Diversity Health and Social Care Limited

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Inspection report

Suite 216-217, Estuary House
196 Ballards Road
Dagenham
Essex
RM10 9AB

Tel: 02085932371
Website: www.diversityhealthandsocialcare.co.uk

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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 carried out an announced inspection of Diversity Health and Social Care Limited on 24 and 25 September 2018. Diversity Health and Social Care Limited is registered to provide personal care to people in their own homes. The 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. At the time of our inspection, the service provided personal care to 241 people in their homes. At our last inspection on 16 February 2016, we rated the service 'Good'. At this inspection, we found concerns with risk assessments, pre-employment checks, care plans, training and quality assurance systems therefore the service has been rated 'Requires Improvement'.

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

Risks to people were not always robustly managed. We found some care plans did not contain suitable and sufficient risk assessments to effectively manage risks. This placed people at risk of not being supported in a safe way at all times.

Pre-employment checks had not been carried out in full to ensure staff were suitable to provide care and support to people safely. We found the provider did not follow their recruitment policy in some instances, which detailed that two references should be requested before employing staff.

Staff had not received mandatory and specialist training required to perform their roles effectively in accordance to people's support needs and circumstances. Some staff had not received Mental Capacity Act 2005 (MCA) training therefore some staff we spoke to were unable to tell us what this was. Consent had been sought from people when supporting them with care and support.

People's ability to communicate were recorded in their care plans. However, there was no information on how staff should communicate with people particularly how staff would make information accessible to people.

Effective quality assurance systems were not in place. Systems were not in place to carry out robust audits on staff training, care plans such as risk assessments and medicine management.

Accurate and complete records had not been kept to ensure people received high quality care and support.

Staff told us they had time to provide person centred care and the service had enough staff to support people. However, we noted where there was a risk staff may be late, this was not being pursued by office staff to minimise risk of late calls or missed visits. We made a recommendation in this area.

Staff, relatives and people were positive about the management team. People's feedback was sought from surveys. However, this had not been analysed in full to identify best practise and areas of improvement ensuring a culture of continuous improvement. We made a recommendation in this area.

People received their medicines on time. Staff had been trained to manage medicines safely.

Staff were aware of how to identify abuse and knew who to report abuse to, both within the organisation and externally.

Pre-assessment forms had been completed in full to assess people's needs and their background before they started using the service. Reviews were held regularly to identify people's current preferences and support needs.

People were being cared for by staff who felt supported by the management team.

People had access to healthcare services if needed.

People's privacy and dignity were respected by staff. People and relatives told us that staff were caring and they had a good relationship with them.

Complaints received had been investigated and relevant action had been taken. Staff were aware of how to manage complaints. However, the surveys were not being analysed to ascertain what the service was doing well in and what area's required improvement. We made a recommendation in this area.

Spot checks of staff supporting people had been carried out to observe staff performance.

We identified four breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to risk management, training, staff recruitment and good governance. You can see what action we have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some risk assessments had not been completed for people with identified risks.

There were appropriate staffing arrangements to ensure staff attended care visits. However, staff call logs were not being monitored effectively to ensure missed visits were minimised.

Pre-employment checks were not always sufficient. Two references had not been requested in accordance with the providers recruitment policy.

Medicines were managed safely.

Staff were aware of safeguarding procedures and knew how to identify and report abuse.

Appropriate infection control arrangements were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received essential training needed to care for people effectively.

Some staff were not aware of the MCA principles and had not received training on it. Consent had been sought from people to provide support to them.

People's needs and choices were being assessed effectively to achieve effective outcomes.

Staff were supported to carry out their roles.

People had access to healthcare services when required.

Is the service caring?

Good

The service was caring.

Staff had positive relationships with people and were caring.

People and their relatives were involved in decision making on the support people received.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans were inconsistent as they did not detail the person-centred support people would require in full.

People's ability to communicate was recorded. However, information did not include how staff should communicate with people effectively.

Staff had a good understanding of people's needs and preferences.

Staff knew how to manage complaints. People and relatives had access to complaint forms should they need to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality systems in place had not identified the shortfalls we found during the inspection.

Accurate records had not been kept to ensure people received high quality care at all times.

People's feedback about the service was obtained from surveys. However, this was not analysed in full to ensure there was culture of continuous improvements.

Staff, people and relatives were positive about the service.

Diversity Health and Social Care Limited

Detailed findings

Background to this inspection

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

The inspection was carried out on 24 and 25 September 2018 and was announced. We announced our inspection because we wanted to be certain that someone would be available to support us. The inspection was undertaken by four inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events which the provider is required to tell us about by law. We also received a Provider Information Return (PIR) from the service. A PIR is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make. We sought feedback from health and social professionals.

During the inspection we reviewed documents and records that related to people's care and the management of the service. We reviewed 24 people's care plans, which included risk assessments and 12 staff files which included pre-employment checks. We looked at other documents held at the service such as medicine, training and supervision records. We spoke with the registered manager, office manager, two care coordinators and a recruitment officer. We also spoke to nine care staff on the telephone.

After the inspection, we spoke to eight people who used the service, 17 relatives and five staff.

Requires Improvement

Is the service safe?

Our findings

Assessments were carried out with people to identify risks. There were assessments that had been completed on moving and handling, mobility and potential hazards around people's homes. However, when some risks had been identified, there was no detailed information on what actions staff should take to minimise risks. For example, people that had been identified with risk of falls, we found that some risk assessments had no control measures in place to minimise the risk of falling. We found one person who had epilepsy had previously fallen from having a seizure and injured their head. However, a robust risk assessment was not in place to minimise the risk of falls to prevent serious injury. Another person had fallen twice in July 2018, putting them at high risk of falls. However, a falls risk assessment had not been completed to minimise the risk of falling. We also found some risk assessments were inconsistent with falls. In one person's care plan, their risk assessment included they were at risk of falling. However, the rest of the section was blank with no information on how to ensure the person did not fall.

We also found that some people had arthritis and osteoarthritis. However, a risk assessment had not been created to include what part of the body was affected to ensure staff were mindful when supporting the person to prevent pain or discomfort.

Risk assessments had not been created in relation to people's health condition. For example, some people had a stroke previously. This had not been risk assessed, particularly the signs that may lead to a stroke and what actions staff may take to ensure the person was in the best of health. In one person's care plan, the person had diabetes and respiratory disorder. The care plan stated that staff should be aware of the signs of symptoms when the person found it difficult to breath or did not have a stable glucose level. However, their care plan did not include what the signs and symptoms were therefore there was a risk that staff may not know how to keep the person safe. Records showed some people had specific health concerns such as Parkinson disease, epilepsy, diabetes and dementia. Risk assessments were not completed to demonstrate the appropriate management of these risks in order to minimise them leading to serious health complications. For example, for people with diabetes, there was no information on how to prevent hyperglycaemia (high blood sugar levels) or hypoglycaemia (low blood sugar levels).

The above concerns meant that risk assessments were not completed to demonstrate the appropriate management of risks and to ensure support and care was always delivered in a safe way. Although some staff were aware of people's conditions, any unfamiliar, new or agency staff would not have this information. This placed people at risk of not being supported in a safe way at all times.

The above issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We checked 12 staff records to see if pre-employment checks had been completed. This ensured staff were suitable and of good character before supporting people. The Disclosure and Barring Service (DBS) is a criminal record check that helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable people. Pre-employment checks such as DBS and immigration checks,

employment history and proof of the person's identity had been carried out as part of the recruitment process. However, we found on six staff files that only one reference had been requested. The providers recruitment policy states 'It is our policy to obtain 2 references covering a minimum of 3 years of the applicant's employment history with at least one from the most current employer. In some circumstances we would request the applicant to provide us with additional references which might include a character reference.' The reference that had been requested was from a previous employer and a character reference had not been requested. In another instance, we found reference had been requested for a member of staff a year after being employed.

This meant that the service could not be fully assured that staff employed were of good character and suitable to carry out the role to ensure people always received safe care.

The above issues were a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People and relatives told us that there was enough staff and they came on time. A person commented, "They are very good at being on time and stay as long as I need them". A relative commented, "They are 100% on time. If they are running late, they would let us know, always." A social professional told us, "As with all agencies there can be issues with lateness, however this is not something that comes up frequently with this care agency." A comment from a compliment received from a person included, 'Always on time with a smile.'

There service used an online call monitoring system to monitor staff timekeeping and attendance. Staff logged in and out of visits by using a landline and a PIN number. This showed they had attended and left their visit after carrying out personal care. Staff had enough time in between visits to travel because they were allocated specific postcode areas to work in. The care coordinator said staff did not usually have to travel more than 15 minutes between visits. We looked at staff rotas and saw they were given adequate time to travel in between appointments. All staff completed timesheets, which we saw were completed and checked by senior staff. Rotas showed the days and times care was to be provided to people. Staff received their rotas from care coordinators in advance on the Friday before the following week. People were kept informed by the office if their carer was running late.

However, we saw some staff did not always log in to their visits. The call monitoring system showed that on both days of the inspection a number of staff had not logged in or out of their calls. The provider informed that there was technical faults they were experiencing with electronic monitoring system, which was part of their contractual agreement with the placing borough but there was control measures in place to ensure staff did not miss visits or were late. The care coordinators told us they called staff to check they had arrived in the person's home but for some staff, they had not followed this up. We asked about this and the care coordinators said it was a continuing problem and that they would remind care staff about this. If they cannot log in, care staff were required to inform the office. The care coordinators told us care staff did not always do this but the service user would phone the office if a carer had not arrived. We were concerned that this could put people at risk if no one in the office checked on either the person or the staff member if they had not heard from either, and just relied on the person or family to call the office to ask where the staff member was.

A relative told us, "They've never ever missed a visit. I know they fill in the folder. Also [person] would tell me if they didn't come in." There were no records of missed visits but care coordinators told us they were kept as email records by senior staff. They said there was only one missed visit. They said that if a staff member missed a visit they would be spot checked and observed to ensure this was not repeated. Staff were

reminded of their responsibilities to always ensure they attended visits. Cover arrangements were made when staff were unavailable to provide care to people. The provider had an out of hours on call system in place for the evenings or at weekends.

We recommend provider reviews procedures for staff call logs to ensure the risk of missed visits or late calls are minimised.

People and relatives we spoke to told us that people were safe. A person told us, "Oh yes, I feel safe with my carers when they come to me." Another person commented, "I always feel safe, they [staff] are very kind." A relative told us, "We feel safe, never been a problem. I feel [person] in safe hands." A social professional told us, "Our service users have had positive experiences with Diversity."

Staff were aware of their responsibilities in relation to safeguarding people. Staff were able to explain what abuse is and who to report abuse to. Staff also understood how to whistle blow and knew they could report to outside organisations, such as the Care Quality Commission (CQC) and the police.

Care plans included the type of medicine people were prescribed and consent had been obtained prior to supporting people with medicines. The service mainly reminded people to take their medicines. Staff had received medicines training and told us that they were confident with supporting people to take their medicines. A relative told us, "[Person] can't administer them [medicines]. [Person] can't break the seal. So, morning and evening they break the seal and give it to [person] and they take the insulin out of the fridge, etc. They are very organised with it and have a good system going." The service supported one person with medicines. We looked at the person's Medicine Administration Records (MAR). MAR charts included the medicine people were given with the dosage and when this should be administered during the day. Staff had received medicines training and told us that they were confident with managing medicines. Staff were also aware on what to do if an error was made such as missing a medicine. They told us they would report this to the office and depending on the type of medicine then contact the GP for advice. The registered manager told us that medicines were audited as part of spot checks and audits. A spot check is a member of the management team observing care staff when they support people to check their performance.

Records had been kept of incidents. This detailed the incident and the action that had been taken. The registered manager told us that they always analysed incidents to ensure lessons were learnt and to minimise the risk of re-occurrence, which was why there was not many incidents. An incident register was kept of the incidents that meant the management team had oversight of the incidents and could identify if there was a trend or pattern to ensure prompt action could be taken.

There were systems in place to reduce the risk and spread of infection. Staff had been trained on infection control. Staff were supplied with personal protective equipment (PPE) such as gloves, aprons and sanitisers when supporting a person. Staff told us they disposed of PPE separately when completing personal care.

Requires Improvement

Is the service effective?

Our findings

Staff gave mixed responses in regard to training. A staff member told us, "Training is ok, it is helpful." Another staff member commented, "Training is helpful." However, some staff expressed concerns with training. A staff member told us, "I have been asking over a year for courses. I even offered to pay. I haven't had manual handling. The last time I had it was about 3-4 years ago in my old job. I am doing hoisting. I actually need it." Another staff member commented, "Diversity don't do training."

Records showed that new staff members that had started employment with the service had received an induction. The induction covered an introduction to the service, it's principles, professional development, and health and safety and safeguarding training. Induction incorporated Care Certificate standards. The Care Certificate is a set of standards that health and social care workers comply with in their daily working life such as safeguarding, infection control, first aid and health and safety. Out of 162 care staff, we saw that 49 staff had completed the Care Certificate. Staff then received mandatory training to ensure they could perform their roles effectively.

We looked at the training matrix. The matrix was not fully up to date because it included staff who had not worked for the provider for nearly 6 months. There was a training coordinator that delivered training to staff. We saw that they had a training qualification to deliver training to staff. Training topics included equality and diversity, safeguarding adults, health and safety, infection control, dementia care, food hygiene, moving and handling and lone working.

Refresher training was held annually but we noted that this was overdue for nearly 40 current staff. The recruitment officer said this was because the provider was unable to secure a suitable training venue to hold training for up to 16 staff at a time. After the inspection, the provider sent us evidence that showed Care Certificate training had been scheduled on a continuous basis starting from 17 September 2018. Training listed as mandatory did not include the Mental Capacity Act (2005). The recruitment officer said it was not listed as mandatory. However, the management team told us that mandatory training included the MCA. This was a concern because it meant contradictory information was being provided by staff and managers.

Records showed that a new member of staff who started on 20 August 2018 had not received training because they had received recent training from a previous employer (another care agency). We did not see any certificates to prove this. The recruitment officer said they were chasing the care agency for the certificate.

A staff member told us, "I support someone with a catheter. I shadowed the previous person but no training." Records showed that the service provided specialist care with catheter care, PEG Feeding, epilepsy and end of life. There was specialist training provided for end of life care and PEG Feed but not in other areas such as catheter care and epilepsy.

This meant that staff had not received training to be able to perform their roles effectively. This would ensure people received high quality care and were kept safe at all times when being supported by staff.

The above issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People and relatives told us staff were skilled, knowledgeable and able to provide care and support effectively. A person told us, "My usual carer has been on holiday. But they are very good. When a replacement person came, she knew what she was doing." Another person commented, "Oh definitely, they always know what they are doing." A relative told us, "They are really good with [person]. Sometimes we get a replacement but they also seem to be fairly au fait (knowledgeable) with the job." Another relative told us, "Regular carer looks after [person] very well. Even when we get another carer, we are happy." A third relative commented, "I honestly can't fault them, they really do look after my relative so well."

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

Most staff had not received training on the MCA as a result some staff did not know the principles of the MCA when we spoke to them. The staff that knew the principles of the MCA told us they had been trained on the MCA in their previous role. Where possible, people had signed a consent to care form agreeing to receive support and care from the service. Records showed that capacity assessments had been carried out by placement authorities and the outcome of the assessment had been included on people's care plans.

Staff we spoke with told us that they always requested consent before doing anything. A staff member told us, "Of course, you have to always ask for consent before doing anything." A relative told us, "They ask permission and respect [person] dignity 100%." A person commented, "Oh yes, they always ask for permission." Care plans also included that staff should ask for people's consent before doing anything.

At our last inspection we found that staff had not received formal supervision to ensure they were supported at all times. During this inspection, we found improvements had been made. Records showed that staff received regular supervision. Supervision included discussions on safeguarding, medicine management, infection control and training. Staff told us that they were supported in their role. A staff member told us, "They [management] are very supportive." Where staff had been working for more than 12 months, records showed an appraisal had been completed that reviewed the performance for the previous year and if further training and development was needed. A comment from one staff members appraisal included, "I am enjoying my job."

Pre-admission assessments had been completed prior to people receiving support and care from the service. These enabled the service to identify people's daily living activities and the support that people required. This allowed the service to determine if they could support people effectively. Using this information, care plans were developed. A person told us, "Yes, they've been round and asked what support I need." The service assessed people's needs and choices through regular reviews. Records showed that changes in people's circumstances had been recorded and used to update people's care plans. This meant that people's needs and choices were being assessed effectively to achieve effective outcomes.

The service supported people with meals, which included preparing meals and making meals from scratch. The service primarily supported people that liked a certain cultural food. Staff from the same culture had been employed and supported people with their preferred meals to ensure people's requests could be accommodated. Care plans included the support people would require with food. People were given

choices by staff when supporting them with meals. A person told us, "They ask me what I want and get it out for me". A relative told us, "They always ask her what [person] wants. We liaise with each other."

Care records included the contact details of people's GP, so staff could contact them if they had concerns about a person's health. A relative told us, "They will tell me if [person] not well or something. They keep me informed. They do pick on things." Another relative commented, "If they are worried about anything, they let me know and I call the doctor." Where staff had more immediate concerns about a person's health, they called for a health professional to support the person and support their healthcare needs. There was information on people's care plan on who to call in the event of an emergency. Staff were able to tell us the signs people would display if they did not feel well. This meant the service supported people to access health services to ensure people were in the best of health.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. A person told us, "Oh yes, very good, kind and caring." A relative commented, "They are really nice with [person]. They have gotten to be more patient with [person] as [person's] dementia has progressed." Another relative told us, "Yes, they are kind and caring." A third relative commented, ""Wonderfully, they treat her as if they are looking after their own family."

Staff told us how they built positive relationships with people. A staff member told us, "We build good relationships by good communication skills. We talk to them nicely and politely. We always say good morning and ask them how they are today. For example, with personal care we always ask if they want a full bath or not. They have a choice." A person told us, "Yes, very good relationship with regular carer." One relative told us, "[Person] can be aggressive sometimes; they cope very well with [person]. Very happy with the relationship." Another relative told us, "Definitely very good. Very positive relationship with all the carers. [Person] learns to take to the new ones too." A third relative told us, "Yeah, from what [person] says [staff] stays and talks about things, because [person] can't go out. They talk about the cricket and stuff. [Person] is very nervous but [person] has great interaction with [staff]. I came in once; they were sitting there together with a cup of tea, watching TV together. That was nice."

The registered manager told us they had supported people that had been transferred from other care companies and that they have employed the same care staff that supported people to ensure continuity of care and to maintain relations. This was confirmed by relatives and people. A person told us, "They're the same ones I had before so they do know me." A relative told us, "[Person] is very nervous about new people. We have had the same carer now coming in twice a day for more than five years. [Person] feels very safe and comfortable with them." Another relative commented, "We were lucky enough to keep the same carers when they changed over [from previous care service] so they know my relative so well."

People and relatives confirmed that they had been involved in decision making on the care people received. There was a section where people and relatives could sign to evidence that they agreed with the contents of their care plan. A person told us, "Yes, they involve me in making decisions about what they do." People's independence was promoted. Care plans included information on where people could support themselves and area's they would need support with. On one person's care plan, information included that a person likes to remain independent in their homes and staff should support the person when needed with care. A staff member told us, "If people can do things, I let them do it. If they can't, I help them. Suppose I make them breakfast and they can eat it themselves, I just make it and leave it for them and then wash their dishes for them. Sometimes when I dress them up they can put their clothes on by themselves and at the end I might fix it for them." A person told us, "They make sure I'm not just being lazy and get me to do what I can before they carry on."

Staff ensured people's privacy and dignity were respected. They told us that when providing particular support or treatment, it was done in private. A staff member told us, "I keep the doors and curtains shut when giving personal care and also ask for their consent to do this. I would ask them what can I do and what they would like me to do." Another staff member told us, "I make sure windows and doors are shut. I ask

them if it is ok to help them and explain what I would be doing." A relative told us, "Yes, they do treat [person] with dignity and respect." Another relative commented, "They give [person] a shower and certainly respect [person] dignity. They cover [person] up with a towel, they deal with it well."

Staff gave us examples of how they maintained people's dignity and privacy not just in relation to personal care but also in relation to sharing personal information. Staff understood that personal information should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting their dignity. We saw that confidential information such as people's care plans and medicines records were stored securely in the office.

People were protected from discrimination within the service. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally. A staff member told us, "This is where you make sure that you treat everyone equal, so everybody has to be equal. You don't treat one person one way and another a different way, treat everyone equal." People and their relatives we spoke with confirmed that they were treated equally and had no concerns about discrimination. A relative told us, "They [staff] have their own culture. [Person's ethnicity] and some of them are from the same background, but [person] relates to all of them. Absolutely they respect [person's] culture and religion."

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that staff were responsive and knowledgeable. A relative told us, "[Person's] regular carer knows [person] very well. You need someone who knows. I wouldn't like it if they didn't know how to look after [person]." Another relative commented, "When I was worried [person] wasn't drinking enough water, they were onto me all the time to let me know whether [person] was or not." Staff we spoke with were knowledgeable about the people they supported. They were aware of their preferences and interests, and their health and support needs, which enabled them to provide a personalised service.

Each person had an individual care plan which contained information about the support they needed from staff. One staff member told us, "Care plan is helpful." A relative told us, "Yeah, we have a folder [care plan] in the home, which has everything in it." Care plans detailed the support people would require with personal care. There was a 'About Me' section that summarised people's risks, support needs, health and safety and key information such as how to gain access to people's home. Care plans were personalised based on people's preferences and support needs. This also included the times staff supported people and the support people required. In one person's care plan, information included that staff should fold a washcloth around their hand to form a mitt when giving the person a bath and then what part of the body to wash first. In another person's care plan, a person needed to be repositioned in bed regularly. A repositioning chart was in place that recorded how often the person had been repositioned in bed to prevent skin complications.

However, we found inconsistencies with some care plans. On two care plans we found the information on the supports needs for both people were identical. We fed this back to the registered manager, who informed that this was a mistake. In another care plan we found on the local authority referral form that staff to ensure a person always wore their pendant alarm before staff left to ensure person can use this in an emergency. This was not listed on the person's care plan. This meant that not all people would get person centred care to ensure they were always in the best of health and received effective support.

A relative told us, "There is good communication between them [person and care staff]." Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS) by law. The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. The information would tell them how to keep themselves safe and how to report any issues of concern or raise a complaint. Staff we spoke to did not know what the AIS was in full but were able to tell us how they communicated with people. However, care plans did not include people's ability to communicate. In one care plan, we found that a person had a hearing impairment. However, there was no information on how staff should communicate with the person. We fed this back to the registered manager, who informed us that they would include this information on the care plan. People and relatives we spoke to had no concerns with staff communication. The registered manager told us as some people did not speak English they had employed staff that spoke the same language people spoke, which made it easier to communicate with people.

There were daily records, which recorded information about people's daily routines and the support

provided by staff. Staff told us that the information was used to communicate with each other between shifts on the overall care people received and if a particular person should be closely monitored. This meant that staff could summarise the care needs of the people on each shift and respond to any changing or immediate needs.

There was a complaints policy in place. There was a complaint register that included the complaints received and the action taken, which ensured the management team were able to track complaints and have oversight of complaints investigations. People and relatives knew how to make complaints. A relative told us, "They gave us some telephone numbers to call if we need to talk to someone about anything. They are usually really quick to get back to you." Staff were aware on how to manage complaints. A staff member told us, "If someone made a complaint then I would give them a complaint form to complete and then I would give this to the manager to review."

Records showed that the service had received compliments from people and their relatives. Comments included, 'Immense thanks for your hard work, time and kindness', 'We would like to say a big thank you to all of your care workers who looked after [person]' and, 'Thank you for your care and kindness throughout [person] illness.'

Requires Improvement

Is the service well-led?

Our findings

The provider had failed to ensure that adequate quality assurance and systems were in place. During the inspection we were not shown system or structure in place to ensure audits would be carried out at frequent intervals. We were sent evidence of this after the inspection. The registered manager told us that they did visual audits on care plans and medicines management. However, the findings and the areas that had been covered for the audits had not been recorded. Recording audits is important to make sure that any identified actions could be monitored and if any actions had been implemented. The visual audits that were carried out had not identified the shortfalls we found at the inspection with care plans and risk assessments. In addition, audits were not carried out on staff files, which may have enabled the management team to identify the shortfalls we found with training and pre-employment checks. This was required to ensure high quality care was being delivered at all times and there was a culture of continuous improvement.

Records were not always kept up to date. We found in some risk assessments, people's ability to communicate in care plans had not been completed in full to ensure staff had the relevant information to provide high quality care at all times. In addition, we found that the training matrix was not up to date at the time of the inspection. Keeping accurate records is important to ensure the service had oversight of the support people required and if support had been delivered effectively.

This meant that robust governance systems were not in place to ensure shortfalls in relation to staff training, staff call logs, safer recruitment checks and risk assessments could be identified and action taken to ensure people always received safe and effective care at all times.

These issues were was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Spot checks of staff supporting people had been carried out and this had been recorded. They focused on infection control, time-keeping, medicines and appearance. This was then communicated to staff and formed part of their supervision. This meant that the service was able to identify what areas staff were doing well in and identify if further development was required, to ensure people received effective care and support.

Staff told us that they were supported in their role, the service was well-led and there was an open culture, where they could raise concerns. They felt concerns would be addressed promptly. One staff member told us, "Yes. Basically, there was a couple of times when I was running late for the clients and I was in a panic, and they arranged someone else to be there before me. I felt that they didn't make me feel bad. They supported me in that way and the client still got support." Another staff member commented, "I am supported here. I do enjoy working here." A social professional told us, "The team in general are very pleasant, helpful and responsive.

People and relatives were positive about the management and the service. One person told us, "No concerns. Very happy with the service." A relative commented, "We have met [Care coordinator], and they do

come round and check [person] is happy regularly. These little details are important." A relative told us, "The service is brilliant." A third relative told us, "Can't fault them. As far as I am concerned, they are doing a really good job."

People's and relatives' feedback was sought through surveys. The survey focused on time keeping, staff appearance, respect and if people had any concerns. Generally, the survey results were positive. Where there had been negative comments, records showed that the management took action to ensure improvements were made. However, we found the surveys had not been analysed to identify trends or patterns and the areas the service was doing well in and areas that required improvement.

We recommend the service analyses the results of surveys to ensure there is a culture of continuous improvement.

Staff meetings were held regularly. The meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff held discussions on spot checks, handovers, safeguarding's, appearances and staffing. Office meetings were also held. Minutes showed that staff discussed recruitments, contingency plans and internal quality systems. This meant that staff were able to discuss any ideas or areas of improvements as a team, to ensure people received high quality support and care.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. Regulation 12(1)(2)(a)(b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider was not robustly assessing, monitoring, improving the quality and safety of the service users and mitigating the risks relating to the health, safety and welfare of service users who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(b). The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user. Regulation 17(1)(2)(c).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Pre-employment checks had not been carried out in full for staff employed for the purpose of

	carrying on a regulated activity to ensure they were of good character and suitable for the role. Regulation 19(1)(2).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received effective training to be able to perform their roles effectively. Regulation 18(1).