Austen Allen Healthcare Limited

Austen Allen Homecare

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

We inspected Austen Allen Homecare Ltd on 19 and 20 December 2016. The inspection was announced so that we could ensure people and records we would need to see were available. Austen Allen Homecare Ltd is a domiciliary care agency registered to provide personal care for people who require support in their own home. The organisation is registered to provide care to people living with dementia, learning disability or autistic spectrum disorder, mental health needs, older people, physical disabilities and sensory impairment.

At the time of our inspection Austen Allen Homecare Ltd were providing care to 99 people who had a range of health needs from dementia, end of life care, renal failure, and catheter care amongst other conditions. The service employed 50 staff, one director, one registered manager, an assistant manager, a training manager, two co-ordinators, a care advisor, a branch administrator, a senior carer and care staff. The registered provider uses an electronic tracker where carers log in and out of care calls using a telephone line for all clients from one local authority and relies on staff to record the time of their care calls for other clients.

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

People were protected from the risk of abuse but were susceptible to the risk from avoidable harm. For example, risks were not assessed comprehensively and where hazards had been identified these had not been mitigated fully. During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report.

Medicines were not effectively being managed as the recording sheets used did not contain information about each medicines and prescribing instructions. In addition this information was not contained on any other part of the care plan.

Staff deployment was not sufficient to consistently meet people's agreed care needs. Staff were not given time to travel between care calls and this meant that they were sometimes unacceptably late.

Consent had not consistently been sought and the principles of the Mental Capacity Act 2005 (MCA) had not consistently been complied with. The registered provider was not assessing people's consent to care and treatment and their ability to consent to other treatment and support.

Care plans were not consistently person centred and did not always contain the detailed personal information required to support someone in a person centred way. Some people's care had been commenced without a pre admission assessment meaning that carers were supporting people without a

care plan in place.

Quality monitoring systems were not effective in identifying shortfalls in the service.

People had access to healthcare professionals but they were at risk of not having their health needs met as information was not consistently updated. For example one person was at risk of skin breakdown and had information for staff on how to support them, but this information had not been updated in over two years. We have made a recommendation about this in our report.

The staff were kind and caring and treated people with dignity and respect. Caring relationships were seen throughout the day of our inspection. Staff knew the people they cared for well. People spoke positively about the care and support they received from staff members.

People receive adequate food and drink and where necessary the registered provider used food and fluid charts to monitor how much people are consuming.

Staff met together regularly and felt supported by the manager. Staff were able to meet their line manager on a one to one basis regularly. Staff were supervised and had annual appraisals. Staff were well trained with the right skills and knowledge to provide people with the care and assistance they needed. However, the training programme did not contain any provision for safeguarding children. We have made a recommendation about this in our report.

Complaints were logged and responded to in line with the registered provider's policy.

Care plans were not always up to date. People's preferences and views about their care were not always recorded. We have made a recommendation about this in our report.

The culture of the service was open and supportive. The management team provided leadership to the staff team and was an active presence in the service.

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 consistently safe.

People were protected from the risk of abuse but were not always protected from avoidable harm.

Risk assessments were not comprehensive and did not demonstrate effective control measures.

The deployment of staff was not always sufficient to meet people's assessed needs due to the lack of travel time between care calls.

Medicines were not managed safely. MAR sheets did not list individual medicines, prescribing instructions and were not signed in.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were trained to carry out their role.

Consent was not always being sought in line with the principles of the MCA, e.g. bedrails were being used with no capacity assessment.

People received adequate food and drink and where necessary had food and fluid charts in place.

People had access to healthcare professionals but their healthcare needs were at risk of not being met due to out of date information in care plans.

Is the service caring?

Good

The service was caring.

Staff knew people well and had fostered good caring relationships with people.

People felt they were given a choice but it was not always clear

they had been involved in planning their care.

People are treated with respect and their dignity and independence is upheld

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always person centred and did not contain important personal information or pre-admission assessments.

Complaints were recorded and logged effectively and had been used as a tool for improving services

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The culture of the service was open and supportive and the registered manager supports the staff team.

The management team provided leadership to the staff team and staff felt supported.

Quality monitoring systems had not been effective in identifying shortfalls in service delivery.

Austen Allen Homecare

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.

This inspection took place on 19 and 20 December 2016 and was announced. We gave the service 48 hours' notice so that we could ensure the registered manager was present and that all of the records we needed to see and people we wanted to speak with were available. The inspection team consisted of three 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.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection, the provider completed 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 also spoke to the local authority quality team to gather their feedback.

As part of the inspection we spoke with the registered manager, the director, the assistant manager, two care co-ordinators, the office administrator, ten carers, 12 people using the service and nine people's relatives. As some people who received a care package from Austen Allen Homecare Ltd were not able to tell us about their experiences, we observed the care and support being provided to three people with pre-obtained consent. During these home visits we were accompanied by a care worker. We looked at a range of records about people's care and how the service was managed. We looked at ten people's care plans, medication administration records, risk assessments, moving and handling assessments, accident and incident records, complaints records and quality audits that had been completed. We last inspected Austen Allen Homecare Ltd in June 2013 when we had no concerns.

Requires Improvement

Is the service safe?

Our findings

People were protected against the risks of potential abuse. One person told us, "I feel very safe with this agency, they are reliable. They've never let me down on the whole." Another person told us, "I had a fall a couple of years ago and they were marvellous, they called the ambulance and afterwards called the hospital where I was to find out how I was and when I could come home. They made sure the house was warm and there was food in the fridge for when I came home this was really nice." A third person commented, "I am in good hands and I feel very safe when the carer is with me." Some people supported by the service had pendant alarms for emergency use, which meant they could call for help if they were on their own. Other people chose used a key safe system that allowed carers access to a house key via a secure, coded box. This meant a carer could enter the house even if the person could not reach the front door.

Staff were knowledgeable about the types of abuse and what signs to be vigilant for. Staff members had received training around safeguarding and in addition to this used the module in the care certificate to demonstrate their competency and understanding. The service kept a safeguarding folder that documented all alerts made to the local authority and tracked the outcomes. Safeguarding alerts had been made appropriately and where necessary the registered provider had taken measures to keep people safe. For example, when one member of staff was suspended following a safeguarding alert all the people they supported had their key safe codes changed.

People were not being protected against all potential risks and sufficient action had not been taken to prevent the potential of harm. We examined several risk assessments and found that they did not consistently identify possible risks. The registered provider used a needs risk assessment that was an overall assessment considering areas such as 'weight, pressure ulcers and mental condition'. These areas were then scored on a scale of one to four and a total score was obtained. However, this needs risk assessment did not take account of mobility and for some people with assessed mobility problems there was no additional mobility risk assessment. For example, one person's care plan recorded that they had memory loss and mobilised with the aid of a walking stick, walking frame and a rota stand [a rota stand is a mobile turntable that enables a carer to help a person to safely move from one seat to another]. However, there was no mobility assessment or mobility risk assessment on file for the person. There was a risk assessment report but several parts of this report were left blank and there was no mention of the person's memory loss or mobility issues and the risks that would be present if their mobility aids were not to hand. The person's care plan later stated, "…can walk independently, but using a frame, please don't leave X unattended while mobile." However, there was no further information as to how staff should support the person or whether other previously mentioned mobility aids should be used. Another person's care plan stated, "I am unable to mobilise independently and use a wheelchair for getting around the house. I use a standing hoist for all transfers." However, there was no mobility assessment, no assessment of the level of risk and no guidelines on how to use the hoist. Carers who use a hoist incorrectly could cause damage to a person.

The registered provider did not ensure that people were kept safe from risks or avoidable harm. This is a breach of Regulation 12 of the HSCA Regulations 2014.

Staffing numbers were not always sufficient to meet peoples agreed care packages. People had been assessed and a level of care had been agreed upon between the registered provider and local authority or the person funding the care if it was privately funded. People were receiving the level of care that was being funded. For some clients, carers logged in on arrival and out on leaving the person's home as required by a local authority funder. This meant that the provider could monitor if a carer was late or a call missed. However, staff members and people told us that the registered provider did not provide sufficient travel time between calls and this resulted in carers being routinely late and rushed. One person told us, "All staff are fine during the week but at weekends it can get difficult. For example I am supposed to have a visit at 8.30am and several times they called me to say they could not be with me before 2pm, so I had to cancel it." Another person commented, "My carer showed me her rota. It is very tight, there was no travelling time between the visits to allow the carers to go from one place to another and it is a shame, because of this they have to rush and be gone." A third person told us, "Time keeping is the one and only problem. I am really pleased with what they do but they are so often late especially at weekends. For example, I am due to have a visit at tea time around 5 to 6pm. At weekends they don't turn up before 7 or 7.45pm. I don't like to complain so I have never complained." One staff member told us, "Call times are tight. Social services see half an hour as enough for most people. So we do as much as we can in that time. We don't get driving time so we are always trying to make up time and normally I do." Another staff member commented, "There's enough time except no travelling time. On your regular round you know the calls well and how to do what's to be done in the time, and how to get from one to the other. But if you're covering elsewhere or are new, you lose time reading care plans and finding your way around." A third staff member commented, "Calls are an appropriate length for doing what needs to be done, but there's no time to get from one call to the next. After your fourth call you're an hour behind. Evenings don't seem so bad, but I do worry some staff rush people in order to get away, or even don't stay the full time, whereas I prefer to not rush people and accept getting late. When I first started I'd get really late and if I'm covering a different run it's really difficult. Sometimes I rely on having a half-hour gap in my rota to help make up for lost time."

We reviewed staffing rotas and electronic call monitoring (ECM) data and found that some calls were being made later than planned. ECM is a system whereby carers log in and out from home visits using a landline telephone. Examples from the ECM data we reviewed showed that for the seven days of data we examined for people who use the ECM system 50 care calls were delivered more than an hour later than the agreed time. Furthermore, of these 50 late calls, 11 were more than an hour and a half late, with some being over two hours late. Some care calls had been longer than agreed showing flexibility on the part of the service to respond to peoples' changing needs. However, some calls had been shorter than the agreed time which could indicate staff members leaving calls early to make the next appointment on time. The calls we examined were a random sample of just some of the care calls that the registered provider makes. Nevertheless, the data demonstrated that some carers are not making their care calls on time and are cutting short some visits. We examined staff rotas and these confirmed that care calls are being booked without any travel time between the calls so that one care call is from 08.00-08.30 and the next call for that staff member will be 08.30-09.00. This pattern can sometimes go on for over five hours, with ten 30 minute calls assigned to a carer without a break or travel time factored in. We raised this with the registered manager and were told that staff members were not paid for travel time but are paid their travel costs. Staff were advised to start their shifts thirty minutes early to allow for time to travel.

The registered provider did not ensure that ensure that staff had sufficient time to deliver care. This is a breach of Regulation 18 of the HSCA Regulations 2014.

Medicines were not consistently being managed safely. Carers told us they were involved with supporting people with medicines and the registered manager told us carers "only do prompt and assist". Where medicines were administered from a pre-prescribed monitored dosage system (MDS) pack the carer signed

the daily record of care. We were told that the provider did not use Medication Administration Record (MAR) charts. We observed during home visits that there were no MAR charts in use. This meant that administration was not recorded for each medicine but aggregated for time of day. There were not full and accurate entries made on the care records to indicate which medicines were prescribed for the person, when they must be given, what the dose is or any special information, such as giving the medicines with food. Where people had medicines delivered in blister packs from a pharmacy staff members who were supporting people with their medicines were recording, "dosette box" on the care record to say the medicines had been given. However, there was no corresponding record to say what was contained in the 'dosette box' (as documented on the care record) covering the administration dates of that chart. Carers signed that they had witnessed medicines being taken, had made them available for the person or the person had refused. The categories on the form were for MDS (dosette box), MDS 2 (if there was a second dosette box), and liquids (which had to be given from a prescription bottle. On another home visit (to a new client who was having a second day of service from the provider) a carer told us "It's my second time." The second carer told us "I haven't been before." And they had to ask a family member "Where's the dosette box for this afternoon's meds?" A carer told us "We haven't got a proper dosette box from the pharmacy." We asked the carer how they would know what the medicines are and they told us, "We wouldn't know."

Application of topical creams was recorded in the daily record of care. The care plan gave written directions for the application of creams. However, we did not see a completed 'body map' in the office copy of the care plan (which contained a blank form) or the care plan at the person's home. The registered provider did not use PRN protocols which would provide guidance for the use of 'as needed' ('as required') medicines. We reviewed a staff induction folder which described recording the administration of PRN medicines. It stated 'When a client is put onto this kind of medication, the carers should enter the details onto the medication record with all details including how many times a day, what dosage, the name of the medication. They should be signed for as you would normally sign to say that you have assisted, prompted and monitored the client taking their medication.' During a home visit to a new client, we saw that a person had four daily visits and that medicines were given four times a day. However, on the 19th December, the first day of service from the provider, administration of medicines had been recorded only twice. In one case, morning, this was in the general notes of care on the upper page, not in the lower medicines section. In another case, lunchtime, it had been recorded on the form in line with the provider's usual practice. At teatime, the relevant box was crossed out and for bedtime nothing was recorded.

The registered provider did not ensure that ensure that medicines were managed safely or in line with best practice. This is a breach of Regulation 12 of the HSCA Regulations 2014.

Safe recruitment practices were in place and being followed. We checked the recruitment files for four members of staff. In all cases thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff members were appointed and references were obtained from the most recent employer where possible.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "They are well trained for sure; they seem to be very knowledgeable." Another person told us, "The staff come every day and do exactly what we agreed." A relative told us, "If anything needs to be discussed, the carer does discuss it with her and not me her daughter, which is good because this is the way it should be. My mum is perfectly able to make her own decisions but needs to be given plenty of explanations and the carer does that well."

Consent had not consistently been sought and the principles of the Mental Capacity Act 2005 (MCA) had not consistently been complied with. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We saw that care plans contained references to mental capacity. However, they lacked an underpinning assessment. For example, one person's individual support plan (viewed at the provider's office) stated 'No' to whether a person had capacity because the person 'forgets to take (their) meds'. The care plan at the person's home, which we viewed with their consent, stated that the person was 'able to make simple decisions, unable to make complex decisions'. We did not see any reference to the decision specific or variable elements of capacity. Other people had statements in their care plans that stated they lacked capacity but there was no capacity assessment. We raised this with the registered manager who felt that the service should always refer to a GP or professional to make capacity decisions. After a discussion with the registered manager and director, around the Mental Capacity Act 2005 and best practice guidelines, the registered provider agreed to amend their policy for assessing people's capacity.

The registered provider did not ensure that consent was sought in line with the Mental Capacity Act 2005. This is a breach of Regulation 11 of the HSCA Regulations 2014.

Staff had appropriate training and experience to support people with their individual needs. There was a training plan in place to ensure staff training remained up-to-date. This system identified when staff were due for refresher courses. The registered manager had recently employed a training manager who monitored staff training needs and scheduled training courses for staff. Staff members were able to request extra training courses. We saw that where people needed specific or specialised support their staff team were trained in these areas. A carer we spoke with had achieved National Vocational Qualifications [NVQ also known as Qualifications Credit Framework or QCF] in health and social care at levels two and three. Carers had received further training on catheter care and percutaneous endoscopic gastrostomy (PEG) feeding to meet specific individual needs. This was done through training provided by a district nurse, completion of an online questionnaire and supervision in practice.

The registered provider had a spacious, well equipped training room that contained a bed and a hoist for practical training sessions. Information was available on types of hoist, rota, stand aid and slings. We saw MDS containers for medicines and a variety of DVDs such as 'moving people', 'pressure ulcer prevention' and 'understanding dementia'. After each training course staff members complete a feedback session in order to improve training provided. The training manager told us that as the service only supports adults they do not cover safeguarding children in their training programme. However as people's visitors or relatives can sometimes be children it would be best practice to include safeguarding of children in the training programme.

We recommend that the registered provider reviews the need for safeguarding children training in their training programme.

Staff members received an effective induction and had demonstrated their competence before they had been allowed to work on their own. New staff members have a three day induction at the head office and then work through the care certificate. The care certificate is a nationally recognised learning tool based on an identified set of standards that health and social care workers adhere to in their daily working life. It has been designed to give everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care. The Care Certificate was developed jointly by Skills for Health, Health Education England and Skills for Care. Staff members had access to supervision and appraisal. One staff member told us, "We get 1-1 supervisions and spot checks. It's important because we work with vulnerable adults and we need to know if anything is not quite right. Should we need help, the office is there, on-call is only a phone call away 24/7." Another member of staff commented, "I've had regular 1-1 supervision, get a text about where to meet. I think it's important for the company to check up on how we are, and that we are providing the care they've taken on." We checked staff files and saw that supervisions were happening in line with the registered provider's policy.

People were supported to have access to sufficient food and drink. People felt that they were supported well with their meals. During our visits to shadow people's care we observed staff members making food and drink for people. One person told us, "They don't cook but they prepare sandwiches for me; one set with jam so I can take my pill [medicine] with it and another set with meat for the evening, the sandwiches are always done with care, they always look nice. The carers always leave me with a cup of tea just the way I like it and they would do me a flask if I need one." People's nutrition and hydration levels were monitored where there was a medical need to do so. Where this was the case staff members would use the person's daily care notes to record how much people had eaten or drunk. People with specialised diets or individual health needs were supported to have sufficient nutrition and hydration. Some people required to be fed via a percutaneous endoscopic gastrostomy (PEG), which is a medical procedure in which a tube is passed into a person's stomach through the abdominal wall to provide a safe mean of feeding. There were clear guidelines in place for giving both food and liquid through the PEG tube and staff members were sufficiently trained to use this system.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician. People had a health action plan which described the support they needed to stay healthy. Some people had a range of professionals involved in assessing, planning, delivering and evaluating care. A person we visited had a district nurse, occupational therapist and physiotherapist involved in their care, and the person told us the district nurse was "very good". However, we found one example of a person's care plan that had not been updated for over two years. The person was at risk of skin breakdown due to pressure wounds. There was advice in the care plan for staff to follow to keep the person's skin healthy and guidance on what to do if staff members feel the skin is becoming unhealthy. However, as this information had not been regularly updated there was potential that the person's needs

had changed or their skin care regime had been altered.

We recommend that the registered manager reviews all care plans to ensure that they are up to date and reviewed regularly.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. Comments included, "They are really kind and caring. I have a very good relationship with all the ladies who come." "My wife has a stroke and can no longer talk; she sleeps most of the time. We get support from [other provider] as well as Austen Allen; the carer always chats to her as if she could understand everything, always smiling, keeping the atmosphere happy for her and telling her what she does as she does it." and "They are really respectful and understand what it is like to be old and needing other people to do things for us we used to do ourselves." One relative told us, "Our main carer is very obliging and understanding of my mum. In three years we have been extremely happy with the agency. My mum has memory problems and wears hearing aids. The carer always checks that she has them in before she speaks with her."

People received care and support from staff members who had got to know them well. Care plans were started at the commencement of any package of care. The registered provider told us that a comprehensive risk assessment of each individuals needs would be completed by the care advisor and that they would obtain information on the client's health needs and personal history and discuss their choices and preferences. The registered provider informed us, "Family members would also be invited to this assessment so that they would be able to provide additional information to allow the care plan to be written in a person centred way. This would take into account any cultural and religious beliefs under the company's policy on the Equality Act 2010 and covering standard four, equality and diversity, of the care certificate. Once the care plan is completed information is fed back to the coordination team who will allocate and match a carer to a client, based on the needs assessment. The care plan will be returned to the individual's home and a signature is obtained to ensure we have their consent to care/treatment." People told us that they had got to know their care staff well and this was evident when we observed support given people in their homes. One person told us, "My main carer is more like a friend now because we got to know each other pretty well over the past two years."

The relationships between staff members and people receiving support demonstrated dignity and respect at all times. A person we spoke with and a relative told us that regular carers were provided and they valued this aspect of the service. During a home visit we made, a relative who was visiting a family member who received care told the carer, "I see you every Tuesday. I don't think I've seen anyone else." The carer told us they usually visited the person twice daily five times a week. A person who had one daily visit told us that they had the same carer from Tuesday to Friday (family assisted at weekends). They told us, "I have one lady who comes on a Monday to give me a shower and hair wash." The person told us they were happy with both carers. Another person told us, "Because I can't move much I tell them what to do and they do it; they are my arms and legs when they come, my 'fetch and carry'. I could not manage without them, they are a lifeline really. It works very well. When I need more done like a little laundry they are happy to do it if there is enough time."

People were supported to maintain their independence and told us they were given choice in their day to day care. One person told us, "My mum is very forgetful but she has all her brain. If anything needs to be discussed, the carer does discuss it with her and not me her daughter, which is good because this is the way

it should be. My mum is perfectly able to make her own decisions but needs to be given plenty of explanations and the carer does that well." One staff member commented, "I believe clients make choices about care plan content where they can. We always have to respect people's wishes if they don't want what's in the care plan. Our training tells us to document refusals of care." Care plans stated what people could do for themselves. One person's care plan described their limited ability to engage with personal care and declared that, "X can roll in the bed on prompting, but does need full assistance for other tasks."

People's dignity was respected by staff. During home visits we made with carers, we observed that they respected people's privacy and dignity when supporting them with personal care. Staff knew people's individual communication skills, abilities and preferences. One staff member told us, "For people with dementia without capacity we are directed to include them in choices as much as possible. If an issue affects safety, like not taking meds, we have to phone in. There can be balance issues when a family member doesn't agree with the client. Dementia training has helped develop ways of working with people with varying capacity. We learnt about approaches to offering encouragement, and recognising things like changed perceptions of time. But it's hard if the family don't appreciate the issues in the same way." There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. People's views were sought through care reviews and annual surveys.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not consistently person centred and a lack of pre-assessment information meant that new clients may not receive a person centred service. Some care plans we reviewed contained good personal information. One persons' care plan gave good background information on their personal history. The plan gave information on where the person grew up, how they found school, where their first apprenticeship was, in this case studying art and needlework. A history of how and where they met their late husband was provided with interests such as 'loved table tennis and cycling when younger', and gave family information such as how many children and grandchildren the person had. Staff members could use this background information when supporting the person either to reassure them by talking about their past or to start conversations.

However, some care pans lacked person centred information. On a home visit to a person who had begun to receive a service recently, we reviewed the care plan with the person's consent. We noted a document entitled 'temporary overview'. This was document was not signed or dated and contained only very basic information, such as 'meds to be given' but no description of what the medicines were and what dosage or illness they were treating. It was not sufficient for care workers to be able to care for the person in a person centred way and carers had to ask lots of questions about how to do things and where things were in the person's home. We spoke to the registered manager about the pre-admission assessment process. The registered manager told us, "[Local authority] give us comprehensive care plans before we start care but [another local authority] are hit and miss. We tend not to get health information and social information. One local authority requests a 48 hour period between us getting the referral and setting up the care service. Sometimes the carers are going in blind. If we don't have the info we have the temporary overview of care." We asked the registered manager how they reduced the risk of sending carers in without a support plan and were told, "We send more experienced staff who know how to do a visual risk assessment and where needed we will send two people."

Care plans were not always detailed enough to allow staff to support effectively and to provide person centred support. One staff member told us, "Care plans are useful but not in depth. Here we just know the basics. There are some person-centred choices, and information about meds. Plans are to the point I suppose, they show what has to be done. I believe clients make choices about care plan content where they can. We always have to respect people's wishes if they don't want what's in the care plan. Our training tells us to document refusals of care." Another member of staff told us, "Care plans are straightforward, mainly bullet points." A person commented, "My main carer is helpful considerate and thoughtful. The replacements when she was on maternity leave were hit and miss though, in and out and not thorough. Quite a lot of different faces. There was no handover and I had to re-explain what I wanted them to do." The care plans we reviewed were functional and relied on staff members having prior knowledge of the person from working with them. People generally had regular staff members who had got to know them well. For example, one person told us, "They do everything they are supposed to, they know how I like things done, for example how I like my bed to be made and how much sugar in my tea, it is the little things like that that count." Despite continuity of staff care plans were written with a lack of detail that did not capture the person's preferences. As such people preferences were not captured. For example, one person's care plan

stated, "Assist X to the bathroom for a full body wash." There was no detail about how the person would like to be washed, e.g. did they use soap or body wash etc. Another person's file stated, "I would like the carers to prepare all food and drinks at each visit." However, there were no details on the person's preferences or dislikes.

The registered provider did not ensure that care was consistently delivered in a person centred way. This is a breach of Regulation 9 of the HSCA Regulations 2014.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The complaints procedure sets out stages and people who are responsible for responding to complaints at different stages of a complaint. Each complaint was given a unique reference number and was assigned an investigating officer. The complaints policy ensured that each complainant received a letter of receipt, an investigation report and if the complaint was not resolved at this stage an arbitration date would be offered.

There had been ten complaints made in 2016. We tracked one detailed complaint to see what action had been taken to resolve it. The registered provider had written to the complainant to apologise and inform them that they will be carrying out a full investigation. There were five parts to the complaint and the registered provider had responded to each part. For example one section of the complaint related to poor procedures being followed around medicines. The registered provider had acknowledged this and had amended the person's care plan to ensure this would not re-occur. In addition they had re-trained the staff member. All areas of the complaint had been responded to in line with the registered provider's policy and an action plan had been formulated to ensure that the organisation learned from the complaint. One action form the action plan was for more regular spot checks to be initiated and for the family to be contacted regularly for their feedback. The management team had ensured this had happened.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives spoke positively about the registered manager, the management team and the registered provider. One member of staff told us, "What I really like is that management are very experienced in care and on-call support is therefore very responsive. I'm on three months' probation. I can't praise the management enough; they keep in touch with how I'm doing." Another staff member told us that the management are always available, "There's clearly no holding back on the part of staff who want to see the manager or coordination team." A person told us, "My carer says she likes her supervisor and the managers. She has been with the agency a long time."

The provider did not have effective systems in place to monitor the quality of care and support that people received. The last quality assurance survey collated the results of 77 reviews which had rated the registered provider on ten questions and rated the service from one to five (with one being poor and five being excellent). The results were fed into a management review and used in the annual quality audit. The registered provider used an ISO 9001 quality monitoring system. The ISO 9001 is a quality management system that is used globally. However, the quality audits had failed to identify several shortfalls in service. Areas for improvement that had not been identified in the quality audit included, care plans that had not been updated for over two years, risk assessments that were partially blank, medicines systems that were not safe to use and mobility assessments that had not been completed.

The registered provider had not ensured that quality monitoring systems were effective in highlighting shortfalls in the service. This is a breach of Regulation 17 of the HSCA Regulations 2014.

The registered manager explained that there were service user reviews where management assess people's care plans and spot checks were in place. The registered manager had six staff members who conducted spot checks to ensure that standards of care delivery were being met. The registered manager told us, "We have created a new position to monitor quality. This is a new post we created two weeks ago as we identified quality as an area we can improve on." The director of the organisation attends staff meetings and branch meetings. During these meetings senior staff members speak about their role and can forward any ideas they may have to improve the service. Staff meetings were held over a two day period allowing staff members the opportunity to attend regularly. The registered manager ensured that daily record reports were read through and checked. There were surveys that had been sent out to people to ask how they viewed the quality of the service they received. The survey asked questions such as, 'How would you rate your continuity of staff' and 'how would you rate your carer in terms of respecting your privacy and dignity'.

The culture of the organisation was open and supportive and staff felt that teamwork was a strength of the organisation. One staff member told us, "We are a strong team; mostly I work in a pair with a consistent colleague." Another staff member commented, "It feels like real team work. A lot of the work involves two staff, but I also know all the other staff well through the office and training. I remember four days solid induction, and shadowing experienced staff. I now have people I see regularly but obviously we all get involved in covering other rounds. The company always stresses the vulnerability of people we care for. They try to make sure people get consistent staff." The acting manager told us, "We have an open door policy and

anyone whether its people, their family, friends or staff they can all come in or call us. We have social events where people can meet us like Macmillan coffee mornings. Our lines of communication can always be improved but people can call anyone in the team or the director. We liaise closely with service commissioners and care managers in the local authorities."

The registered manager described how the director of the business gives supervision and appraisal to management posts and is highly visible in the business, which feeds in to the open culture of the organisation. The registered manager told us, "[Director] knows all about the issues and provides support. I also have the support of an external HR advice line. We don't sit on any issues staff bring to us; we act and that is part of the culture." We examined records of staff disciplinaries and found that the management team had been proactive in dealing with staffing concerns and performance issues. We reviewed the performance management record for one staff member and found that the registered provider had followed their disciplinary policy and this resulted in a positive outcome.

The registered manager provided effective leadership to the service and told us, "I am a strong leader and can identify with the issues that staff members bring to me. I work very closely with the assistant manager and the director and we have group meetings to discuss any problems. I'm always available to speak to staff if they don't want to talk to another manager and as I used to be a carer the staff relate well to me and feel able to chat to me and raise issues." The registered manager described how the organisation recognises when staff go over and above their job, and they are bought flowers or given other forms of recognition. The registered manager identified that recognising staff who do well is an important part of managing the service. The registered manager told us, "Senior staff have been given a bonus for their hard work and we have a continuity of service bonus. One staff member started as an apprentice and worked their way up. Another staff member started as a carer was promoted to a co-ordinator, then lead co-ordinator and now is training to be a manager. The staff know they can progress in their role here." The registered manager identified recruitment as one of the main obstacles in the future for the organisation.

The registered provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered provider confirmed that no incidents had met the threshold for Duty of Candour.

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 registered provider did not ensure that care was consistently delivered in a person centred way.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not ensure that consent was sought in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure that ensure that people were kept safe from risks or avoidable harm. The registered provider did not ensure that ensure that medicines were managed safely or in line with best practice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured that quality monitoring systems were effective in highlighting shortfalls in the service.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider did not ensure that ensure that staff had sufficient time to deliver care.