Admiral Care Ltd

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Inspection report

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13 July 2016

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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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 25 and 26 April 2016 and 13 July 2016. It was unannounced.

Admiral Care Limited provides personal care to people in their own homes. At the time of this inspection the service provided care to 88 people with a range of needs including people living with dementia, older people, and people with a physical disability. The service had 38 care staff.

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

We carried out a comprehensive inspection of this service on 28 July 2015. We found breaches of legal requirements and gave the service an overall rating of inadequate. This meant the provider was placed in special measures.

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

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.

At this inspection we found some limited improvements had been made. However there was not enough improvement to take the provider out of special measures because we judged the service was inadequate for one key question.

We are considering the appropriate response to the shortfalls we found during this and previous

inspections. Where registered persons have not been meeting the fundamental standards, we have a range of enforcement powers we can use to protect the safety, health and welfare of people who use the service. When we propose to take enforcement action, the provider can challenge our decision through a variety of internal and external appeal processes. We will publish a further report on any action we take.

The provider had made improvements in the way it managed concerns about the safety and welfare of people made vulnerable by their circumstances. However their systems for identifying, assessing and managing risks to people's safety and welfare were not fully effective, which meant people were not fully protected from such risks.

The programme of training and supervision was not always effective. Some staff did not show sufficient knowledge in important areas. Care workers were not familiar with legal requirements when supporting people who did not have capacity to consent to their care and support.

People were satisfied the care and support they received met their needs, but it did not always conform to their preferences. Calls were not always at the time agreed, and people did not experience consistency in the care workers who supported them. The provider had started a review of all care plans, but this had not completed at the time of our inspection. People were confident they could complain if they had concerns, and the provider investigated and followed up complaints.

The provider had taken steps to improve the management of the service, but changes were recent and not embedded or sustained. The provider's systems had not identified or addressed concerns we found during the inspection. The provider's system for obtaining feedback from people on the quality of service they received was not reliable or effective.

The provider took steps to make sure staff were suitable to work in a care setting. Appropriate processes were in place to make sure people's medicines were managed safely.

Where appropriate people were supported to eat and drink enough and to access other healthcare services.

People had caring relationships with their care workers and had the opportunity to take part in decisions about their care and support. Care workers took steps to promote people's independence, dignity and privacy.

We found five breaches of the Health and Social Care Act (2008) Regulations 2014. 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.

People were not adequately protected against risks to their safety and welfare, including risks of abuse and avoidable harm.

People were supported by staff who had been checked for their suitability to work in a care setting.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff whose training was not always effective.

People were supported by staff who did not know the legal requirements where people lacked capacity to make decisions about their care.

Where needed people were supported to maintain a healthy diet and to access support from other healthcare services.

Is the service caring?

Good

The service was caring.

People had caring relationships with their care workers.

People's independence, privacy and dignity were promoted.

People could express their views about their care and have them listened to.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care in line with their preferences. People's care and support were not always based on

assessments and care plans which reflected their individual needs. Records were not up to date or complete for all people who used the service.

The service responded to complaints, comments and compliments.

Is the service well-led?

Inadequate

The service was not well led.

The service had not improved quickly and thoroughly enough since the last inspection.

Measures taken by the provider to improve their management system were not embedded or sustained.

Measures taken by the provider to improve their assessment of the quality of service provided had not taken effect.

Communication with staff was inconsistent.

Admiral 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 25 and 26 April 2016. The inspection was unannounced. In the days following our inspection, the registered manager made arrangements for care diaries normally kept in people's homes to be returned to the office. We returned on 13 July 2016 to look at these and to provide provisional feedback on the inspection visit.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

We spoke with 13 people who received care and support from the provider, one family member of a person who used the service, and two people who used to use the service.

We spoke with the registered manager, the deputy manager, training manager and four care workers.

We looked at the care plans and associated records of six people. We reviewed other records, including the provider's policies and procedures, audit reports, quality assurance survey returns, training and supervision records, staff rotas, meeting minutes, an action plan, supervision and appraisal records, and recruitment records for four staff members.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe with their care workers. One person said, "I feel safe when they move me to my wheelchair. They know what they are doing." All the care workers we spoke with considered people were kept safe while they supported them with personal care. However, the provider had not taken adequate steps to make sure people were protected against risks, including the risks of abuse and avoidable harm.

At our inspection on 28 July 2015 we found the provider had failed to identify and appropriately investigate safeguarding concerns and ensure all staff received relevant and up to date training. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found new processes were in place, but not all staff had received effective training.

The provider had introduced a new safeguarding policy in March 2016 and had new procedures to support the policy. Records showed out of 12 safeguarding concerns, two had been closed and the remainder were under investigation. The provider had raised seven of the 12 concerns with the local authority. We had received notifications of 13 safeguarding concerns since the last inspection in July 2015.The provider had made contact with the local authority in order to improve cooperation where the local authority instructed the provider to carry out further investigation into safeguarding concerns reported by the provider.

The registered manager told us care workers had benefited from training in safeguarding adults and were now more likely to report concerns, such as unexplained bruising. However training records showed 13 out of 38 staff had not received the training. Two out of four care workers we spoke with were unable confidently to describe the different types of abuse and signs and indicators to look out for although these were clearly described in the provider's policy. All care workers were confident that if they reported a concern, the registered manager would deal with it appropriately.

People were still at risk because the provider had not made sure all staff were aware of the types of abuse they should report. This was a continuing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 28 July 2015 we found the provider had failed to assess and review the risks to the health and safety of service users and to identify, investigate and learn from incidents and accidents. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there were still concerns about the management of risk.

The provider did not manage risks to protect people's safety and wellbeing. Risks were identified in people's care assessments but not followed up by effective risk assessments. One person was identified as being at risk of exhibiting aggressive behaviour. However the risk assessment form used to assess this was designed to document risks around assisting people to move and reposition themselves, rather than behaviours. Their care plan described possible triggers for aggressive behaviour such as food and medication, however this important information about their risks had not been included in the risk assessment because the form

used was inappropriate and ineffective for this type of risk. The same form had been used to assess another person's risk of pressure injuries. Using this form meant the staff member undertaking the risk assessment had not been prompted to ask all the relevant questions in relation to this risk.

Another person's care plan noted the person declined to use a thickener in their drinks. The care plan stated, "[Name] is aware of the risk." However there were no instructions or guidance for care workers to reduce the likelihood of the person having difficulties swallowing, or what to do if they choked while drinking. A fourth person had a pressure injury on their leg, and was living with diabetes. There were body maps which showed the location of the injury and an additional area of soreness. The registered manager had reported these to the community nurse, but there were no risk assessments in relation to these conditions. There was a list of moving and handling equipment in this person's home, but no associated risk assessments. Their care plan indicated that two care workers should help them reposition themselves, but where the form requested "please specify" it read, "Lifting could be a problem." There were no specific instructions for care workers to support this person safely.

Failure to assess risks to people's safety and to take steps to reduce those risks was a continuing breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people and all the care workers we spoke with were happy there were enough staff employed to fulfil all the scheduled calls. One person said, "Different ones come but I don't mind." However one person expressed concerns in this area. They told us, "Weekends can be a problem with staff. I feel there is not enough." The registered manager showed us the computer based rota system they used to assign calls. There were sufficient numbers of suitable staff to support people and keep them safe.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, employment history, and good conduct in previous employment. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working in a care setting.

At our inspection on 28 July 2015 we found the provider had failed to make sure staff had the appropriate competence and skills to administer medicines and understand requirements associated with covert medicines. This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found where people were supported with their medicines, they were satisfied this was done safely and according to their needs. One person said, "They give me my medication and fill in a form to say they have done so." Another person said, "Sometimes I want to eat before I take my medication, but that is my choice." Where care workers supported people with their medicines they described suitable procedures for administering and recording medicines. They were aware of people's needs and preferences relating to their medicines. There was no longer a breach of Regulation 12 (g) which refers to the safe management of medicines.

Requires Improvement

Is the service effective?

Our findings

People gave us mixed replies when we asked them if they thought their care workers were suitably trained. Most were satisfied care workers were trained to provide care that met their needs. One person said, "I am quite happy with the way they are trained. They know what they are doing." Another person said, "They are absolutely well trained." A third person said, "Yes they seem well trained and efficient at what they do."

However one person said they were occasionally supported by a staff member who did not know how to use a medical device used to administer their medicine. Another person said new care workers were not always prepared properly. They said they lacked the basic skills and awareness of how to meet their care needs. The person said, "Some of the new girls do not always know where everything is so it takes time to show them."

At our inspection on 28 July 2015 we found the provider had failed to provide staff with appropriate support, training, professional development, supervision and appraisal. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements but these were not sufficient to meet all the requirements of the regulation

The provider had taken steps to make sure staff were supported and trained to deliver care and support according to people's needs. Senior staff had attended "teach the teachers" courses in moving and positioning, safeguarding and mental capacity. The provider had engaged consultants to deliver training in other areas. An experienced care worker had the responsibility to manage and coordinate the training plan as training manager. They had given individual support to a care worker who was not able to take part in training which depended primarily on an ability to read the written word.

The provider was in the process of reorganising their training records at the time of our inspection. A computer file was used to keep a high level record of training completed and training required for all staff members. The provider was in the process of moving from one file to another. Staff in the office were not familiar with the new file. They had to phone for assistance before they could use it to show us the current status of the training programme. Where certificates of training completed were kept in staff files, they were not always correct. The provider's training supplier had delivered certificates which did not refer to the course the staff member had actually taken.

Where records showed training was required, arrangements were in place to provide the training. For instance, 24 staff were shown as requiring training in mental capacity, and courses were booked in the following month. However not all staff had had necessary training at the time of this inspection.

Care workers told us they felt supported, and there had been recent appraisals and supervisions. One care worker said, "We have regular supervisions more than we used to. The last one was less than a couple of months ago." Another care worker said they had regular supervisions with the last one two months ago.

Care workers said they had sufficient training. One said, "I have loads of training." Another had noticed an improvement in training. A third described their recent refresher training in moving and positioning, food hygiene, medicines, control of substances hazardous to health, and reporting incidents. However, concerns we identified with care workers' knowledge about safeguarding and risk assessment indicated that training had not been effective in these areas.

At our inspection on 28 July 2015 we found staff did not understand or apply the principles of the Mental Capacity Act 2005 and its associated code of practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found none of the care workers we spoke with were able to speak confidently about the principles of the Mental Capacity Act 2005. The Act 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 the least restrictive possible.

Care workers who supported people living with dementia were not familiar with the Act or its associated code of practice. One said they had "read about it" and had "answered questions in a booklet", but they were not able to tell us what they had learned. Another care worker said they could not remember their training in mental capacity and were not aware how to put the Act into practice. At the time of this inspection 24 care workers had been booked on but had not received training in mental capacity.

Records showed that where people were able to they had signed consent forms for various aspects of their care and support such as support with medicines and to have thickened drinks. Where the provider suspected a person might lack capacity, they had carried out assessments which followed the principles of the Act. They assumed people had capacity and assisted them to make decisions where possible. The assessments followed the two stage process required by the Act. Records of the assessments were kept in people's care files, but had not resulted in a greater awareness of the requirements of the Act among the care workers we spoke with. The principles of the Act were not embedded in the practical care and support people received.

Failure to make sure staff received effective training was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Where the service supported people to eat and drink enough, this was done effectively although we found two examples where risks associated with swallowing were identified but not assessed. Care plans included information about people's preferences and how care workers should support them. One person was identified as being at risk of poor nutrition. Their risk was assessed using a standard tool. They were weighed regularly, and their prescribed medicine dosage had been adjusted where necessary.

People were supported to access other healthcare services if they needed to. One person said, "They have called a doctor for me in the past when I felt poorly." People's care plans contained contact details for people's GPs, and showed where the service worked in cooperation with other healthcare professionals such as district nurses.

Good

Is the service caring?

Our findings

People told us they had caring relationships with their care workers. One person said, "Excellent, I cannot say anything against them." Another said, "I am quite happy with my regular carer she is very caring." A third person said, "What they do for me they do well. I think they are very caring."

People were able to express their views about the service they received and have their views acted on. One person told us, "There was one carer. I did not like her manner. They listened to me and I did not have her again." Another person said, "They will listen to me and do anything I ask of them. I think that makes them very caring."

Four people told us they had been involved in a review of their care plan in the previous three months. However six people told us their care plans had not been reviewed recently and it was at least a year since they had a review meeting.

People were supported to be as independent as possible. One person said, "I try to do things myself even though I am in a wheelchair, but they will do anything I ask them to do like getting a vase down for me."

Care workers told us they let people do as much as they could and encouraged them to take part in activities of daily living. One care worker said, "Preparing dinner I would ask [Name] if they would like to peel the potatoes or prepare the vegetables." Other care workers described how they saw their role as making sure people were safe while looking after themselves. One said, "If [Name] is having a wash, I would say 'If you need me just call me.'" Another said a person who was living with dementia shaved several times while staff were there, and staff made sure this did not make them sore.

Care workers described the steps they took to respect people's dignity and privacy. These included protecting people's modesty while supporting them with personal care, and making sure doors and curtains were closed if necessary.

Requires Improvement

Is the service responsive?

Our findings

Where people were supported by the same, regular care workers they were satisfied their care and support met their needs, although four people raised concerns about late calls. One person said, "I wish I did have regular carers. I have got two, both are very good. The girl in the morning is excellent but I am never sure who I get in the evening." Another person said, "Recently in the mornings I have had the same carer, but who knows who is coming for the rest of the day."

Two people were satisfied because they did have regular care workers. One person said, "Everything is sorted now. I get regular carers and I like the continuity. I have no problem in complaining." Another person said, "I am lucky. I have the same carer. She will do anything I ask and is always on time."

At our inspection on 28 July 2015 we found the provider failed to make sure people received person centred care that was appropriate, met their needs and reflected their personal preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had started to make improvements. There was no longer a breach of Regulation 9, but further work was required in the area of people's care records.

Where people had concerns about late calls, one said, "Times are a sore point. They come late quite often... I try to ask for a list of who is coming but that is not easy. They always make excuses and say they do not have enough cover." Another person said, "I have the same carer every day but if she does not come then who knows who is coming, or if anyone is coming, or what time." A third person said, "One morning they were one and half hours late. No one rang me." The registered manager was aware of some problems with late calls. They did not consider they were due to insufficient staff to meet the rota, but pointed out there were frequent traffic problems in the areas where people lived and there had been a recent incident on a nearby motorway which had led to particular difficulties travelling in the area. There was an automatic call monitoring system in place where people had agreed for staff to use it. This enabled the manager to track if late calls were likely to become a major issue.

Most people told us they did not have a lot to do with the office or manager but one person said the office were helpful when they called. People said they would feel comfortable calling the office if they needed to raise a complaint. We received three comments from people which showed the service could improve its communications.

At the time of our inspection, the provider was in the process of reviewing and rewriting people's care plans. The new style care plans were detailed and contained more information about the person, their preferences and their care needs. The registered manager estimated that 65% of people's care plans had been reviewed and rewritten and that it would take another three to four months to complete all people's plans.

The new plans that had been reviewed and updated contained pen portraits of people including their life stories and interests. There were detailed accounts of the support people needed, and how they liked their support to be delivered. Where appropriate the plans made clear the order in which care workers should

carry out their tasks according to people's preferences. The plans included provision for people to be included in decisions. One contained, "Ask [Name] what he would like to have for breakfast. He usually likes to have a bowl of muesli and a glass of water."

Although people's files showed their care plans had been reviewed, there were examples of inconsistency in their content. One person's "routine on retiring" stated, "Likes dentures removed? Yes." Whereas their "personal hygiene" record stated, "Wears dentures? No." Their medication assessment and general medication file record stated the person looked after their own medicines and did not require assistance, but their care plan stated, "Carer to administer medication." Another person's care plan contained contradictory information about their support with medicines. Different records indicated they were "self-medicating", required prompting or required assistance. These people were at risk of receiving inappropriate care because their records were ambiguous.

There was inconsistent and confusing information in people's care plans where risks had been identified. In one person's environment risk assessment, it was noted that smoke detectors were installed in the person's upstairs hallway. Staff had answered the question "Are they in working order?" with "not applicable". The person's assessment identified they were allergic to detergent, but their care plan stated "Allergies – none".

While the provider had started the process of updating records with regard to people's personal care needs, this work had not progressed in a timely enough manner since the last inspection and records were contradictory or ambiguous. Failure to make sure records of people's care and support were up to date, clear and accurate was a breach of Regulation 17 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers told us the care plans and care diaries kept in people's homes contained the information they needed to support people according to their needs and preferences. If people's needs changed there was a process for updating their care plans. Care diaries contained records of the care and support provided on a day to day basis. These were returned to the office periodically, and audited. The provider took steps to make sure people received care and support in line with their plans and assessments.

At our inspection on 28 July 2015 we found the provider had failed to investigate and take proportionate action in response to any failure identified by a complaint or investigation. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made.

The provider had introduced a new process for handling complaints, concerns and compliments in March 2016. Complaints since that time had been logged and followed up. Where the provider's investigations were complete, they had replied to the complainant.

Five compliments had been logged since October 2015. These included comments such as, "You were a great support to Dad, and he really took a shine to you, so it was especially good that you were with him for his final months." Another comment referred to the "excellence of the professional care" and "help, advice and guidance" given.

Inadequate

Is the service well-led?

Our findings

People gave us mixed reports about the management and leadership of the service. People told us the service did not always communicate well or respond to concerns. One person said, "Nobody has been here from the office in last 18 months. No updated care plan as far as I am aware." Another said, "I am not aware of any meetings or questionnaires, but I do know who the manager is. I know her name." Two people told us they found it difficult to speak to the registered manager and two people were unhappy with the administration of their contract. Another person told us, "I have little contact with the office, but when I do they are helpful."

At our inspection on 28 July 2015, we found the provider did not have systems and process in place to monitor the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care (Regulated Activities) Regulations 2014. At this inspection we found the provider had started to make improvements but had not made enough progress to meet the requirements of the regulation.

The provider had started to make improvements since our last inspection. They had reorganised their management team and engaged external consultants to assist with and monitor their improvements. The registered manager told us they considered they were 60% through the improvement process with an outlook of completion by the end of December 2016. The manager considered the improvements made so far had resulted in happier staff and a more pleasant atmosphere.

The care workers we spoke with gave mixed views about their contact and communication with the office and management. Two care workers were satisfied with their relationship with the office. One of them said that they could get on with the job. They said, "I love what I am doing. If I have any issues I will let them (the office) know. They can call me if they need to tell me anything." Two said they did not have a lot of communication with or guidance from the office, although all the care workers had noticed an increase in spot checks and formal supervision meetings since our last inspection. Three out of the four care workers we spoke with were not aware of the outcome of that inspection.

The registered manager had established a management team comprising a deputy manager, care coordinator, training manager and senior carers. They were recruiting an additional senior and for administrative support. The manager told us they wanted to increase the team's IT skills. Staff members we spoke with were aware of their roles and responsibilities in the new organisation and were in favour of it. At the time of our inspection the service relied on one of the three engaged consultants for practical support, for instance in running meetings and engaging with the local safeguarding authority. This consultant also undertook appraisals for the registered manager and deputy manager. We understood the consultant had been retained until the end of 2016 when the provider expected their improvement programme to complete.

There was a new programme of meetings in place, which had been operating since the middle of March 2016. There were minutes of weekly meetings with the office staff. There had been a governance meeting in April 2016 and a meeting for all staff in February 2016. The service had been in special measures since

October 2015, but the new management system implemented by the provider did not start until four months later. As a consequence it was not fully embedded or showing all its potential at the time of our inspection.

Following our last inspection in 2015 the provider had engaged a consultant to review their performance across the five key areas covered in our reports. The provider had reports of visits made in October 2015, January 2016 and March 2016. The most recent report noted that there had been improvements since the first two visits, but these were recent and there was a need to build on the work which had started. Findings in the consultant's reports were described as "more positive" but questioned whether the provider recognised the further work required and the need for systems and structures to make sure improvements were sustained.

The provider had an improvement action plan which was reviewed at the governance meeting in April 2016. Not all of the recommendations from the March 2016 consultant report had been incorporated into the action plan. For instance, there were no actions relating to concerns about the provider's recruitment process, senior staff job descriptions or structures intended to sustain the improvements being made. There were 34 actions in the plan with columns for the responsible staff member "By Whom", target completion date "By When" and "Date Completed". A responsible staff member was identified for each action. Twelve actions did not have a target date for completion in the "By When" column. In the "Date Completed" column, one action only had a completed date, 13 were described as "Ongoing", and 20 had no information about completion. The action to "update all care plans" had a completion date of 31 May 2016. It was shown as 55% complete with a target of 75% by "the next visit" of the consultant engaged by the provider. It was not clear that the action plan was being managed actively.

The provider had relied on a client feedback service which collated data from three voluntary online feedback sites including NHS Choices. The registered manager had a report of 43 client reviews between June 2015 and March 2016. These were all favourable reviews, giving the service between three and five stars based on the response to seven questions. The average rating was given as 96% (five stars). However, people we spoke with who had concerns about the service were not aware of these surveys, which questioned the completeness of the information used to assess the quality of service provided.

The registered manager told us they had engaged a new supplier to provide them with quality feedback information, but they were yet to submit their first quality questionnaire. The registered manager had also sent out their own feedback forms in October 2015. They told us the returns were positive and did not identify any areas for improvement.

The service had been placed in special measures following the previous inspection which took place on 28 July 2015 with the report published on 26 October 2015. The provider's management systems had not identified or fully addressed concerns we found at this inspection with risk management and ineffective and incomplete training. Where improvements were in progress these had not been managed to complete within six months which is the guideline period for services in special measures. The provider had not responded quickly or thoroughly enough to the concerns identified at the previous inspection and had not identified all the concerns we had at this inspection. This was a continuing breach of Regulation 17 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 28 July 2015 we found the provider had not displayed the ratings given at the previous inspection. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the ratings were displayed in the office and on the provider's website.