Handle With Care (Portsmouth) Limited

Handle With Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 14, 16 and 21 March 2018 and was announced. Following the previous inspection on 13 July 2017, this service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection, the service demonstrated to us that improvements have been made and is no longer rated as Inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Handle With Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and specialist housing. It provides a service to older adults, including people living with dementia, younger adults and people with a physical disability. Not everyone using Handle With Care receives a service which is a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

There was a registered manager was in place who was also the provider. 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. Another manager had also been recruited and they were in the process of applying for registration. We have therefore referred to the 'registered manager' and the 'manager' in this report.

At our last inspection in July 2017, we found risks to the health and safety of people were not always assessed and were not always safely managed. At this inspection, whilst we found some improvements, we also found that information about people's risks was not always clear, up to date and available to staff. This meant that staff may not have access to the information they needed to guide them to provide safe care and all the actions they could take to reduce risks as much as they could. The provider had not sustained the improvements they told us they had made to people's risk assessments following the last inspection.

At our last inspection in July 2017, we found the provider had failed to operate effective systems and processes to monitor and mitigate risks to people and maintain an accurate, complete record in respect of each service user and staff member. At this inspection we found that some improvements had been made. However, we also found other concerns about the quality and safety monitoring of the service and the accuracy and completeness of records.

People's rights under the Mental Capacity Act (2005) were not always fully supported through recorded mental capacity assessments to assess their ability to make decisions about their care and treatment. This is important to ensure people are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible.

Although the provider had a procedure for end of life care planning, people, their families or carers had not been involved in creating and recording a care plan which would support staff to know, understand and act on people's end of life care needs and wishes. The lack of information and guidance could put people at the end of their life at risk of receiving inappropriate care and treatment.

At our last inspection in July 2017, we found the provider had failed to safely manage and dispose of people's medicines. At this inspection, we found systems and processes had been improved and medicines were disposed of safely. Some improvements were still required in record keeping to support safe disposal and administration.

At our last inspection in July 2017, we found the provider had failed to establish and operate effective systems and processes to prevent abuse of people. At this inspection we found improvements had been made and safeguarding concerns had been raised with the Local Authority and investigated appropriately.

At our last inspection in July 2017, we found the provider had failed to operate an effective recruitment procedure. At this inspection we found improvements had been made and safe recruitment practice had been followed. However, records did not always evidence that plans in place to monitor risks associated with the employment of staff had been adhered to. We have made a recommendation about this.

Incidents and accidents were monitored to check action had been taken to address safety issues and prevent a reoccurrence.

People and their relatives reported some dissatisfaction with the timing of their calls, the duration of their call and communication from the office when care staff were running late. We discussed this with the provider who told us care was contracted to be delivered within a two hour window. However, from the feedback we received people were not always aware of these arrangements and said the service was not meeting their expectations. We have made a recommendation about this.

At our last inspection in July 2017, we found the provider had failed to provide appropriate supervision and training to enable staff to carry out their duties effectively. At this inspection we found a system was in use to check staff competencies through observed supervision. This system enabled senior staff to confirm people were cared for effectively.

People's needs were assessed and these included information about people's cultural and spiritual needs. Staff demonstrated an awareness of people's diverse needs and a respect for people's chosen lifestyles.

People's dietary needs were assessed and people told us they were supported with these appropriately.

People were supported to access healthcare services as required. However, where there was a delay in the response from a healthcare service, this was not always robustly followed up to protect people from deterioration in their condition. The provider has assured us future delays will be reported to the local authority safeguarding team to protect people from this risk.

People and their relatives told us staff were kind and caring and their privacy and dignity were respected by staff.

Staff we spoke with knew about the interests of the people they supported and some people told us they were cared for by familiar staff who showed an interest in their lives and wellbeing. The provider checked staff were delivering kind and compassionate care through competency based supervisions, although not

all of these were up to date.

At our last inspection in July 2017, we found the provider had failed to operate an effective and accessible system for dealing with people's complaints. At this inspection, we found improvements had been made. However, records to evidence the outcomes and actions taken in response to complaints were not always fully completed to show the complaints system was operated effectively for people.

People told us the care they received met their needs, even when they expressed dissatisfaction with the timing and duration of their care calls. People's care plans were not always up to date and this was being acted on by the manager to ensure care plan guidance for staff was accurate.

Peoples needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. People's communication needs were assessed and staff demonstrated an understanding of how to meet these.

At our last inspection in July 2017, we found the provider had failed to notify the Commission without delay of any abuse or allegation of abuse in relation to a person. At this inspection we found the provider had failed to notify us of one allegation of abuse. The provider had notified the local authority and the appropriate action had been taken in response to this concern. We have made a recommendation about this.

At our last inspection in July 2017, we found the provider had failed to display their current rating on their website. At this inspection we found there was a link on the provider's website to the most recent report.

Staff spoke positively about changes in the service since our previous inspection. This included the appointment of a new manager, improved communication between managers and staff and an improved team culture.

We found four 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. Full information about CQC's regulatory response to the more serious 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

Risk assessments were not always completed to provide staff with the guidance they needed to deliver safe care and all the actions to take to reduce risks as much as they could.

Overall there were enough staff to care for people safely. However, people were not always satisfied with the timing and duration of their calls and the communication from the office when calls were late.

People received appropriate support with their medicines. Records to support safe disposal and administration required improvement to ensure the safe management of medicines.

Incidents and accidents were monitored to check actions had been taken to address safety concerns and prevent a reoccurrence.

People were protected from abuse. Staff understood their responsibilities to safeguard people and referrals were made to the local authority when appropriate.

Is the service effective?

Requires Improvement

The service was not always effective

People's rights under the Mental Capacity Act (2005) were not always fully supported through recorded mental capacity assessments to assess their ability to make decisions about their care and treatment.

People were supported to access healthcare when needed. An improvement was required to ensure healthcare support was timely when people were at risk of deterioration in their health.

People's needs were assessed and care was planned to meet these. Policies and procedures were in place to support staff to deliver appropriate care to meet people's diverse needs.

Staff completed training and competency based supervisions to

check their skills and knowledge in providing effective care for people.

People told us their dietary needs were met. Needs assessments guided staff on how people preferred to be supported with eating and drinking.

Is the service caring?

Requires Improvement

The service was not always Caring

Further improvements were required to ensure people always received a caring service. This included checking all staff provided a caring service and that records to support people's care and decision making were clear and accurate to support staff in providing a caring service.

People told us they were cared for by kind and caring staff.

People told us that staff respected their privacy and dignity when providing care.

Care plans provided guidance to staff on people' views and preferences and people told us they supported in line with these.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's preferences and choices for their end of life care were not recorded. This meant people could receive inappropriate care and treatment.

People's complaints were responded to. However, records to evidence the outcomes and actions taken in response to complaints were not always fully completed to show the complaints system was operated effectively for people.

People told us they received care that met their needs, even when they were not always satisfied with the duration and timing of their calls. Staff were knowledgeable about people's needs. However, care plans were not always accurate and up to date and this was being addressed at the time of our inspection.

Is the service well-led?

Requires Improvement

The service was not always well led

The system in place to monitor the safety and quality of the

service people received was not always effective. Audits, action plans and monitoring procedures did not always show they had identified and addressed concerns to drive continuous improvement to the service people received.

People's records were not always accurate and up to date. This could put people at risk of inappropriate care and treatment. This was being addressed at the time of our inspection.

People and staff had been asked for their feedback on the service and this had been analysed and acted on by the provider.

Staff and people told us there had been improvements in the culture of the service. Staff spoke positively about the support they received in their role and were confident any concerns they raised would be acted on.

Handle With Care

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. CQC were aware of a past incident which had a serious impact on a person using the service which we are currently investigating.

The inspection was carried out to check whether improvements had been made following our previous inspection on 13 July 2017 when this service was placed in special measures. CQC were aware of a past safeguarding incident which had a serious impact on a person using the service which we are currently investigating. At this inspection we explored aspects of current care and treatment related to this incident.

This inspection took place on 14, 16 and 21 March and was announced. We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure that the staff and people we needed to talk to would be available.

Inspection site visit activity started on 14 March 2018 and ended on 23 March 2018. It included visiting the office location on 14, 16 and 21 March to see the managers and office staff; and to review care records and policies and procedures. We carried out telephone interviews with people who used the service, their relatives and staff. We sent questions by email to staff and we also visited three people in their own homes.

The inspection was completed by two adult social care 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. The expert by experience had experience as a family carer of a person living with dementia who used domiciliary care services. The expert by experience carried out telephone interviews with people who used the service and their relatives.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to

help us decide what areas to focus on during our inspection. The provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We discussed this information during the inspection. We requested and received feedback on the service from the local authority adult social care senior business manager. We reviewed the local authority contract monitoring report dated 19 February 2018.

During the inspection, we visited three people who received a service from the provider in their homes and observed interactions between people and staff. In addition, we spoke with nine people by telephone and the relatives of four people. We spoke with six care staff, and four care staff responded to our questions by email. We also spoke with one care coordinator, the provider and registered manager and the service manager.

We reviewed records which included 14 people's care plans, daily records and medicine administration records (MAR's) staff training, recruitment, supervision records and staff meeting minutes. We also looked at records of accidents, incidents and complaints along with records relating to the management of the service, such as quality assurance audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us the provider's staff supported them (or their relative) safely. People's comments included "Yes I feel safe, I know them very well and they give me good care" and "She (carer) is hard working and thorough and I definitely feel safe."

At our last inspection in July 2017, we found that care was not always safe because risks for people had not been appropriately assessed and plans implemented to reduce the risks. This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements, for example we saw how staff had recognised an increased risk as a result of one person's mobility. They had taken action to reduce this risk by discussing this with the person and making a referral to the appropriate external professional for an assessment of their needs in relation to equipment that would support them. However, we also found that at times people remained at risk because appropriate risk assessments and actions to manage risks had not been completed when a risk was identified. For example, one person's care records identified risks to them and others including behaviours which could be aggressive, making accusations about others and significant self-neglect. Staff had an understanding of this person's needs and had consulted with the person's social worker to develop plans to manage the risk of self-neglect. However, there were no clear assessments regarding the risks of behaviours that may challenge, and no clear risk management plan which guided staff about what they should do to monitor and reduce the risks and what to do if the risk presented.

For a second person an entry in their care records stated that they could bleed a lot if they knocked themselves. We were told this person's mobility needs had changed and their condition had deteriorated, increasing this risk. However, there was no clear assessment and plan in place which would ensure staff had access to information they would need to reduce the risk of bleeding, monitor for subtle signs of bleeding and the action to take should they bleed.

Where risk assessments were in place, they did not always provide sufficient guidance to staff. For example, one person's care records contained a risk assessment which stated the person was prone to infections but did not identify what type of infection. In addition, the assessment did not provide guidance about how to reduce the risk. Although staff we spoke with knew how they would try to reduce the risk, the lack of clear guidance could put the person at risk if they received care from new or unfamiliar staff.

Staff told us that when a person started using Handle With Care services staff are given information about their needs and the support staff should provide. However, we found that new people to the service did not always have clear risk assessments and plans in place to reduce risks. For example, one person, who started using the service the week of our inspection, was at risk of falls. This person had previously been admitted to hospital with an injury as a result of a fall. Although a falls risk assessment was in place this was not fully completed and as such we could not be assured the assessment was accurate. This also recorded "no action plan needed". Whilst the care plan included guidance about how to support this person to transfer, it did not identify any risk of falls for this person and how staff might ensure this risk was reduced for the

person when they left their visit.

In their action plan dated 27 October 2017, the provider stated that all 'service users have an up to date and current risk assessment'. However, we found information about risks and safety was not always comprehensive or up to date. This meant that staff may not have access to the information they needed to ensure they provided safe care and all the actions to reduce risks as much as they could. This could place people at risk of unsafe care and treatment. We discussed this with the registered manager and the manager and they told us they had a plan in place to review and update people's risk assessments. However, more time was required to ensure this was completed.

A failure to ensure staff had access to information about risks for people and the action to take to mitigate these risks was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents and accidents were recorded into the case management system as 'client events'. The manager printed off and reviewed all client events on a daily basis. Actions taken in response to the event were recorded on the client notes and records showed these were reviewed fortnightly for outcomes. For example; when there had been a missed visit, action had been taken to check the person was safe and an alternative visit was arranged. A medication error had been reported to a doctor and staff stayed with the person to reassure them until confirmed there was no risk to the person. This meant risks to people from accidents and incidents were monitored and action was taken to address safety issues and prevent a reoccurrence.

At our last inspection in July 2017 we found the provider had failed to safely manage and dispose of people's medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found this had improved and was no longer a breach. However, some improvements were still required. We found systems and processes had been improved and that medicines were disposed of safely. Medicines for disposal were recorded by the staff member who transported these medicines appropriately in a container for this purpose to the pharmacy for disposal. The reason for disposal was recorded and staff phoned into the office to report any refusal of medicines and these incidences were monitored for any follow up actions required. Prepacked medicines in a monitored dosage system that were unused were collected by the pharmacy from people's homes for safe disposal. However, there was no record of these unused medicines. Even though these medicines were in a prepacked container, where the provider is responsible for disposal because they are providing full support, these records are important to ensure medicines are fully accounted for.

Staff completed training in the administration of medication and staff competency was planned to be checked on an annual basis during a spot check to ensure staff continued to support people with their medication safely. Although we saw some evidence these were completed, the manager told us the competency checks were not up to date and they were currently working to complete them.

People's care plans included information about the kind of support people required with medicines. Medicine Administration Records (MARs) were completed by staff to show staff had administered people's medicines as prescribed. However, these records were not always fully completed with the reason when the medicines were not taken as prescribed. In two of the records we reviewed, we found gaps in these records. Whilst staff were able to tell us and daily records confirmed the reason these were not given, this was not always recorded on the MAR. These records were planned to be audited monthly by supervisory staff.

However, the registered manager confirmed these audits were not up to date. It is important to ensure non administration is accurately recorded and monitored to ensure any concerns about people's use of medicines are acted on.

The provider had introduced a dedicated medicine round so that people received their medicines on time at regular intervals during the day. This was a trial being evaluated by the local authority. Staff told us this had improved the management of people's medicines and one staff member said "We have reduced the amount of medicines going back to the chemist as everyone is getting everything on time, we had issues in the past."

At our last inspection in July 2017 we found the provider had failed to establish and operate effective systems and processes to prevent abuse of people. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and this was no longer a breach. Safeguarding concerns had been raised with the Local Authority and investigated appropriately to keep people safe.

Staff we spoke with understood their responsibility to protect people from abuse and policies and procedures were in place to inform staff how to act when safeguarding concerns arose. Staff had completed training in safeguarding adults from abuse and told us they were confident managers would act upon concerns.

At our last inspection in July 2017, we found that safe recruitment practices were not followed. Applicant's fitness to work was not always assessed, gaps in employment history and reasons for them leaving previous employment had not been explored and references were not collected. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made and this was no longer a breach of regulation. However, some improvements were still required. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. It asked applicants to confirm any reason for gaps in employment. Staff were asked to declare any health issues that may impact on them or others while at work. Where staff had declared an issue this had been discussed with the staff member and assessed to reduce any risks. There was also a statement that confirmed if this person had any criminal convictions that might make them unsuitable for the post.

A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff that may be unsuitable to work with people who use care services. However, the provider only kept a record of the DBS number with no date recorded that it was seen, or confirmation this was clear. Where potential concerns had been disclosed, discussion had taken place with the applicant and plans implemented to reduce any risks while monitoring the staff member's performance during their probation period. It was not always clear that the risk assessment had been adhered to because the records were not clearly maintained. The provider told us that where references provided dates only they followed these up with discussions to ensure an assessment of the applicant's character, however, they did not always record these discussions.

We recommend the provider seek advice and guidance from a reputable source about maintaining records to evidence legal requirements in relation to recruitment are met.

The provider and manager told us they had enough staff deployed to meet people's needs. The care

coordinator said "Meeting people's preferred times are a challenge, we have enough staff and cover sickness and annual leave with our own staff including the office staff, I try for 30 minutes either side of the person's preferred time". We received mixed feedback from staff about staffing levels. Some staff reported feeling rushed when other staff were absent and they had to cover additional care calls. Other staff told us staffing levels were adequate to meet people's needs.

People and their relatives reported some dissatisfaction with the timing of their calls, the duration of their call and communication from the office when care staff were running late. In addition some people told us care staff did not stay the full allocated time of their call and some people reported feeling rushed at times. People's comments included "She (carer) is supposed to be here for half an hour but she sometimes only stays 20 minutes". "They don't ring if they are going to be late." They are supposed to come at 08.00am but often don't come till 09.00am and they don't ring me." Other people said "It's the same carer every time and she feels safe." "The carer is very punctual and she's here at 08.30am every day". One person said "I have asked and asked and asked the office for a rota. We never know exactly when they are coming. They are supposed to give us a rota every week, sometimes they do and sometimes they don't, it's really annoying." "I have the same one (carer) three times a week and another one comes but she wants to get a move on so they are in and out quite quickly" and "At lunch time and the evening they are in a hurry so they are in and out".

No one we spoke with told us they did not have their needs met due to the timing or length of their call or that their safety had been compromised. One person who had four calls per day was dissatisfied with the timing of the calls because they were too close together between the lunch time and tea time calls to be fully effective. In the records we reviewed we saw people's calls had not always been for the stated duration.

The provider told us care was contracted to be delivered within a two hour window, this meant people could not always be sure when the care staff would arrive. Although the care coordinator told us they scheduled calls as far as possible to meet people's preferred times, this was not always possible. We discussed this with the care coordinator, the provider and registered manager. The provider told us they were aware of the impact on people of operating on a time banding rather than a set time. They told us people "Should be aware of this". However, from the feedback we received from people and their relatives this was not evident. Overall there were sufficient staff to meet people's safety needs; however people did not always receive a consistent and reliable service.

We recommend the provider ensures people using the service are clear about the service being offered and takes action to manage people's expectations.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us staff were sufficiently skilled to meet their needs. People's comments included "For what my mum requires they are sufficiently skilled" and "I couldn't ask for anything better, they have been very good all of them."

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.

Staff completed training in the MCA, the principles of the MCA were displayed in the provider's offices and staff supervisions checked staff knowledge and competence in this area. Staff we spoke with were able to tell us about these principles and how they used them in their work with people. Two people's relatives told us they observed care staff asking the person's consent prior to delivering care and staff respected their relative's decisions.

However, the information about people's mental capacity in some people's records was inconsistent. Records did not always show that assessments of people's mental capacity had been carried out prior to decisions being made about their care and treatment. For example, a person's needs assessment stated they were able to give consent to their care and treatment although a partially completed mental capacity assessment stated they did not have the capacity to consent.

Another person's needs assessment stated they had dementia, a lack of understanding and were unable to remember conversations. However, there was no evidence to show a mental capacity assessment had been completed with regard to decisions made about their care and treatment to determine if they were able to make those decisions. For example, although the information in their medication risk assessment indicated a lack of understanding about their medicines, there was no mental capacity assessment to support their medication agreement which stated 'unable to sign (shaky)'.

Another person had a 'consent to share information with CQC' form in place. This stated the person was unable to sign. The person's care plan similarly stated they were unable to sign because they were 'unable to grip the pen'; the care plan was signed by a staff member and the manager. There was no information about whether the person had the mental capacity to make this decision. From information in the care plan, and our discussion with the person, it appeared they may lack the mental capacity to make an informed decision, however this had not been assessed. This was not consistent with the provider's 'systems for consent' explained in the 'service users rights' document.

When there was a possible lack of mental capacity to make a particular decision, a recorded assessment was not always in place. This meant there was a risk people's rights under the MCA would not be upheld

Failure to ensure that clear records were maintained in relation to people's ability to make decisions and provide consent was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in July 2017, we found the provider had not provided staff with appropriate supervision and training to enable them to carry out their duties effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found this had improved and was no longer a breach. New staff completed an induction when they first started which consisted of a local introduction to the service as well as the completion of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. As part of this process staff were required to complete a work book which was then assessed to ensure staff knowledge was sufficient.

Records confirmed a programme of on-going training was completed by staff in topics such as; dementia, moving and handling, safeguarding, food and hygiene, infection control, health and safety and medication. Staff told us the training provided was effective. For example, a staff member said, (dementia training) "It's helped me how to understand someone with dementia. My first time with a person (living with dementia) I didn't know what to do or say and the training was very helpful." Another staff member said "I feel it is very useful to all staff so you can give the care that's correct for the individual client and no two clients have the same symptoms or diagnosis".

Supervisions had changed since our last inspection and were now competency based and involved discussion with a senior member of staff, observations of their practice and at times feedback from the people they supported. This meant that staff competency following training could be checked and further learning needs identified. Most staff told us they received supervisions and found these helpful in their roles. They also said they were able to contact the office staff at any time with any concerns to discuss these. All staff had also received an appraisal. People were supported by staff who completed an induction, training and on-going supervision to enable them to care for people effectively.

People's needs were assessed and this included their physical, mental health and social needs. Needs assessments also included people's needs related to their religious and cultural needs, communication needs and expressing sexuality. Staff we spoke with showed an awareness of how to support people with their diverse needs. This included a commitment to respecting people's beliefs and lifestyles and to address discrimination. Competency based supervision included the opportunity for staff to discuss with their supervisor 'how you can practice in a way that observes equality and diversity' and staff told us training included equality principles and practice.

People's dietary needs were documented and care plans included details of people's preferred meals, drinks and snacks and the support they required to eat and drink. People we spoke with told us they had sufficient to eat and drink and that care staff supported them appropriately.

People were supported to access healthcare services when required; this included emergency services when staff identified an urgent healthcare need. One person told us how a carer had "Saved my life" when they called emergency services. The person went on to explain the staff member did this even though the person had not thought their condition was serious. Another person said "They look at my legs and see any marks on them and say they will keep an eye on that. One morning I wasn't very well and she (carer) rang 111 and my blood pressure was high and a paramedic came. So that was good I suppose."

People's records showed healthcare professionals had been contacted when health concerns arose. However, the responses from healthcare services were not always robustly monitored to ensure the person received prompt care and attention. We were concerned that although the service had contacted community nurses to assess a person with a pressure sore, this person was not seen for at least nine days. Whilst this had been observed by care staff and communicated to the office staff, the person's condition had worsened prior to the nurses visiting. We discussed this with the registered manager and manager and they told us the local authority safeguarding team would be contacted if this situation arose again to protect people from the risk of deterioration in their health.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. People's comments included "She is very kind and caring, she is spot on" and "They are kind and caring, they have a chat and ask what else they can do." A person's relative said "I've only met the carer a couple of times but Mum is very relaxed with her and likes her very much. She listens to what my Mum wants." Some people also said that at times some care staff were rushed which left them feeling less cared for. One staff member we spoke with said when they were rushed this meant they were not able to build 'trusting relationships' with people.

Staff we spoke with and observed were knowledgeable about the people they supported and a person said "I can't fault her (carer) she is very important to me, she is definitely interested in my life and is caring". A staff member said "In people's house, they often have their interests on display. One person liked 60's music so we put it on and sang along, little things make it better like discussing TV programmes, paintings etc. "

Staff understood the importance of building relationships with people and most staff told us they had regular calls which enabled them to get to know people. People also told us that seeing familiar staff was important to them and a person said "When you need a carer you lose a certain amount of dignity, that's changed and I'm really happy about this." The care coordinator told us "People requiring two carers have one main consistent carer and one other. We try to ensure people have a maximum of three main carers at a time, especially for people with dementia." This meant most people were cared for by familiar and consistent staff who understood their needs.

People's care records included a care plan summary which explained how they preferred to be supported. This included, what people liked to be called, their communication needs and what they preferred to do for themselves. This provided guidance for staff on people's views and decisions and people confirmed they were asked about their preferences prior to care being delivered. One person's care plan summary explained how the person had limited speech but liked to be involved in conversation. This person's relative told us "The staff do talk to my Mum and in fact she talks more to them than she does to me, to be honest." Another person explained how they liked to do as much as possible for themselves and this was respected by staff.

Staff we spoke with demonstrated how they provided care that was respectful and promoted people's privacy and dignity. For example; by providing care in privacy and in the way the person preferred. A staff member said "Don't rush, talk to the person, don't speak to the other worker behind their (person's) back." Another staff member said "Knock on the door; ask family to leave for personal care, close the curtains to make sure people are not exposed." A person said "They help me in the shower, they respect my privacy and they close the door when I use the loo." People told us they received dignified and respectful care.

The provider used a competency based supervision session to check whether staff were caring. This included checking staff's 'communication skills, the dignity and respect that you show your client and the approach to challenges with clients that use the service.' This enabled the staff member and supervisor to identify any learning and development needs and to check people received appropriate person centred

care. Not all staff had received this supervision session; the provider required more time to ensure all staff had been assessed and supported to provide people with a caring service.

Although we found staff to be caring in their approach, improvements needed to be made and sustained to ensure people receive a caring service. This included checking all staff provided a caring service and that records to support people's care and decision making were clear and accurate to support staff in providing a caring service.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2017, we found there was no system in place within the service to identify, receive, record, handle and respond to any complaints that may be made. 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 and this was no longer a breach. However, records regarding complaints needed to be improved to show a consistent, open and transparent approach was taken. The registered manager kept a record of complaints and compliments. Where complaints had been raised, records were mostly kept which reflected the action taken to investigate the complaints, who the provider had shared the information with and the outcome. However, at times the records did require improvement. For example, for one complaint we found this had been resolved to the complainant's satisfaction but the records did not clearly reflect the investigation into this. For a second complaint, records documented by the registered manager appeared to dismiss the person's concerns. In discussion with the new manager, the concerns had been managed and the complaint had been resolved to the complainants' satisfaction. Records to evidence the outcomes and actions taken in response to complaints were not always fully completed to show the complaints system was operated effectively for people. We discussed this with the registered manager who acknowledged that some complaint management records required improvement, which they would address.

The new manager told us that two people were receiving end of life care at the time of our inspection; however their care plans did not reflect this. There was no mention of end of life care for these people, other professionals to contact and no information to ensure staff could deliver this care in the way people wanted and needed. Staff told us they had not received any training to support them in end of life care and would call the office to find out what support people needed. The provider had a palliative care policy in place that included end of life care. However, this had not been followed because an end of life care plan had not been developed. There was no evidence that people, their families or carers had been involved in creating and recording a care plan which would support staff to know, understand and act on people's end of life care needs and wishes. The lack of information and guidance could put people at the end of their life at risk of receiving inappropriate care and treatment.

The provider had not done everything reasonably practicable to ensure the care and treatment of service users was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst some people and their relatives told us they did not receive a reliable and consistent service due to planning and delivery of their care calls, they also told us they received care that met their needs. A person said "The care meets my needs at the moment." And people's relatives said "Yes, the care she receives totally meets her needs and "The service meets his needs at the moment. We are pleased with what we get." However, one person commented "I am reluctant to ask them (carers) to wash my hair, as they are usually in a hurry if they are short staffed."

The care coordinator told us that when people's needs changed, carers were informed by phone and care plans updated to reflect these changes. A staff member said "Enough information is available for me the first time I see someone. The office does care plans; it's the first thing I look at in case something has changed; they are updated". However, we found that care records were not always updated with people's changed needs or completed in a timely way. For example, we visited a person whose needs had changed when they returned home from hospital, although their regular carer was aware of these changes, the care plan had not been updated to reflect these needs. Another person, who had started using the service on 8 March 2018, had not had their care plans developed although a care plan summary for each call was available for staff. Whilst staff knew about these people's needs, there was a risk that people could receive inappropriate care from new and unfamiliar staff. The manger showed us care plan completion and update was part of their action plan on coming into post and was being addressed.

Other care plans showed people's needs were assessed and plans developed to meet their needs. Care plans were developed with people and their representatives, as far as possible, prior to care being delivered. Two people we visited told us they were aware of their care plans and these had been discussed and reviewed with them. People's needs at each call were detailed and care plans also included specific information about people's moving and handling needs and medication support when this support was provided. Care plans also included an assessment of people's needs in relation to their sexuality, social, religious and cultural needs. This enabled the provider to take into account people's needs in relation to the protected characteristics under the Equalities Act 2010, including age, disability, gender, marital status, race, religion and sexual orientation.

We saw personalised information was included about the communication needs of people with a disability or sensory loss, such as sight and hearing impairments and how these were to be met. This information is important to demonstrate the provider is complying with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post who was also the provider. The provider had employed a new manager who has applied for registration with CQC. The provider told us this would enable them (the provider) to "concentrate more on the business side" whilst the registered manager was focused on the day to day running of the service. In addition, the provider was recruiting for a deputy manager to support the registered manager and care co coordinator in their roles.

At our last inspection in July 2017, we found effective systems and processes were not in place to monitor and mitigate risks to people. In addition, there was not always an accurate and complete record in respect of each service user and staff member. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that some improvements had been made. However, we also found other concerns about the quality and safety monitoring of the service and the accuracy and completeness of records. This was a continuing breach of Regulation 17.

Following our previous inspection, the provider had submitted an action plan to show what improvements they planned to make. We saw that some of these improvements had been made and we have reflected these throughout this report. However, some of the actions had not been fully completed to show that an effective monitoring system was in place.

For example, the provider had stated that staff supervisions would be audited to check and monitor staff competency and that supervision had taken place. Whilst the staff records we looked demonstrated they had received supervisions, the system the new manager told us they used to track these was unclear and did not identify any action to be taken. For example, one record showed a number of staff had been allocated for supervision during January 2018 but this only recorded that two of these staff had received supervision. The record reflected no supervisions had been allocated for February or March 2018. Audits had been completed by the registered manager but these did not identify whether all planned supervisions had taken place, were recorded or that any improvement actions were needed.

The provider had stated that a complaints log and audit system would be developed to enable them to identify trends to inform changes in practice and policy. However, whilst records of complaints were held alongside a log, we found the log only recorded the complaint and the action taken. The registered manager and new manager told us this was their audit and analysis, however this did not look at themes or patterns and there was no action recorded which would help ensure similar complaints were not raised by other people because learning across the organisation had taken place.

The new manager had their own action plan which detailed what they wanted to achieve. However, this lacked timescales and the detail that would support the effective monitoring of planned improvements.

We received mixed feedback from people and their relatives about their call times, the duration of their calls and communication from the office when staff were running late. Even when people told us they were satisfied with the care they received, the management of their calls was a recurring concern. We have

reported this in the safe domain. We found an effective system was not in place to monitor the service people received in this respect. Some people using the service had their calls monitored via an electronic system, whereby the carer phoned in at the start and end of their care call. This system, when used effectively, enabled the provider to monitor the calls had taken place and the duration.

We were told by the care coordinator, registered manager and manager that call monitoring for people who were not on this electronic system was carried out by a monthly review of people's daily records which were brought to the office by staff. However, we found this was not accurate and most people whose records we looked at in the office contained no daily records from September 2017 and we were required to ask office staff to ensure these were collected and bought to the office. In the records we reviewed, we found these did not always show the length of time stated in the package of care was delivered. For example, we found examples for four people who had received a shorter call than commissioned. Of the records that were in the files, there was no evidence to suggest that these had been checked, meaning that the there was no effective system to check for the discrepancies we found and take action as appropriate.

We spoke to the registered manager and manager about the shortfalls in the quality monitoring system. By the end of the inspection the registered manager had contacted the provider of a care quality monitoring system which they planned to implement to achieve a more effective system.

In the care plans we reviewed, we found shortfalls in some people's records. These did not always contain an accurate and up to date record of the risks to people's care and treatment, their ability to consent to their care and treatment, their end of life care needs or their changed needs. Whilst we were told the auditing and update of people's care plans was on-going, the lack of an accurate and complete record of care provided to people could put people at risk of inappropriate care.

A failure to have effective systems and processes in place to assess, monitor and improve the quality and safety of the service provided to people was a continued breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents regarding people's care were monitored daily by the manager and these were reviewed fortnightly for outcomes. This enabled the manager to check action had been taken in response to individual incidents. However, the format used did not show that trends and learning were identified from incidents to continuously improve the service.

At our last inspection in July 2017, we found the provider had failed to notify the Commission without delay of any abuse or allegation of abuse. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. At this inspection we found improvements had been made and notifications of abuse had been made in a timely way.

However, we found the provider had failed to notify us of one incident of alleged abuse. The provider had alerted the local authority safeguarding team to protect the person's safety, but had not notified the Commission as required. We spoke to the registered manager about this who told us they had not understood that all allegations of abuse should be notified to CQC. This is important to ensure CQC can monitor the safety of the service people receive. The registered manager confirmed they would submit all the required notifications going forward.

At our last inspection in July 2017, we found the provider had failed to display the rating from their previous inspection on their website. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009. At this inspection, we found improvements had been made and

there was a link on the provider's website to the latest report and rating of this service.

The provider used a survey to gain feedback from people and developed an action plan following the analysis of this. They produced a report which was shared in summary with people. This report detailed the immediate action taken to address issues of concerns raised such as changes to time of visits, requests for more mature carers and clearer communication when the client cancelled the visit. Where issues raised required follow up, once action had been taken we saw this had been done and the service user confirmed they were now happy. Whilst we received positive feedback from people and their relatives about the service people received, the feedback also showed there was on-going dissatisfaction with communication about late calls and the timing of calls. Although the provider told us people "should be" aware of the timings for calls, the service delivered did not appear to be meeting people's expectations in this respect. We have made a recommendation about this in the safe domain.

Following the previous inspection the provider had carried out a questionnaire with staff to address some of the concerns raised by staff during that inspection. The provider had collated the responses and met with staff or provided information in response to their comments. Staff told us improvements had been made since the previous inspection. Staff spoke positively about the new manager; their comments included "You can talk to her and she listens and solves problems, she's made a big change. The atmosphere is relaxed and professional and if you don't know about something she will talk you through it." Another staff member told us "There have been changes in communication and team work – we are together more and with the managers" and a third said "Influences from outside have changed care; it needs communication from managers to tell us this so we can then do it in the community – if they don't, we don't know. Its good now the communication (In the last 6 months it's improved) If I ring up now it gets done." Most staff told us they were supported in their role and would be confident to raise safety concerns with managers and trusted they would be acted on. One staff member felt their concerns about people would be acted on but did feel requests for professional development training were 'brushed aside'.

Other improvements mentioned by staff which had been actioned included a weekly newsletter to staff for updates and information on practice issues, more in depth care plans and a dedicated medication round.

People also commented on the change in management; one person said "New management do understand that (relationship between person and regular carer) is important, before you felt like a name on a bit of paper". Another person said "New manager is very good and very nice".

The provider had an Equal Opportunities statement displayed in the office This outlined the provider's commitment as to how staff would be treated equally and without discrimination in relation to the protected characteristics under the Equalities Act 2010, including age, disability, gender, marital status, race, religion and sexual orientation.

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 The provider had not done everything reasonably practicable to ensure the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure staff had access to information about risks for people and the action to take to mitigate these risks. Regulation 12 (2) (a)(b)

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure an accurate and complete record of the care and treatment provided to each service user including in relation to people's ability to make decisions and provide consent. Regulation 17 (2) (c) The provider had failed to operate effective systems and processes to assess monitor and improve the quality and safety of the service provided to people. Regulation 17 (2)(a)

The enforcement action we took:

Impose a condition