

Accommodating Care (Driffield) Limited

# Accommodating Care (Driffield)

## 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 was an announced inspection which took place on the 4th and 18th January 2018, and 15 February 2018. The inspection was announced to ensure that the registered manager would be available to assist with the inspection visit. At the last inspection, the service was rated good. At this inspection we found the service to be requires improvement in safe, effective, responsive and well-led.

Accommodating Care (Driffield) is a domiciliary care provider which supports people with personal care who live in their own homes in areas of the East Riding of Yorkshire. They support people with a range of needs, including people living with dementia. At the time of our inspection there were 48 people using the service.

Not everyone using Accommodating Care (Driffield) was receiving the regulated activity; the Care Quality Commission (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 in post at the time of our inspection that had been running the service since August 2017. Following the inspection the local authority advised us that the registered manager had served their notice and was due to leave the provider within a couple of weeks. A registered manager is a person who has registered with CQC 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.

Staff were knowledgeable about maintaining people's safety and how to report any abuse or allegations of abuse should they need to. However, we did find that safeguarding information had not been recorded centrally and the provider lacked oversight in this area.

Staff training schedules were not in place to identify training that had been completed and highlight when refreshers were due. Some staff records showed very little training and the provider did not have this information. We could not be sure that staff had received the training necessary to carry out their roles effectively. This was an area the registered manager was reviewing in order to ensure all training was current for all staff.

Disciplinary procedures were in place and the provider had utilised these when necessary. However, when errors had been identified and the disciplinary process opened, staff had not been offered additional training to support them and observations to check competency had not been considered.

Accidents and incidents were recorded in people's individual care files. However, these were not always fully completed and lacked details of actions taken and referrals made to other health professionals. There had been no overall analysis or review so that lessons could be learnt.

Recruitment processes were not robust. The registered manager had obtained only one reference for some employees, identification documents were not always present and some application forms contained conflicting information that differed from the curriculum vitae provided. We could not evidence that the registered manager had questioned these discrepancies at the interview stage.

Risk assessments did not always contain sufficient detail to guide staff in how to mitigate risks and some had not been reviewed since 2015.

The provider had failed to implement regular checks to identify medicine errors despite their being recent issues with medicines administration. Since our inspection the local authority were supporting the registered manager to improve in this area.

People told us they received consistent carers that attended within thirty minutes either side of the allocated timeframes. People told us that staff offered choices to them and supported their independence. People felt that staff respected their privacy and dignity at all times and were competent and skilled to meet their needs

Policies and procedures were in place. However, these had not been regularly updated and some did not contain sufficient information to guide staff on current legislation and best practice.

Staff supervisions and appraisals had not been completed in line with the provider's policy and procedures. Staff meetings had not been held regularly to support staff and gain their feedback to improve the service.

Staff supported people to maintain relationships with their families and friends. Relatives and representatives had been invited to attend reviews of their care and support needs.

People were supported to eat nutritional diets and staff offered them choices and knew people's preferences. Daily notes contained information about tasks staff had completed during their visits and recorded important information, such as people's health and well-being, food and fluid intake and weekly weights for those people at risk of dehydration.

Staff told us that communication had improved in the service and they felt confident that the registered manager would address any concerns or issues they might have. People and their relatives told us that the registered manager kept in regular contact and was always helpful and polite. Some people told us that they had received a visit from the registered manager and that they felt they had really listened to them.

Satisfaction surveys had been completed by people and their relatives and the majority gave positive feedback. However, for those that contained complaints and issues there was no evidence that these had been addressed or that any actions had been taken.

The registered manager provided information on advocacy services so that people could make informed choices and gain additional support if required. Best interest decisions had been recorded and relevant health professionals and representatives had attended when people were unable to make decisions for themselves.

End of life support had been provided to people and compliments had been received from one of the families for the support and care shown during this time.

There was a lack of senior management oversight. Systems and processes were not in place to ensure that

risks were mitigated and issues identified, analysed and improvements made. The registered manager had been attending calls and struggling to implement improvements to the service due to a lack of leadership support. Recently the organisation had employed a care coordinator to oversee rotas and support with daily duties.

Staff raised concerns that the provider found it difficult to maintain staff and senior management roles. Over the last 12 month period the registered manager had struggled with staff shortages and therefore improvements to service delivery had not been prioritised.

People's personal information was kept in locked cabinets to maintain confidentiality. The staff handbook included information about the data protection act and the responsibilities of staff.

We found three breaches of legal requirements relating to safe care and treatment, on-going governance of the service and staffing under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Safeguarding incidents were not logged in a central place so that the provider could analyse them to ensure preventative measures were put in place and lessons learnt.

Accidents and incidents were recorded in people's files, no overall analysis had been completed and actions taken were not always recorded. Risk assessments did not always include details of preventative measures to mitigate risks so that staff had guidance to follow.

Medicines were not always safely managed and administered.

The provider supported people to be as independent as they could be and supported people's choices and preferences.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

We found not all records demonstrated staff had completed inductions, competency checks and basic training. No records were in place to identify training staff had completed and needed to refresh.

Supervisions and appraisals had not been completed in line with the providers policies and procedures.

Staff knew the importance of gaining people's consent and respecting their choices. Staff supported people to access services from other health professionals when needed.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

People told us that staff were kind and compassionate towards them. They were knowledgeable about their needs and

**Good** ●

supported them well.

Care plans detailed people's likes, dislikes and preferences and staff offered choices in line with the information recorded. Staff supported people to maintain relationships with their families and friends.

Staff supported people to be as independent as they could be by encouraging them to do things for themselves when they were able.

### **Is the service responsive?**

The service was not always responsive.

Staff felt that additional training specific to people's needs would assist them to support people in a more person centred way.

People were involved in their care planning and reviews. However, these were not consistently and regularly reviewed so that they reflected people's current needs.

Complaints were investigated thoroughly and regular correspondence was sent to complainants outlining actions taken and what they could do if they were not satisfied with the outcomes.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Senior management lacked oversight of the running and management of this service. Systems and processes were not in place to regularly analyse and monitor information to drive improvements.

Staff had not been given the training, skills and support to carry out their roles in an effective person centred way.

Safeguarding and accidents and incidents information had not always been fully documented, it was difficult to see whether appropriate actions had been taken and, where actions had been put in place, whether these had been carried out.

**Requires Improvement** ●

# Accommodating Care (Driffield)

## **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 4 and 18 January and 15 February 2018 and was announced.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

On the first day the inspection consisted of one expert-by-experience contacting people that received a service and their relatives by telephone for their feedback on the service. A further two days were completed on site by one inspector. The three days included telephone discussions with people using the service and their relatives, a visit to two people's homes and review of records kept in people's homes. We visited the office location on 18 January and 15 February 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection team consisted of one adult social care inspector 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. Our expert had this experience.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make." We contacted the local safeguarding team and commissioners. We also reviewed notifications sent to us by the provider. Notifications inform us of important changes and events that may affect people receiving a service.

During the inspection we spoke with ten people using the service, three of their relatives, one care co-ordinator and the registered manager. We observed interactions between staff and people supported by the agency. We also reviewed records, including training and recruitment for five staff; five people's care plans and reviews, minutes of meetings and other documentation relevant to the running of this service.

Following the inspection we were contacted by two health professionals who gave us feedback about the service and we spoke with a further five members of staff by telephone.

## Is the service safe?

### Our findings

The provider had a safeguarding folder in place which included a monitoring log; this did not contain all safeguarding referrals made and actions taken. This meant that it was difficult to have oversight and analyse information to ensure people's safety was maintained. We identified one notification of abuse that had not been sent through to the Care Quality Commission (CQC). The registered manager advised that this would be submitted to CQC without further delay. This was a recent and isolated incident.

When we asked staff about whether they had completed safeguarding training they advised, "I have had no safeguarding training since my employment here, I did some basic training in 2016 as part of my induction with another employer" and other comments included, "I would like to do more refresher training, the only training I have redone is for medicines last week" and another member of staff said, "The only training I have completed in the last twelve months is medicines training last week." A further two staff we spoke with could not remember when they last completed their safeguarding training. Systems were not in place to record when training had not been completed and training was not provided as recorded in the provider's policies and procedures. This meant that the provider had failed to ensure staff had the competence, skills and experience to deliver safe care to people.

Despite the lack of training, staff were knowledgeable about the different types of abuse and how to report them. One member of staff told us, "I would report to my manager. I have a list of safeguarding numbers in my car if I need them." Another member of staff advised, "I would report any abuse to my line manager, the office and make sure a concerns form documented any incidents or concerns."

We saw some incident reports within people's folders. However, the incident forms were not always fully completed and often lacked details of the actions taken or referrals made to other agencies or health professionals. This meant that we could not be certain that appropriate actions or referrals had been taken as no overall analysis had been documented.

When asked about call times, staff told us, "I visited one person at lunchtime who had not received their morning call. Their last call would have been the previous day at lunch time. The person was still in their nightwear, I reported this incident to the office staff." On further discussion the staff member advised us that this person was totally dependent on them to prepare meals on their behalf and provide personal cares."

We asked people if they received their calls on time and if staff were running late were they informed. We received mixed feedback, one person said, "Morning call is often a half hour late and no I don't get told," another person told us, "Yes I am first call at 7am and carers will let me know if they are going to be late" and "No not always and I don't get informed if carers are late. If over half an hour late, I call Accommodating Care." Relatives advised, "Carers can be a half hour late, but mum will wait" and "They are timely and if late carer always calls us." The registered manager told us that a new system would hopefully enable them to monitor call times more accurately and that they were scheduling spot checks so that they could speak with people and gather their feedback.

On the whole staff told us they had enough time to meet people's needs as stated in their care plans. However, one member of staff said, "Some people's needs have changed due to their mobility so they take longer than the call time given. This then makes us late for our next call."

We looked at the recruitment files for five members of staff including: employment references and application information. We found that recruitment processes were not robust. For the five staff records we reviewed there were four previous employment references obtained and two of those required further verification as they were not on letter headed paper or stamped by the company. One file had no identification documents and another application form and accompanying curriculum vitae stated different dates for the same previous employer. The registered manager could not show that any further checks had been completed or that these discrepancies had been questioned during the interview stage. The registered manager advised that they would ensure thorough checks were completed during the recruitment process.

Both generic and specific risk assessments were in place. Some of the generic risk assessments advised, 'refer to needs reflected in care plan' – these lacked sufficient detail for staff to follow. We saw that fire risk assessments included identified risks and actions taken to mitigate them. The fire service had supported the agency to obtain fire blankets, fire alarms and smoke detectors for people that smoked and were classed as a higher fire risk. Lifeline pendants and vibrating alarms for those hard of hearing were in place. However, some generic risk assessments did not include enough detail about the measures in place to mitigate risks so that staff had guidance to follow. For example, one housekeeping and shopping risk assessment stated 'needs support around food safety' – no other information was included so it was unclear as to the type of support required and the exact area of risk.

Another risk assessment identified a person as being at 'risk of falls and vulnerable to skin tears' it also stated that they had a pressure sore. There were no details of any referrals made or any involvement from other health professionals. There was no guidance for staff to monitor or complete any type of recording such as a body map to show the current extent of any skin damage. The same person had a risk assessment in place for control and prevention of infections that had not been reviewed since 2015. We could not be certain that the information was current and reflective of this person's needs. This meant that the provider had failed to do all that is reasonably practicable to mitigate risks to people's health and safety.

We saw that medicines were stored safely, obtained in a timely way and disposed of appropriately. However, when we reviewed administration records (Dom Mar Charts), we saw that when staff should have administered medicines some had been missed - no notes or codes were recorded to advise why they had been missed. The providers 'Medication Policy and Procedure' advised that it was the registered manager's responsibility to monitor medicine practices through regular supervision and auditing. The provider had failed to comply with their medication policy and procedure.

Staff had not fully completed dom mar charts – some medicines that staff administered did not have codes to confirm why they had not been given. When a medicine is not given, the local authority's policy states that the code should be documented and for some codes additional notes are required. Records for transdermal patches did not record where they had been placed on a person's body – it is best practice to record this information so that they are alternated to lower the risk of skin soreness and irritation that may be caused when re-applied to the same site. The registered manager told us they would ensure these were recorded on either body maps or on the dom mar charts in future. Medicines that were taken 'as and when required' (PRN) had protocols in place for staff to follow.

In addition to the above, we saw that medicine administration errors had been raised as an issue during team meetings back in 2016 and since then several errors had been reported to the local authority. The

provider had failed to put systems in place to support staff with medicines administration. Regular audits and competency checks had not been completed to identify the errors we highlighted during the inspection. We raised these issues with the registered manager and they liaised with staff to ensure everyone completed medicines training so that their knowledge was up to date – since the inspection we have received confirmation that all staff whose medication training was out of date have now attended this training.

The above concerns were a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with supported by the agency communicated that they felt safe. One person said, "I always feel safe and comfortable" and another told us, "I have no reason not to feel safe." Relatives advised, "I am sure [Name] does, we feel quite safe with carers" and, "[Name] feels safe in the knowledge that carers are coming daily."

## Is the service effective?

### Our findings

We checked the provider's 'Staff Training and Development Policy'. The policy recorded staff should receive induction training which covered; moving and handling, food safety and hygiene, infection control, health and safety, record keeping, accidents and emergency procedures, administration of medicines, policies and procedures, introduction to work practices and requirements and safeguarding. This policy was last updated in March 2015. Although this policy did not detail how often training was to be updated, the 'Infection Control Policy' which had been reviewed January 2018 advised, 'All staff will commence infection control training and update bi-annually (twice a year) as well as part of their induction training. The registered manager could not provide evidence that staff had completed this training or received updates in line with their policy.

We reviewed five staff files and could not find evidence that inductions had taken place prior to new staff commencing employment. One member of staff told us, "I did not receive an induction as such. I spent a period of about two weeks shadowing other staff." This member of staff also advised that the only training they had completed was medicines training online and moving and handling. They had received no competency checks during or after their shadowing period. Another member of staff said, "I received policies and procedures to read through, online medication training and was introduced to people who used the service" Two other staff told us the only training they had received was the medication training completed in-house since our inspection.

The provider had no monitoring systems in place to ensure that refresher training was booked to keep staff skills current and up to date. However, we did see some training certificates in the files we reviewed, which included; safeguarding, medicines, moving and handling, infection control and fire training. One member of staff employed by the company for nine months had only two certificates in their file for medicines and safeguarding training. Another member of staff employed for the same length of time had certificates for safeguarding, medicines and moving and handling. These two people had other certificates from previous employment, but some of these were not current and some were last completed in 2015.

Some staff we spoke with told us they felt further training would be useful. One staff member told us, "We look after a couple of people that are diabetic, one is diet controlled and another insulin dependent. The family support them with the insulin." Another member of staff told us that they supported people with diabetes and said, "We monitor to ensure meals prepared are low in sugar content." Both members of staff had not received any diabetes training to support them. Staff told us they supported people with dementia, cancer and diabetes. Staff we spoke with said, "It would be nice to be offered more training. We are caring for people that have conditions we know very little about." The provider had not considered additional training to support staff when meeting the needs of people with specific illnesses or diseases.

Staff understood the principles of the MCA and their responsibilities. Staff could tell us when they may need to assess someone's capacity or when best interest decisions may need to be considered. At the time of our inspection the registered manager advised only one person lacked capacity and they were due to end their service shortly. The registered manager could not show us how many staff had received MCA training and we

saw no training in the five staff files we reviewed.

The 'Staff Training and Development Policy' stated that all domiciliary staff would receive supervision every six to eight weeks and six monthly appraisals. In the five staff files we audited we found two staff that commenced employment in May 2017 had no evidence of supervisions being recorded. The other three evidenced their last supervisions took place in September 2016, March 2017 and October 2017. The supervisions that had been completed identified training that staff would like to complete such as first aid, but this had not been completed at the time of our visit. In addition, appraisals had not been completed in line with the agency's policies and procedures. Of the five files we audited only three had been completed in October 2016.

One member of staff told us, "I have only received two supervisions in the last two years." Another member of staff advised, "We used to have supervisions with observations at the same time. I haven't had either since October 2017." We had discussed supervisions with the registered manager on the first day of our inspection and they had scheduled all staff supervisions that needed to be completed. One staff member told us, "I have had one within the last month and it was very supportive."

This meant that the provider had failed to follow their policy and procedure to ensure any training, learning and development needs were identified, planned for and supported. Staff did not receive regular supervision and appraisal of their performance in their role from an appropriately skilled and experienced person.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the above findings with the registered manager and they advised that the training matrix was currently being completed so that refresher training could be rescheduled. The registered manager had completed a new supervision format and had booked staff supervisions for the next couple of months. Annual appraisals were due to be scheduled once all staff supervisions had been completed.

The majority of people receiving a service and their relatives felt that staff had the right skills and competencies to meet their needs. One person told us, "Yes, very much so" and "Well there is a difference in some carers, some take their time." A relative advised, "From what I have seen when carers are hoisting [Name], then yes." Health professionals said, "The agency offers a great service."

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. In order to comply with this, applications must be made to the Court of Protection. At the time of our inspection no applications had been submitted to the Court of Protection.

We saw various consent forms in people's care files; these were for key safes and financial support. Staff told us how they gained people's consent, one staff member advised "We always ask before carrying out any personal cares" and "Where people lack capacity to consent or make decisions for themselves we invite family or their representatives to best interest meetings." One relative said, "Yes they do ask consent before

doing any task such as bathing or toileting." People's comments included; "Yes, my three carers always do" and "Yes they always ask consent and respect my choices. If I don't feel like it, carers don't push me."

Health professionals told us that they were happy the registered manager contacted them to arrange best interest meetings as and when they were needed and that people's families or representatives were involved in this process. One relative confirmed that best interests meetings had been held, but they were at the start of the service. We did see best interest documentation in one of the files we reviewed and, when asked, the provider did confirm that only one person currently lacked capacity to make significant decisions for themselves.

Staff told us they tried to encourage people to eat a healthy and balanced diet. One member of staff told us that they looked after a person with diabetes, "We monitor foods to ensure they are low sugar content." Staff assisted people to the shops so they could purchase and choose what they would like to eat independently. During our visit to one person's home we saw that the staff asked them what they would like to eat and drink, the staff gave the person choices and waited patiently for them to answer.

We observed a health professional visiting a person's home and in people's files we could see that letters had been sent to the GP for reviews of medicines or to obtain clarification around any changes that had been made. People told us, "I phone the GP and have a chiropodist visit monthly" and "I have no problems getting a GP. I have a district nurse visiting quarterly." One health professional told us, "I often give advice to staff which they try and if it doesn't work they ring and we discuss other options – we work together."

The provider carried out environmental checks to ensure that people's premises were safe for staff to work in. Occupational therapists had been contacted to carry out assessments when adaptations were required.

## Is the service caring?

### Our findings

People told us staff were kind and compassionate, comments included, "Yes carers are kind and compassionate – they (Staff) know what I want daily" and "All three carers are kind and compassionate to me." Relatives said, "They (Staff) are extremely kind, I can't fault them" and "They give [Name] hugs."

Staff created meaningful interactions with people and showed a genuine interest in them. We observed one member of staff interacting with a person in their home; they were calm and cheerful towards the person. They asked the person if they were ok and did they need anything? They asked them how they were, the person responded positively when engaging with them.

We asked people if staff promoted their independence. People told us, "Carers have helped me to be independent over the past five years and enabled me to do as much for myself" and "I am helped to do as much as possible with personal care." Another person told us, "Yes, carers encourage me to do things I probably would not do." One relative advised, "Carers help [Name] to move from A to B safely daily."

Equality and diversity policies had been reviewed January 2018. However, these did not include sufficient information to guide staff and raise awareness of relevant legislation that was currently in place to protect people from issues such as discrimination. The registered manager told us they would be reviewing current legislation and updating this policy to incorporate the Equality Act 2010.

The service had policies in place to ensure that people were not discriminated against and staff understood the importance of protecting people's human rights. Staff told us they tried to treat everyone as they would wish to be treated themselves.

People's likes, dislikes and preferences were clearly recorded on a summary sheet within their care files. Staff had good knowledge of these and were aware of people that had allergies, specific diets or that preferred male or female staff to assist them. Staff told us, "Some people just require a prompt. I look after one person that has dementia and they forget they have eaten, I gently prompt them and prepare something for them to eat." Another member of staff advised, "Some people do prefer a male to help them with personal cares and others prefer females. We try our best to accommodate people and respect their wishes."

Daily notes captured important information about people's daily lives, such as people's mood and well-being, personal cares that had been completed and types of meals that had been requested and cooked. Some people that were at high risk of dehydration had their weight monitored and staff noted their fluid intake to mitigate any risks.

People were supported by staff to maintain relationships with their families. The registered manager had several calls with relatives of people receiving a service whilst we were at the office. Relatives felt they were involved and informed of any changes that happened within the agency.

Staff understood about maintaining people's privacy and dignity. One person said, "When I am showering or using the toilet carers leave the room and close the door" and "If I am using the toilet they close the door. They knock on the door if I am not up in the morning and call my name." One relative told us, "Yes they knock on the door before entering and close the bathroom door when showering [Name]."

One member of staff told us that improvements had been made around communications since the new registered manager had come into post, "We work as a team and have good communication with clients and office staff. Everyone's more helpful." Staff were aware of people that had sensory impairments and adapted their methods of communication to accommodate them. For example, where people were hard of hearing staff would ensure people could see their face so they could read non-verbal communications.

The registered manager told us that advocacy information was available and kept in the office in case people's needs changed. Advocacy services help people, particularly the most vulnerable in society to access information and services, be involved in decisions about their lives, explore choices and option and help people to defend and promote their rights and responsibilities.

People's records were kept securely in a locked cabinet in the main offices that were locked when senior management were not in the office. Computers were password protected so that only authorised personnel could gain access to them. We could not evidence that staff had received training on data protection, although when asked they knew their responsibilities under the current Data Protection Act 1998. However, one member of staff told us about previous concerns, "In the past you would hear office staff discussing other staff's concerns and confidentiality was not always maintained. Things are better now and that doesn't happen anymore."

## Is the service responsive?

### Our findings

We received mixed feedback in relation to care planning and reviews. Health professionals told us, "Family are always invited to attend reviews." The local authority carried out annual reviews which the provider attended. The registered manager advised they reviewed their own care plans every six to twelve months or when people's needs changed. However, the records we audited showed that care plans had been reviewed, but not consistently. For example, one care plan had been updated September 2016 and another January 2017.

We asked people if they had seen or been involved with planning and reviewing their care plan, comments included, "Yes. The manager, supervisor and social services set up my care plan and it is reviewed regularly" and "Yes, I have had a meeting with my daughter and social services for my care plan but haven't had a review for a while" and "My care plan is in my folder, but I don't think I have had a review." Relatives told us, "Yes, I set it up with the help of social services and accommodating care for [Name] and it has been reviewed every six months" and "Care plan is in the folder and we have had a recent review with district nurse, social services and carers." It appeared that the majority of people had received a review. However, records did show some inconsistencies and information from staff highlighted that documentation in people's homes may not be current and reflective of people's needs. The registered manager told us they were in the process of reviewing each person's file.

Initial assessments had been completed prior to services commencing and these included details of people's care needs and the exact services required. Care plans detailed people's needs such as; personal cares, nutritional needs, medicines administration, social activities and safety. One person's care file held two separate care plans with conflicting information about the support they required to manage their finances. This meant that staff could not be sure which care plan to follow. This person had recently had a safeguarding concern raised as their money did not tally with the more recent care plan advice – we brought this to the attention of the registered manager as this had not been identified as part of the internal investigation. It was agreed that this could have been a factor in the monies not tallying up. During the investigation it had been identified that recording of people's financial support had not been robust and new measures had been put in place to address this.

Health professionals told us, "The quality of the care plans is good." When we asked people if they felt involved in decisions about their health and welfare they advised, "Yes I had an assessment of care needs 2 years ago" and "Not really – I haven't seen anyone for a while" and another person said, "No, I don't think so."

Staff were aware to offer choices to people and we observed them asking people what they would like for lunch. The registered manager told us that staff had identified some people that required additional support and had discussed whether they would like to be put in touch with a befriending service once a week – this was accepted by the person. Staff told us, "I offer plenty of choices for meals or when asking what they would like to wear - so [Name] can decide which they prefer."

The complaints procedure was comprehensive and we saw records that demonstrated the registered manager followed their own policy and procedures. During 2017 there had been two complaints and none so far in 2018. The registered manager had investigated and resolved both complaints in 2017 and contacted all parties involved to ensure they were satisfied with the outcomes.

We asked people if they were aware of the complaints procedure and whether they had ever made a complaint. People told us, "I have made a complaint about a carer and [Name] was removed immediately" and "I directly contacted Accommodating Care as one carer was two hours late for a morning visit and the manager removed [Name]" and "Only once complained because the manager changed the names of the carers and I reported [Name] for rudeness." One relative said, "Yes I do know how to make a complaint and No I never have had to."

Staff told us that in the past prior to the new registered manager coming into post, they had raised concerns and felt that they were brushed under the carpet instead of being addressed. Two staff told us that things had improved with the new registered manager in post; they had introduced a system that enabled people to raise concerns anonymously which also helped. One member of staff told us, "Communication has greatly improved since the new registered manager has been in post. I am confident they would deal with any concerns I might have to raise."

The registered manager used different methods of communication to reach people within the local community and rural areas. The registered manager told us they had a Facebook page where communications and events were displayed and relatives or people receiving a service could post their feedback about the agency. Facebook is a social media and networking site that allows people and companies to set up accounts where they can display content of interest to others. The provider had recently purchased a new type of software which calculated routes for staff rota's and enabled the care co-ordinator to put templates together for planning routes and allocate sufficient time for staff to attend and travel from each person's home. This software had only been introduced within a few days of our inspection and allowed staff to print people's rotas so that staff knew where they would be going and for people to know which staff would be attending their calls.

The provider had received compliments from relatives and people receiving a service. Comments included, "We have been very satisfied without exception with the carers and their cheerful visits will not be forgotten" and "Just wanted to say thank you so far for your efficiency with [Names of two people receiving a service]. The carer you are sending is lovely and they have appreciated [Name] visits this week. [Name] has gone into hospital with a lighter load knowing that someone will be calling in on [Name]."

The service had also received compliments from one family for the end of life care they had provided. This made reference to the support carers had given to the person and their family during a difficult time. The registered manager told us that no end of life care was being delivered at the time of our visit. Some staff had received end of life care training and the registered manager told us they tried to ensure that appropriately trained staff were allocated to these calls. The emphasis was on respecting people's wishes, caring in a dignified manner so that people remained comfortable during their last days. Staff also offered additional support to people's families and were aware of the need for families to have private time with their loved ones.

## Is the service well-led?

### Our findings

Records such as care plans, risk assessments and policies and procedures were not always reviewed regularly so that they contained current information. This meant that staff did not always have the details needed to provide safe and effective care to people. On one occasion conflicting information in a person's file resulted in a safeguarding incident being reported. This showed us that the systems in place were not effective in ensuring data was current and reviewed at regular intervals.

Safeguarding incidents were not recorded together or analysed. The registered manager had not always documented the actions taken and when referrals had been made to external agencies, such as the local authority safeguarding team. Accidents and incidents had been documented in some people's files, but actions taken were not always fully completed. This meant that patterns and reoccurrences of similar incidents were not identified and preventative measures put in place to improve service delivery.

Staff training was minimal, the provider could not evidence that all staff had completed an induction and the relevant training to carry out their role. No training had been given to staff to enable them to support people with specific needs and conditions in a person centred way. The registered manager told us that this area would be addressed and staff would be offered additional training to support them. There was no training schedule in place to monitor training that had been completed and to schedule refresher training when it was due.

Observations had not been completed in line with the agency's policies and procedures. The 'Spot check' policy and procedure stated, "The spot checks will be centrally planned in line with the quality assurance policy and processes and the frequency of these will be undertaken every six to eight weeks." These had not been completed.

Staff supervisions and appraisals had not been completed in line with the agency's policies and procedures. The registered manager had started to schedule supervisions and evidence that some had been completed. However, this had been an issue for some time and not addressed prior to the registered manager coming into post.

The 'Quality assurance' policy and processes only detailed one type of audit, "random and regular medication audits, will be completed." These had not been completed despite there being several medication errors prior to our inspection taking place. We discussed this with the registered manager, they immediately scheduled medicines training for all those staff that needed refreshers and told us that regular competency checks would be carried out so that any errors could be addressed immediately and lessons learnt.

People had returned satisfaction questionnaires in 2017 and out of twenty-three, there were two that had concerns and issues. Although the majority of people were happy with the service provided, there was no analysis of the results. It was unclear whether the two that had raised issues had been followed up as no outcomes or actions were recorded. The registered manager was unsure if these had been addressed as

they had been received prior to them coming into post.

The registered manager, their staff and records indicated that team meetings had not been held regularly. One member of staff told us they had attended two meetings in the last 12 month period and another could not remember having attended one.

The registered manager was in the process of updating the policies and procedures and had implemented a new 'read me' folder. Updated policies were put in the read me folder for staff to read and sign to confirm they understood them. However, records showed that some policies had not been updated since 2015. Those that had been updated did not include the correct management structure and the old manager's details were still present.

Since coming into post the registered manager had been trying to make improvements within the service. However, they did not appear to have received the level of support and staff required to be able to make these changes. They had struggled with staff shortages and several new commissioned services had been accepted to grow the business, which added additional strain to the agency and its staff. This had meant that the registered manager had been completing care calls themselves to ensure there was little disruption to people's services. This had taken them away from managing the service and having the time to implement the changes required to improve the overall standards within the agency.

When asked about the culture of the agency, staff told us, "Prior to the new registered manager arriving it was not good. [Name of registered manager] is very supportive, has an open door at all times and I can talk about any issues with them." Another member of staff advised, "The registered manager is supportive and approachable, they respond to anything I ask them and the new care co-ordinator in the office seems the same."

The aims and objectives stated, "Accommodating Care aims to: Offer skilled care to enable people supported by us to achieve their optimum state of health and well-being." With the absence of training and supervisions to support staff the agency was failing to fulfil their aims and objectives.

Senior management had lacked oversight of the running and management of this service as systems had not been effective or in place since 2016. Therefore, management had failed to identify the issues we highlighted during our inspection. Care plans and risk assessments did not include sufficient information to guide staff to carry out their role safely and had not been regularly reviewed so that they were current and reflective of people's needs. The last business plan was completed in April 2014 and the registered manager confirmed to us that no current plan had been put in place.

The above concerns were a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new registered manager had over twenty-two years' experience working in adult social care. They had achieved a level 5 qualification in Health and Social Care, a diploma in how to provide advice and guidance to people, medicines training from the local authority, positive behaviour training to manage complex behaviours, person centred practice, customer service, management skills and end of life care.

The registered manager had obtained general feedback from staff during face to face discussions, satisfaction surveys and by operating an open door policy for staff to approach them with any issues or concerns at any time. The registered manager was happy with suggestions staff had made and was looking to discuss these with the owner to improve staff value and morale.

The registered manager had shared best practice with staff and had enrolled to receive updates from the Care Quality Commission website, Advisory Conciliation and Arbitration Service (ACAS) for advice and guidance on employment issues and regularly visited the government and skills for care websites to check for updates or changes to current legislation. The registered manager told us that the regional manager visited every two months and was available to contact by telephone if needed. During our inspection the registered manager could not demonstrate that appropriate support had been provided by senior management to drive the improvements needed within the service.

The registered manager had utilised staff's existing knowledge and experience. For example, they had a diverse team of staff, some of which had experience of caring for people and they had utilised this knowledge and experience to ensure that more experienced staff were allocated to people that had more complex needs. They told us this had improved the service delivery for one person as the service was more tailored to meet their needs as the staff member could relate to them and offer additional support due their existing knowledge and skills.

Notifications about changes and events that had happened within the agency had been sent to CQC apart from one recent safeguarding incident that the registered manager had yet to submit to us. Apart from this isolated incident they had complied with their registration requirements.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had identified risks to people's health and safety but not done all that is reasonably practicable to mitigate any such risks. Staff providing care to people did not have the necessary qualifications, competence, skills and experience to do so safely - care and treatment was not provided in a safe way for people. There were no systems in place to regularly monitor the proper and safe management of medicines.</p> <p>Regulation 12 (1) (2) (b)(c)(g)</p>
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not ensured quality assurance, auditing systems and processes were effective in highlighting shortfalls in the service. The systems in place did not always effectively monitor and mitigate risks relating to health, safety and welfare of people using the services and others.</p> <p>Records in respect of people using the service, staff and the overall management of the regulated activity were not always accurately maintained, complete and sufficiently detailed.</p> <p>Regulation 17 (1) (2) (a)(b)(c)(e)(f)</p>
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p>

Staff did not receive appropriate induction training, supervision or appraisal as is necessary to enable them to carry out their duties.

Regulation 18 (2) (a)