Mears Care Limited

Mears Care - Norwich

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 26 June 2017 and 3 July and was announced. The inspection was carried out in order to follow up some concerns we have received over the last year. It was also carried out to follow up on an area we identified which needed further improvement when we last inspected this service in June 2016. The provider did not have an effective audit system in place to ensure that medicines were being administered correctly.

At the time of our inspection visit 580 people were using the service.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a registered manager in post who was present for both days of the inspection.

At this inspection we found three 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 this report

The systems in place around monitoring the administration of medicines were not fully effective, and we could not be assured they were always managed safely. There was a lack of oversight with regards to some medicines, and the provider was not able to assure themselves that they were being administered and managed safely. There were no systems in place to check that the content of care plans was relevant with enough individualised guidance for staff about people.

People's visit times were not always carried out at the agreed times for the agreed length of time, and there was no system in place leading to action to improve this. People's preferences were not always reasonably met. Care records did not always contain sufficient guidance for staff with regards to people's individual risks around specific health conditions or behaviours.

People's mental capacity was not assessed for specific decisions, and there were no records of best interests decisions for those people who did not have full capacity.

People knew how to complain, however some people did not feel comfortable to do so. The organisation obtained feedback from people during visits and through surveys.

Staff supported people with their mealtimes when they needed and supported them to access healthcare services. Staff had knowledge of safeguarding and how to report any concerns they had about people. Risk assessments were in place for people's home environments with guidance for staff on mitigating these risks.

The organisation had a comprehensive training programme in place for staff which included subjects

relevant to their role, as well as an induction for new staff. Staff were also supported to complete qualifications in health and social care. Staff were well-supported by their management team.

There were enough staff to cover visits to people, however they were not always at the agreed times. The staff had a good morale and teamwork, communicating well with each other. Some people had consistent staff members visit them and had built up a strong relationship. People were supported by staff who were compassionate.

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

There was a lack of oversight of how medicines were administered and managed. There were no care plans around some higher risk medicines.

There was not always sufficient guidance for staff about mitigating risks to themselves and individuals.

There were enough staff who were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective

Where people had been deemed to lack capacity, there were no assessments that were decision-specific. There were no records of decisions made in people's best interests.

Staff supported people to eat and drink enough and access healthcare services.

Staff received training relevant to their roles and new staff completed a comprehensive induction.

Is the service caring?

Good

The service was caring

Staff were caring towards people and accommodated their needs where possible.

It was reflected in people's records where staff could support people to maintain as much independence as possible.

Staff respected people's privacy and dignity and involved people in their care.

Is the service responsive?

Requires Improvement

The service was not always responsive

The service did not always provide care according to people's preferences and agreed terms.

There was a complaints procedure in place, however not everybody felt confident to use this.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were limited systems in place for auditing and monitoring the management of medicines and the content and quality of visits and care plans.

The culture of the staff team was positive and they worked well as a team.

Mears Care - Norwich

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The provider was given 48 hours' notice because the location provides a domiciliary care service. Notice was given to ensure the management team was available to assist our inspection. The inspection was carried out by two inspectors and two Experts 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.

Prior to this inspection we reviewed statutory notifications we had received from the service. We also reviewed any complaints, enquiries or concerns we received about the service. Providers are required to notify us about events and incidents that occur in the service including deaths, serious injuries and safeguarding matters. We also liaised with social care professionals from the local authority's quality monitoring team.

During the inspection we spoke with 15 people using the service and relatives of eight people. In addition we visited two people at home, accompanied by care staff. We also spoke with the registered manager, the deputy manager, the trainer and seven care staff including four senior members of care staff.

We reviewed 13 people's care records and a sample of 10 daily communication records including medicines' records. We also viewed records relating to the monitoring and oversight of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection carried out in June 2016, we found that improvements were required in the records with regards to medicines administration. At this inspection we found that although the service had improved their process for auditing the administration of medicines, further improvements were still required.

Medicines were not always recorded on people's MARs which lead to a risk of medicines being mismanaged. For example, one person had been prescribed a short course of antibiotics, and there was no record on a MAR of this medicine. We saw for another person that the amount of tablets in their blister pack had changed from seven to eight, and there was no record of what this change was.

Where people had more than one MAR in place for different medicines, some had been overlooked in the auditing process. For example, one person had a MAR for their daily medicines. However, this person also had been prescribed a transdermal patch for pain management. These patches were listed in a recent prescribed medicines list within the care plan on 13 March 2017. We saw when we visited the person at home that a new MAR for their patch had been started on 1 July 2017, and there were no further MARs for this medicine prior to this date available. We had no record with which to check if they had the correct amount and that this added up with what they had received. We receive inconsistent feedback from management and care staff about how these medicines were administered and recorded. This meant that there was a significant risk that people may not receive these appropriately, which could pose a risk to their wellbeing.

People did not always receive the agreed support with regards to their medicines. We spoke with one person who stated that they had forgotten to take their medicines recently because the care staff member simply left them out to be taken. We looked at this person's care plan and saw that the agreed support was for staff to administer and observe the medicine being taken. However, daily records showed that on one recent visit, a care staff member had recorded that they left them there to be taken, with no further information about the reasons for this. This concern was also reflected by another person we spoke with.

For people receiving medicines 'as required' there were no protocols in place for care staff to follow on when to offer these medicines. For one person, their care plan suggested they were at times 'confused', and they had been prescribed different painkillers on an 'as required' basis. One staff member who knew the person well, told us how they established whether to administer the painkillers. However, this was not recorded as guidance so there was a risk that staff may manage this medicine inappropriately. This information is necessary where people may not be able to verbalise how they are feeling. A protocol would provide care workers with information on symptoms a person may display if they were in pain.

We saw that people's visit times were not always carried out as per the agreed plan, which meant they were not always administered their medicines as prescribed. For example, for one person whose records we looked at, they received paracetamol four times a day. Staff had recorded a visit in between 4.30pm and 4.55pm and stated that medicines were given, and again at a visit between 6pm and 6.25pm. This meant

there was a risk that staff had administered paracetamol with just over one hour between doses which exceeded the minimum of four hours interval recommended. The inconsistent times at which medicines were administered may have an impact on some medicines not being fully effective when they were needed or posed a risk of overdosing.

There were risk assessments carried out with people when they came to use the service, and this included information and guidance around people's mobility and health needs. We found for two people using the service, that risk assessments were not in place around their presentation of behaviours which staff could find challenging, despite this having been identified as a potential concern. There was no guidance for staff around mitigating risk to themselves or the people. The registered manager told us that staff would ring if they were concerned, and that social services were asked to provide guidance for one person. In the meantime however, staff were continuing to attend visits without this in place. We noted that staff had not received training in dealing with behaviours which may be challenging.

For people with specific health conditions such as diabetes and epilepsy, there were no individualised risk assessments around this. For example, one staff member explained how they supported one person to mitigate the risks with regards to their diabetes, and what their normal blood sugar range was, including what they would do if they were concerned. This information was not in the care plan. It is important for staff to be aware of this information so that they are able to identify if there is a potential concern.

We also looked at a care plan for one person with epilepsy, and found no information to guide staff on mitigating risk to that person. The registered manager said that staff would take action by calling an ambulance as a response if they were concerned. They said they did not expect staff to know how to support someone if they experienced a seizure. However, it was not clear from the care plan how staff would identify whether a person was having a seizure or how they would support the person to stay safe until an ambulance arrived.

We found for one person, that care staff had consistently reported that the person refused their meals. There was no guidance or risk assessment around this which provided staff with guidance about when to raise concerns. One person whose care records we reviewed was prone to feeling 'down', and another who suffered with depression. However there was no guidance in place with regard to how best to support the people with this and what actions to take.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care staff we spoke with were able to tell us about how they administered people's medicines safely, and we saw that most staff recorded information about this in the daily communication log. Staff received training in administering and managing medicines and this was renewed annually, followed by a competency test. We concluded that although staff had received training in how to manage medicines, there was a lack of planning around medicines for individuals and lack of oversight across the service.

Environmental risk assessments had been completed which identified potential hazards within people's homes, such as checking fire alarms, trip hazards, lighting and access to property. These ensured that care workers and people were aware of risks that could affect them.

People told us they felt safe when receiving support from the service. One said, "I feel safe and I trust all of them [staff]." A relative told us how staff supported their relative to stay safe whilst on their own "They always make sure [relative] has got their pendant [alarm] on." Another relative said, "I'm confident

[relative's] in good hands." Care staff had received training in safeguarding adults from abuse. They understood the required procedures relating to safeguarding and their responsibilities to ensure that people were protected from abuse. They were able to explain various types of abuse and knew how to report concerns.

A relative gave us a good example of a staff member responding to an emergency, "A carer found [relative] collapsed on the floor and did extremely well, rang me, refused to leave, kept calm, kept them calm, covered them with blankets and put a pillow under their head. They checked the first aid procedure." There was summarised guidance in place in the form of a card which staff took with them, which alerted them to signs which may indicate a person was becoming unwell, and who they should raise it to. People's daily log of notes made reference to checking this, demonstrating that care staff had considered the person's well-being during their visit. This helped to ensure that any adverse signs were picked up, and that people remained safe.

The manager told us the service had plans in place to respond to emergencies. There was an on call service which operated out of office hours, which senior staff and the manager took in turn to manage. This was for staff to call if they needed advice. We noted from looking at people's records that staff supported some people to wear their pendant alarms between visits, so that if they required assistance, they would be able to call for it.

Recruitment procedures were robust and only suitable staff were allowed to work with people. Staff records showed the provider interviewed applicants for jobs and took up references and criminal record checks before they were allowed to work with people. This ensured that people received care and support from staff that were suitable to work in this type of occupation.

We received mixed feedback from people about whether they felt there were enough staff, as several people we spoke with felt that staff were rushed. One person reported a recent missed visit. We looked at staff rotas and people's timetables, and found that there were enough staff to carry out the visits, but that staff did not always stick to the agreed times. However, the service was organised within areas where staff had visits geographically very close together. The registered manager explained that if they needed to cover, then one of the office staff was always available to go out and complete a care visit. This was also reflected by staff we spoke with, so we concluded that there were enough staff.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. People who were able to tell us about their care told us that staff asked for consent before delivering support. One person said, "They're very good. They generally ask if I require anything."

People's care records made reference to their mental capacity, however the assessments of people's mental capacity had not included specific decisions. For example, one person's mental capacity assessments stated that they could 'make most decisions', and there were no further records about what these were. We saw in people's care plans that there was guidance for staff where people preferred to make their own decisions about what to eat or what to wear. There were no records of decisions made in people's best interests or who had been involved in these decisions. We saw for one person, who was deemed to lack capacity, that they had been receiving a medicine covertly (hidden by staff in their cereal) for a period of time until December 2016. There were no records in place of best interests around this decision, or records to show that the relevant people or health professionals had been consulted. There was no guidance within people's care plans for staff by about what constitutes day to day decisions, more complex decisions, and who should be involved in these situations. We also saw that one person had signed their care contract despite being deemed to lack capacity to consent meaningfully. We also saw that none of the mental capacity assessments we looked at had been reviewed recently. This demonstrated some lack of understanding about requirements around MCA, which meant we were concerned that the MCA was not fully understood and properly implemented.

Most of the people we spoke with told us that they felt staff were well-trained to deliver the care they required. Staff we spoke with said they were provided with appropriate training to carry out their role effectively. There was a programme of core training, including safeguarding, moving and handling, health and safety, MCA, dementia, skin integrity, medicines awareness and a system in place to make sure staff were kept up to date with refresher training.

On joining the organisation, staff completed an induction training programme which included a period of work shadowing experienced staff followed by a five day training course covering the vital aspects of the role. Staff were also supported to undertake relevant qualifications in health and social care. One new staff member told us how the training in the induction was effective as it had aspects of practical learning and discussion. We also spoke with the member of staff responsible for training, and they showed us some

materials they used.

We looked at some records of supervisions which had taken place for some staff and saw that these included checking the staff member's uniform, how they spoke with people and delivered care, and how they administered medicines where relevant. Staff told us they felt well-supported and that the management team was available when they needed anything.

The support people received with their meals varied depending on their individual circumstances and what they required. Where required, people were supported to prepare food and maintain a balanced diet, and staff supported some people to eat soft diets. One person told us, "They [staff] do good food, they prepare it for me and put it in the slow cooker for me to eat when I need it." Records showed that people's dietary needs were documented, for example, those on a diabetic diet.

People were supported to access healthcare, for example, if they required an occupational therapist to review their equipment needs. They were also supported to access healthcare from district nurses when they required. The staff kept in contact with social services so that they could review people when needed.

Good

Is the service caring?

Our findings

Staff provided support to people in a caring manner and involved them in their care as much as possible. Staff demonstrated this when speaking with us about how they managed their visits to ensure that people received the care and support they needed. One person explained how staff changed their call time to better suit them.

Most people we spoke with were complimentary about the care staff and told us they had a good attitude. One relative told us how staff had a good rapport with their relative, "I think [relative] likes the social side of it really." Another person said, "They are all nice people. I also chat and joke with them. I get on with them and they get on with me." Another relative told us, "They [staff] treat [relative] with respect. They are like a family. I pull their leg and we have a laugh." A staff member we spoke with said, "You've got to treat people as your own family."

However, one person said, "I wonder if they [staff] care at times ... some aren't so good.'" Another person said referring to a specific carer, "[Staff member] doesn't care." Another two people described the carers as "average" and "alright".

One person said to us, "I know the carers well and I know who is going to be here." They said this helped them develop a relationship. We concluded from speaking with staff that they knew people well, including their needs, likes and dislikes. One staff member explained how they communicated with people, saying, "You just have to understand the person." People also told us that staff respected their privacy and dignity.

We saw in some people's care plans where staff encouraged people to do what they could for themselves, maintaining their independence as much as possible. For example, providing prompting to people who could do a certain amount for themselves, and identifying where people required full support.

The registered manager told us how some staff went beyond their role to assist people, for example, getting extra bits of shopping if people needed it. A relative we spoke with also explained to us that the care staff always checked if they needed anything and asked after them, even though it was their relative they were caring for.

We received mixed feedback about whether people felt they were involved in making choices about their care. One person and their relative told us about a piece of equipment that had been introduced into their home without any discussion. Another person said they had told staff how they wanted their cream applied, and did not feel listened to. One relative told us, "I'm totally involved in the care and I'm happy. I check the books to see what they've been doing, and we have an annual review." Another two people said they felt that staff listened to them and involved them. A member of staff explained that they involved families when appropriate, especially if they were concerned about someone, for example, if they refused care.

Requires Improvement

Is the service responsive?

Our findings

We had received some concerns from people prior to this inspection regarding the punctuality of care staff and the times they visited. We found that people were not receiving their visits punctually and visits were not always being planned for the times people requested and care staff were not always staying the required amount of time. A relative said, "'How they cover is a shambles!". They told us that the service was unprepared to cover shifts properly when regular care staff were off. The registered manager said they covered shifts with office staff who could go out and deliver care if needed.

Care staff rotas we looked at demonstrated that care staff were regularly scheduled to attend visits with no travel time in between to allow them to get from one location to another. Care staff did not always stay for the agreed time. Three people and a relative told us they felt visits were cut short by staff. Some people we spoke with stated that they felt staff rushed to their next visit and were pressured for time, and said they shaved time off either side of their visit. One person told us, "They seem to do the job, but in a bit of a rush." This was reflected by several people we spoke with. One person said, "They're [carers] only allowed certain minutes to be here, then they have to rush off, get to the next customer." Another said, "They [Staff] spend their time worrying because they've got to the get to the next one."

Daily record entries made by care staff demonstrated that they did not always stay the required amount of time. For example, we found that one person had agreed visits at 10am for one hour, and 7pm for half an hour. We saw that on two days out of four we looked at, an evening visit was ten minutes, and none of the morning visits were longer than 20 minutes. We looked at another record which stated the person preferred staff to visit at 10am for 45 minutes, 12pm for half an hour, and 6.15pm, for half an hour. Out of seven visits we looked at, we saw that none of them were for the length of time agreed, and all were shorter.

Care was not always provided at the time people required it. We spoke with 11 people who felt that staff did not come within any agreed timescales. One person told us, "The most late is one and a half hours' late, but it's not very often. But I've phoned the office and the times don't correspond with ours [rota], so it's still the same situation." Another person said, "We're allowed half an hour a day, the earliest they come is 8am which is fine for us, but it can be 10.30am that they come. Once they came at seven which was too early." Another person said, "They come at any time. I'd prefer a fixed time." The lack of consistency around people's visits had resulted in a negative impact for some people, one telling us, as "They [staff] get me ready for bed, give me a nice cup of Ovaltine. If they're late, I don't have this." We saw that other people received medicines at inappropriate times.

Care records demonstrated that people did not always receive care at agreed times. One person's care plan, which had been reviewed recently, stated that they required support from 8am. We checked the recorded start times for one week in May 2017. These varied between 6am and 6.45am. Their evening visit was required at 8pm, and the times for this visit varied between 4pm and 6.30pm. For another person, their agreed visits were at 10am and 7pm. We saw that the person was visited before 8am for three consecutive days we looked at, and the evening visits were all before 5pm. The registered manager told us that staff worked out their shift based on people's preferences, and tried to stick with these times. This had not been

updated in the care plan. We observed this to be the case across all of the daily records we looked at, that people were not receiving visits at the agreed time, for the agreed length of time.

We received mixed feedback from people about whether or not they received consistent carers and knew who was coming. One person told us that they used to be told who was coming, but this had changed and they felt anxiety about not knowing which staff member was coming. They said, "You need to know who's coming, it's my home." Another person said, "Sometimes the office don't get it right - we have a list (rota) with the names, but they don't correspond with the ones that turn up." However, staff we spoke with told us that wherever possible, people received consistent carers. When people had more complex needs, they received consistent care staff who knew their needs well. One person told us, "It's the same carer, oh yes." One person we spoke with said, "A letter comes that says who is coming and what time they're coming." They told us their carer was always on time and stayed the proper length of time. They also told us that if the carer was going to be late someone lets them know.

Not all of the people told us they received their care in a way they wanted. Two people said they required a particular gender of care staff. Prior to this inspection, we received some complaints from people and relatives where they had requested a preference of gender of carer, and they had not been able to meet this preference. This had resulted in distress for some people. The registered manager acknowledged that they had not always been able to send the preferred gender of carer, but that for personal care visits they would make every effort to do so.

Although we saw that care records had been reviewed regularly, they were not always updated with relevant changes. People did not always receive individualised care they had agreed with the service.
These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us that staff knew what they needed. One person said, "They do everything we ask them." Another told us, "They [staff] do the same every time they come, and they knew from the start what they're meant to do." However, two people said staff did not always do everything they needed because they rushed, one saying, "They don't always do what's on the paperwork."

People we spoke with told us that staff communicated well between each other by writing in the communication log book and reading this prior to delivering care. One person said, "They do write what they've done, or if there's something different they've seen medically." People's care records included care plans which guided care workers in the care that people required and preferred to meet their needs. These included people's diverse needs, such as how they communicated and mobilised. Care plans explained what people were able to do for themselves and provided instructions for staff on what support people required to meet their needs.

The service had a complaints procedure where each formal complaint was recorded and investigated. However, not everybody felt comfortable to make a complaint. Whilst some people said they would, some people worried about this. For example, one person said they, "Didn't want to rock the boat." Another person said, "If I started moaning and groaning, I worry that instead of better treatment, it will get worse." A third person said, "I don't want to upset people."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in June 2016 we found that there were limited systems in place to oversee the safety of the administration of medicines. We found that the service had not previously identified many concerns we found. At this inspection in June 2017 we found further concerns around the oversight of medicines administration as well as oversight of the care plans and delivery of people's care. There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were some audit systems in place, however they were not effective.

There was a system in place for auditing the MAR (medicines administration records) charts along with the daily communication records. However, there were two different MAR systems used within the organisation. We found that whilst some improvements had been made to the auditing of medicines administration records (MARs), further improvements were required and there was a lack of oversight of some medicines. There was no system in place for ensuring that all relevant MARs for people were returned to the office where they received different medicines, and no system for checking that some medicines had been given as prescribed. Where the service was fully responsible for managing people's medicines, there was no system in place which included staff visiting the person's house to ensure that stock tallied with the records.

The systems in place had not identified that people were not always being given their medicines as prescribed. Where some people were at risk of receiving their medicines at inappropriate times, the registered manager said that staff would call and ask if they were concerned about this, however there was no system in place which had identified or mitigated potential associated risks. We asked the registered manager if there were checks in place within people's homes to check the stocks of medicines, where the service was responsible for these. There was no system in place to check against what had been given, as well as that medicines were managed safely, for example with regards to opening dates if need. This posed a risk that medicines could be used when they were no longer effective or safe to use. The registered manager said that there was not a system in place to carry out these types of checks, but that care staff would ring in if they found any problems. One senior care worker told us they did check this when they had time.

The audits of care delivered did not include analyses of visit times and lengths, and therefore it had not been identified that people did not always receive visits of the length and time required. The manager told us that the daily record was audited when it was returned to the office. We found that it did not address if the person was receiving their allotted time at the time they required, or if this tallied with the time agreed in the care plan. Therefore there was no system in place which checked that people received the care they required and agreed. This had not been included in the auditing of the daily communication book so that action could be taken to address this if needed. The service quality assurance processes had not identified that people were not always receiving care and support for the amount of time they had been assessed as needing it.

We found that there were no systems in place to audit care records to ensure the content and quality was consistent. This posed a risk that an unfamiliar member of staff may not be aware of how best to support people with regards to their individual risks such as nutrition, epilepsy, diabetes and pressure areas. It had

not been identified that some people did not have sufficient guidance in place in their care records with regards to risk. This had led to inconsistent support provided. For example, one relative told us that some staff pointed out any redness on their relative's skin, and some staff did not. There was no system in place for auditing the content of care plans to ensure that they were up to date. It had not been identified where there was a lack of up to date documentation around the MCA and best interests for some people.

Consequently, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of oversight and systems in place to monitor and improve the quality of the service.

The registered manager told us that they had recruited a member of staff specifically to oversee medicines on a full-time basis, and they were starting in post the week following the inspection. Where audits of some medicine records had identified missed signatures, action had been taken to address this. For example where a member of care staff had not signed a medicines record, they were spoken with about this so their practice could improve.

We saw that there has been a new system put into place which updates automatically, and electronic monitoring system so that the office staff are able to see who has received and completed their visits. They were then able to follow up any missed or late visits in a timelier manner.

Prior to this inspection we received a number of complaints associated with staff carrying out visits significantly outside those of times agreed with people. One person we spoke with told us that a carer had not turned up to administer their medicines and they had to do this themselves. When they rang the office the office had not been aware of this. One person told us that they had complained about a specific carer coming in late consistently to visits. They told us that the staff member in the office said that staff member was, "Always like that", and that they didn't do anything about it. This was also reflected by another relative we spoke with, and another person using the service, who told us that one particular staff member was always late. They said they had told the staff in the office but nothing had been done to resolve it.

We received mixed feedback about whether the management team were responsive to concerns raised. One relative said, "They send a survey. No one every takes any action. I don't bother to fill them in now." One person using the service said, "The carers had to take them back in so they know who filled the form in - it's not anonymous." This said this made them feel powerless. However, some other people we spoke with said that they felt comfortable to raise any concerns with care staff and they were resolved. One person said, "If I've needed anything, they (office) soon seem to know."

The staff team had a positive morale, and told us they felt well-supported. One said, "There's always someone on the end of the phone." They said that if their rota changed then they were contacted and informed. One member of staff explained how they coped in their team if care staff were too busy, saying, "If carers don't have enough time I'll go and do the visit for them." All of the staff we spoke with felt that they communicated well between each other. The staff retention was good and many staff we spoke with had worked for the organisation for many years.

The registered manager knew what incidents they were legally required to notify authorities such as the local authority or CQC of.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive the care and treatment they had agreed with the service. Regulation 9 (1) (a) (c) (3) (b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always recorded and there was a lack of oversight of the administration and management of medicines. They were not always administered as prescribed. Risks to people were not always adequately assessed and mitigated. Regulation 12 (1) (2) (a) (b) (f) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records. Regulation 17 (1) (2) (a) (b) and (c)