires Improvement ●

Improvements were required in order to ensure people consistently received the care they wanted in the ways they preferred. People, their relatives and staff knew what action to take if they wanted to raise complaints and concerns and systems were in place to address these.

Is the service well-led?

The service was not well-led.

Improvements were required to ensure people benefited from receiving a service that was consistently well-led. Systems needed to be improved so the registered manager could be assured people were consistently receiving the care they wanted. The registered manager had not consistently informed us of important events which affected the way people's care was managed.

Inadequate ●

Evolving Care Limited

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 done because we had received some concerns about the care provided after our announced comprehensive inspection on 22 June 2016 had been made.

We started the inspection by undertaking an unannounced inspection of this service on 3 August 2017. This part of the inspection was undertaken by two inspectors. After speaking with people who use the service and their relatives we undertook an announced inspection of Evolving Care Ltd on 10 August 2017. This was because we had received concerns about how people's needs were met and how their care was managed. This element of the inspection was undertaken by one inspector.

As part of the inspection we reviewed the information we held about the service and looked at the notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also checked information which had been sent to us by other agencies. We requested information about the home from two local authorities. Local authorities have responsibility for funding some people who used the service and monitoring its quality.

We spoke with nine people who used the service by telephone. Not all people who used the service were able to talk to us directly so we spoke with nine relatives by telephone. We also spoke with a health professional who had recently treated a person who received the service. In addition, we spoke with the registered manager, who is also the nominated individual, and ten staff. Five of the staff had responsibilities for both caring for people and helping to organise their care.

We looked at 11 records about people's care. This included their care plans and reviews, medicines and sampling how their visits were managed and recorded. We checked two staff recruitment files and staff training records.

We also looked at the checks the registered manager made to satisfy themselves the service was meeting people's needs. These included questions within people's reviews about the quality of the service. We saw comments made by people and their relatives. We also looked at records about people's safety and records showing what processes and actions the registered manager had taken when people or their relatives had

raised complaints.

Is the service safe?

Our findings

At our first inspection of this service on 10 April 2015 we found improvements were required in the way risks to people's safety were managed. At the following inspection on 22 June 2016 we found improvements had been made. After that inspection we received concerns which indicated the improvements made may not have been sustained. We were informed of these concerns during May 2017 and July 2017.

We undertook this inspection on 3 August 2017 and 10 August 2017 because we had been advised people may not be receiving the care they needed at the times required to help them to stay as safe as possible.

Prior to this inspection, we had been contacted by three people or their relatives to say people had experienced occasions when care staff failed to provide the care planned. Two relatives of people using the service told us care staff arrived too early to provide the care required. One relative and one person who used the service also advised us they experienced late care calls. A further person told us calls were short. We were contacted about missed, early, late and short care calls between January 2017 and continued to July 2017.

At this inspection we found plans to reduce risks to people's safety were not always followed, so people did not consistently receive the care they needed. The care provided did not ensure everyone using the service received a safe level of support or that risks to people's safety were reduced. Some people relied on support from their care staff to have their medicines, or support with food at specific times linked to their medicinal needs. Plans had been put in place to provide people with the support they needed to have medicines, but these were not always followed. This increased the risks to people's safety.

We received very different views from people and their relatives about the support they received to have their medicines safely. Three relatives highlighted the way care was provided meant risks to people's safety were increased. This was because some people did not receive the required support with their medicines, because care calls had either not been made, or had not been made at the time needed.

One relative told us their family needed support with their medicines as these needed to be evenly spaced throughout the day, so risks to their family member's safety would be reduced. The relative gave us an example of when a call had been made two hours earlier than scheduled, so risks to their family members health was increased because they didn't have their medicines as prescribed.

Another relative told us it was very important their family member was supported to have their meals at specific times. The relative told us this was because their family member needed to their meals immediately after their medicines. The relative said a number of care calls had been made late or were missed. This led to an increased risk to their family member's well-being and safety. The relative told us because they could not rely on care being provided at the right time alternative arrangements had to be made, so their family would receive the care they needed. A further relative said, "There's been no problems with medicines, unless there's been a missed call." The relative told us there had been occasions where their family member had experienced missed calls.

We saw senior staff regularly checked people's medication records, but the systems used meant there was a delay of up to four weeks in these being checked. There was therefore a risk people may not have received the medicines they needed for an extended period of time.

Whilst people's risks had been considered when their care was planned initially, people and their relatives told us these plans were not consistently followed. People were not always provided with the care they needed to ensure risks to their health and well-being were reduced. A combination of nine people and their relatives said there were occasions when care staff failed to attend to provide the care they needed. People and their relatives highlighted there were times when care calls were later, earlier or shorter than as assessed and planned for. Some people had calls where care staff had not arrived to respond and meet people's care needs.

One person said, "The morning call is fine, but there have been problems since the night calls started." The person told us staff had not arrived to provide some of the night calls agreed. A relative of a different person explained, "[Staff] have turned up at 12.30 pm, instead of between 9.00 am and 10:00 am [to assist the person to get up]." The relative explained this made their family member very anxious.

Senior and care staff told us there had been occasions when people had not received the care they needed to reduce risks to their safety. A staff member gave us an example of when they had arrived to provide care to a person and found the person was distressed. The staff member explained this was because the person's earlier care call had not been provided as planned

We checked people's care reviews and care call attendance records. We saw five people experienced occasions when care staff failed to attend or had calls later, earlier or shorter than as assessed and planned for. Some people had calls where care staff did not arrive to respond and meet people's care needs. We saw one of the people who had not received the care calls as scheduled lived with diabetes, was at risk of falls and choking and experienced poor skin health.

We found the systems used to monitor if staff had attended calls did not always work effectively as senior staff were not consistently alerted promptly if people had not received the care they needed. The registered manager accepted there had been missed calls. They gave us an example of a care call which had recently been missed, where they had not been notified promptly. This had resulted in the person not receiving the care they needed at the time required. This told us people did not always receive the support they required to reduce the risk of avoidable harm and there was a potential risk people could have suffered harm.

Some people and their relatives told us they were not always supported by staff who understood their safety needs well. One person said, "They have had a lot of [care] staff leave." One relative told us their family member lived with dementia. The relative explained unexpected changes to the staff that cared for their family member meant they were sometimes awakened by staff who they did not know. The relative said this led to anxiety for their family member. A further relative said, "Staff turnover has been worse recently." Records we saw showed some people had not been cared for by staff who knew their safety needs well. For example, we saw one person had received support from 14 different people in one month. We also saw another person had been cared for by 10 different staff in one month.

The registered manager confirmed there had been some care and senior staff changes since our last inspection. We met with a new manager who had recently been appointed to oversee the day to day running of the service. People who had already met the new manager and senior staff told us they felt reassured by the appointments. However, some of these changes took place in the week of the inspection, and further time will therefore be required to ensure benefits to people using the service are sustained.

These were breaches of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as this gives rise to potential risk to people using service because people did not consistently receive the care they needed to reduce risks to their safety.

Other people's experience of the care provided was different. Other people and their relatives told us they were supported to have their medicines and manage risks to their safety, by staff who knew their safety needs. For example, one person told us, "They're [staff] always on time." Another person told us, "They [staff] help me with my medicine. A further person highlighted staff took action to help them move around their home safely. The person said, "They do this regularly." Staff told us they were not allowed to administer medicines until they had received training and their competency had been checked.

Staff understood the different types of abuse people may experience and how to raise any concerns they may have. Staff gave us examples of when they had raised concerns with senior staff because people's care calls had been missed.

The registered manager told us recruitment of appropriate staff was their biggest challenge. The registered manager explained they recruited new care staff based on the needs of the people using the service. They gave us an example of when they had recognised a different service was needed to care for one person, because Evolving Care Ltd care staff were not available to continue to support the person.

Staff told us they were not allowed to start caring for people until references had been checked. We reviewed three staff files and saw that the provider had a system in place for ensuring all Disclosure and Barring Service (DBS) checks were made. This check is carried out as part of a legal requirement to ensure care staff were able to work with people and any potential risk of harm can be reduced. We also saw references had been obtained for staff.

Is the service effective?

Our findings

People did not always receive support from staff they knew and who had received sufficient support to enable them to meet people's needs. Half of the people and relatives we spoke with raised concerns about the continuity of staffing. One relative told us, "This can mean they [staff] don't understand [person's name] needs".

Two of the five care staff members we spoke with told us they were not always provided with the support they needed before they cared for people for the first time. One care staff member told us this had been arranged, but the more experienced staff member was unavailable. The care staff member said, "The staff member due to do this walked out [of their job] on their previous call, so they [senior staff] asked me if I felt I could do it on my own. [Person's name] was never told I was going to the call. They were ok, but would have liked to have known." Another care staff member said they, "Had to rely on other staff, not the office, [senior staff]", for information and guidance before caring for people.

One care staff member told us there had been a delay in their initial training being completed, and they had not received any additional training since joining the service. Other staff gave us examples of the training they had done so they would develop the skills and knowledge needed to be support individual people in the best way for them. This included supporting people to have enough to eat safely, and dementia and autism awareness. We saw staff training was recorded and some checks were undertaken by senior staff so they could be assured staff had refreshed their training over time. The registered manager explained additional training had been planned for the week after our inspection. This included training to help staff to promote people's safety and rights.

Three of the care staff we spoke with told us they had not yet had the opportunity to meet with their managers on a one to one basis for support. Two care staff members explained this had been planned but the senior staff member responsible for meeting with them had left. Senior staff who had recently joined the service told us they were in the process of arranging the meetings required.

Other people and their relatives told us their care was provided by regular staff and were positive about the way staff used their skills to support them. One person said about the way staff cared for them, "It's really good." Another person said, "[Staff member's name] is brilliant, they know how to care for me thoroughly." One relative highlighted how the needs of their family member matched the training staff undertook so their care needs were met

Other care and senior staff told us they initially worked with more experienced staff, so they could find out the best way to care for people. Two care staff members said this, plus the induction they had undertaken, helped them to understand how they could meet people's care needs.

People did not always receive the support they required to have enough to eat and drink. Two relatives told us because people's care calls were not always provided as assessed and planned they had raised concerns with senior staff that their family members did not always have the food and drinks they needed regularly

enough to remain well. One relative explained they had raised this concern a number of times with the service. The relative told us improvements required had not been sustained. The relative said this had subsequently been resolved as alternative care had been arranged for their family member, so they could be assured they would have enough to eat at the times required. Another relative explained they had taken back responsibility for preparing their family members drinks, so they could be sure they were hydrated, as staff did not consistently stay the length of time required to do this.

Some people were supported to have enough to eat and drink by staff. People told us where staff supported them to have enough to eat and drink they chose their own meals, and staff prepared them for them. One person said, "It's really good, because they [staff] help me cook meals." One relative explained how staff took particular care to make sure the consistency of the food their family member was offered met their needs. The relative said, "[Person's name] has reflux problems, and poor digestion. They take this into account." Another relative told us, "[Person's name] does not drink much. Staff are good at prompting them to drink." Staff gave us examples of how they encouraged people to have enough to eat and drink by leaving them snacks based on people's individual preferences, where they had any concerns people were not getting enough to eat and drink.

People were confident staff would help them if they needed help to maintain their health, however, we knew from discussions with some people, their relatives and the records we saw, risks to people health and well-being were not always managed well. This was because people did not always receive their care as planned.

Other people who received their care from regular care staff experienced better support with managing their health risks. One relative told us their family member did not experience pain, so it was really important any changes in their health were noted. The relative said, "Staff have to look out for things, they notice if [person's name] is not well, and keep an eye on things."

The registered manager and senior staff gave us an example of how they had worked with other health professionals, so people would receive the health care they needed. This included staff staying longer than planned with people, so they could assist health care professionals when they unexpectedly needed to provide treatment for one person. The health professional told us, "They raised the referral to us. They did a good job and [person's name] got the care they needed."

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. We checked whether the service was working within the principles of the MCA. Senior staff we spoke with understood the role of the Court of Protection and how this would potentially affect the way they cared for people. The registered manager told us they had not needed to make any applications to the Court of Protection at the time of our inspection.

People told us staff always checked with them to make sure they were happy to receive the care planned for them. One relative told us staff were skilled and patient in encouraging their family member to receive the care they needed if they did not initially agree to the care offered. Staff we spoke with knew how MCA affected the way they needed to care for people. One staff member said, "If a person said 'No' I would offer to do things in a different way, but it's their right and choice." Staff told us they would communicate any concerns they had for people's well-being, if people regularly declined care.

We saw the registered manager had made sure staff had access to training to help them understand the requirements of MCA and that further training was planned. We also saw people's care records recorded where particular individuals had the legal right to make some decisions on people's behalf.

Is the service caring?

Our findings

Eight people or their relatives told us the number of different staff who provided their care meant it was difficult to develop bonds with staff. One person said they were regularly supported by different staff. The person said this made them more anxious and told us, "It's putting me out." Another person told us, "We are upset because some staff are fed up and leaving." A further person said, "It would be nice to have some [staff] who are a bit more regular." One person told us, "They [care staff] just turn up and show I.D [identity badge]. I would prefer the same staff."

One relative told us, "If calls are made by staff they don't know [person's name] cries. Staff changes upset them." Another relative said, "Once they are here they are brilliant", but highlighted staff turnover meant their family member was not always supported by staff they knew well. A further relative told us "It's a different one [care staff member] every day." Some people and their relatives told us this was improving, whilst other people and their relatives told us this problem had increased recently. Records we saw confirmed people were not consistently supported by staff who knew them well. The registered manager agreed there had been changes in the staff supporting people.

One staff member told us they were not always provided with the information needed prior to undertaking a care call with a person for the first time. The staff member explained this had resulted in one person being anxious when they were initially cared for. Another staff member said, "It's a bit of a lottery who [which care staff member] is sent in." The staff member gave us an example of one person's care preferences not being met as a result of this.

The registered manager told us they wanted people to benefit from receiving support from a good and caring service. We found some of the systems used to monitor people's care did not alert senior staff, the registered manager or provider promptly enough if people did not receive the support they needed in the ways they preferred. As a result of this, some people experienced increased anxiety because their care was not always delivered based on their assessed needs and preferences.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care, as people did not consistently benefit from receiving a service which was appropriate to their needs and reflected their individual preferences.

Other people told us they were supported by regular staff and said they had developed close bonds with them. One person said of their regular care staff "It's going well because staff are very caring." A health care professional who had recently provided treatment to one person and who had been supported by staff to do this, said, "Staff were compassionate and you can tell they really loved [person's name]."

All the care staff we spoke with talked respectfully about the people they cared for and we found where staff cared for people regularly they knew people's preferences well. One staff member told us how much they valued the relationships they had built with people they cared for regularly. The staff member said, "I love my calls. You have such different conversations and find out about their histories. It gives you a perspective

on your own life." Staff told us they got to know people by chatting to them and their relatives and reading their care plans, so they could find out what was important to people.

People told us care staff encouraged them to decide what day to day care they wanted, and how they wanted this to be given during their care calls. This included decisions people made about the food they ate and which elements of personal care they wanted. One relative we spoke with highlighted their family member sometimes declined care initially. The relative told us staff were very patient and found different ways to support their family member, so they would decide to have the care they needed.

People told us staff cared for them in ways which promoted their dignity and privacy. One relative said staff understood how important it was for their family member's sense of identity and dignity to be assisted to shave regularly, and said staff did this. Staff we spoke with gave us examples of the way they promoted people's dignity and supported them to have the privacy they needed. This included following people's preferences when supporting them with their personal care. One staff member said, "You make people as comfortable as possible. You cover people, and you make sure doors are shut." We heard staff were polite and respectful when people and their relatives contacted the office.

Is the service responsive?

Our findings

We found people's care had been planned to reflect their needs, individual risks, histories and preferences but the plans agreed were not always carried out. As a result, people were not consistently receiving the care they wanted in the ways preferred, or at the times or for the duration it had been assessed people needed care.

Nine people or their relatives told us care was not always provided at the time or for the length of time planned to meet their needs. One person explained they had previously agreed for care to be provided in the evening, but took the decision to stop this care call because staff did not arrive to provide the care at the agreed time. The person said they had subsequently planned with staff to restart the evening care calls again, and agreed the times for the reintroduced care calls with staff. The person said, "They [care staff] should come at 8.30 pm, but have come between 7.00 pm and 9.20 pm." As a result of this, the person was not getting their care as planned and there was an increased risk to their well-being because of the additional anxiety they experienced when staff did not provide the care at the times arranged.

One relative said they had seen a decline in their family member's call time preferences being met prior to our inspection. The relative told us, "The times given are nothing like the times they come." Another relative told us, "They [care staff] have turned up at 12.30 am instead of between 9.00 am and 10.00 am, so I end up getting [person's name] up." Another relative said plans had been put in place for their family member to have a call lasting an hour, so all their care needs would be responded to. The relative said, "They stay for forty five minutes." The relative explained as a result of this they took action themselves to make sure the person had the full care they needed.

Two people told us their preferences for the gender of the staff to support them were not always taken into account when care was provided. One person told us they had declined care when their staff gender preferences could not be met.

We saw one person's care plan recorded the person needed support to have their medicines. This did not match other records, which indicated staff were not required to support the person with their medicines. We also saw another person's care calls had changed, but their care plans did not reflect this. Senior staff provided reassurance this would be updated to show what care they wanted. There was therefore increased risks to people because people's care plans were not always updated to reflect their current needs.

The registered manager said as a result of the feedback we had provided plans had been put in place for each person to have a meeting with senior staff so their care needs and preferences would be reviewed.

People told us they had been given information on how to make a complaint and how to raise any concerns they had. One person told us they had made a complaint as the care was not provided at the times agreed. The person said, "I 'phoned the office, but it's not really any better." One relative we spoke with told us their family member had not had their care as planned. The relative said they had attempted to contact senior staff, but their call had not been returned.

Records we saw showed actions taken by senior staff did not always address the complaints people or their relatives made. For example, we saw one relative had made a complaint in relation to a missed care calls for their family member. Despite this complaint their family member experienced further missed care calls. However, there were also examples where senior staff had taken the action necessary to address complaints made. For example, if people had decided they did not want to receive care from a particular care staff member this had been actioned. We saw where complaints had been received these were investigated and responded to. We also saw examples where the provider's director had been made aware of complaints received. Minutes of meetings with the provider's director, registered manager and other senior staff highlighted complaints were discussed and actions agreed.

Other people and their relatives told us they were getting the care they wanted in the ways that suited them, and their complaints or concerns were listened to. One relative said they were involved in planning and reviewing their family member's care. The relative told us this had led to additional care being provided for their family member. Another relative said care staff took their family member's sensory needs into account when caring for them. One care staff member gave us an example of the care they had given to one person. The care staff member told us the person had been so pleased with the care they received they had contacted the office to let them know.

We saw other people's care plans did reflect their needs. For example, where advice had been provided by external health professionals this was recorded in people's care plans.

Is the service well-led?

Our findings

There was a registered manager at the service. 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. Registered managers and providers have statutory duties to ensure there are robust systems and processes in place to monitor and assess the risks to the welfare of people who use the service.

A combination of nine of people and relatives raised concerns about the care provided and told us there had been times when care had not been organised and managed well. People and their relatives told us this was because they were not able to consistently rely on staff providing the care agreed. Three people and one relative highlighted senior staff did not know calls were late or had been missed until they alerted staff. We saw a care review for one person highlighted they had tried to contact senior staff to advise them they had a missed call, but were not able to get a response from staff.

We found some systems used for monitoring the quality of the service provided were inadequate, as they did not highlight promptly when calls had not been made. As a result of this, senior staff were not able to take corrective actions required. The quality assurance systems used by the registered manager did not identify the increased risk to people's safety and well-being as a result of early, short, late or missed care calls.

One of the key systems used to manage people's care calls did not work consistently. We were told the system was unavailable for staff to use for part of 10 and 11 August 2017. We saw there was a separate system used to check people had the care they needed. However, this was done retrospectively at the end of each month, and would not alert staff promptly to instances where care had not been provided.

We asked the registered manager how they would know promptly if people had not received the care they needed. The registered manager told us if the system they used was not working effectively, they would be reliant on people using the service or their relatives or staff contacting them. The registered manager gave us a very recent example when one person had not had the care they needed. The registered manager told us there had been delays with senior staff being alerted by the systems they used that the care had not been provided, so they were not able to address this without delay.

Five people and two relatives we spoke with told us checks on the way their care was provided to by care staff had not been undertaken by senior staff. One person said, "No one seems bothered about it. No one has checked on the care." Four out of the five care staff we spoke with told us they had not had a check completed on the way they cared for people. Two staff told us this was because the senior staff member responsible for their undertaking this had left the organisation. The registered manager told us they were "Trying to do (these)." Given people's inconsistent experience of the care provided, some of which had been reported to the service, and the above findings in relation to systems used to manage the service, the registered manager could not therefore be assured people were always receiving their support safely and in ways which reflected people's preferences and needs.

The systems for monitoring the quality and safety of care were not effective in identifying and responding to areas where service improvement was required. The systems used to monitor people's care had not driven through improvements needed in the care people received in a timely way. As a result, we found improvements evidenced at the last inspection had not been sustained.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the systems and processes used to assess, monitor and improve the quality and safety of the services provided did not always operate effectively.

The registered manager told us as a result of this feedback, and their own recent experience where the system had not alerted staff a care call had been missed, they planned to introduce a new system so they would be assured people were receiving the care they needed. The registered manager was not able to confirm when this would happen.

People, their relatives and staff told us there had been a number of changes care staff and senior staff who managed people's care. Some people told us as a result of these changes the care provided had started to improve. Other people highlighted a decline in the way their care was provided. The registered manager gave us examples of the actions they had taken to address some specific quality concerns people and their relatives had raised. This included the recent appointment of a new deputy manager and care-coordinator to drive through improvements in the care people received.

When we arrived for the inspection we found there had been a change in the location of the service. We talked with the registered manager, who is also the nominated individual, about this. They told us they had submitted the necessary notifications to CQC but were unable to provide a receipt to confirm they had done this. We asked for the necessary notifications to be sent to us without delay. The registered manager has subsequently started to address this, however, not all notifications required have yet been sent to us.

This was a breach of Section 33 of The Health and Social Care Act 2008, as the provider was failing to comply with a condition of their registration.

On the first day of our inspection we saw the provider's previous inspection rating was not displayed at the location. Staff advised us this had previously been displayed, and took immediate action to address this.

Before the inspection we checked to see if the provider was displaying their previous rating on their website. We saw the previous rating was not displayed. The registered manager gave us assurances this would be displayed. At the time of writing this report the action required has not yet been taken.

This was a breach of Regulation [20A] 3), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not followed the requirement as to display of performance assessments.

One person we spoke with told us they had recently had regular contact with the registered manager, who occasionally provided their care. The person told us they felt the registered manager did this well. We also saw six positive comments had been received from relatives about the care provided to their family members, since our last inspection. One staff member told us senior staff had come out to check they were supporting people well. Staff said they were able to speak to senior staff without delay if they had any concerns for people's well-being. Minutes of managers meetings showed us the learning from the provider's other services was communicated to staff.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care based on their assessed needs and preferences.