TLC Homecare Limited

Town & Local Care

Inspection report

St Peter's Chambers
St Peter's Street
Huddersfield
West Yorkshire
HD1 1RA

Tel: 01484818218

Date of inspection visit:
08 September 2016
27 September 2016

Date of publication:
25 October 2016

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

The inspection took place on 8 and 27 September 2016 and was announced. The service was previously inspected on 15 May 2014 and met all the requirements in place at that time.

Town and Local Care provides a domiciliary care service for approximately 195 people in the Calderdale and Kirklees area. They are registered to provide the regulated activity of personal care. It is a condition of registration with the Care Quality Commission that the service has a registered manager in place and there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our inspection confirmed staff had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

The service practised safe recruitment to ensure people were cared for by staff who had undergone the necessary checks.

Environmental risks had been assessed to ensure a safe working environment for staff. The service had assessed the risks to people supported, but we found the identification of risk and measures put in place to mitigate risk were not specific to the person. As a result not all risks had been identified to ensure they were reduced.

We found people had assistive equipment in place which was not referenced in their moving and handling care plans and there was insufficient detail in the method staff were to follow when moving and positioning people.

We found the management of medicines was not in line with good practice and there were incorrect dosages recorded in care plans when referenced against the medicines administration records, not all medicines recorded in the care plans and gaps in the medicine administration records.

The service was not meeting its responsibilities under the Mental Capacity Act 2005. No capacity assessments or best interest decisions had been recorded and staff did not have a good understanding of the principles of the Act although they could describe how they supported people to make decisions.

Staff received regular training to ensure they developed skills and knowledge to perform in their role and received regular ongoing supervision and an appraisal to support their development. Staff competency was checked through two direct care observations each year.

People were cared for by staff who were caring and compassionate and who respected their dignity and privacy.

Care records were person centred and recorded people's preferences, views and how they wanted their care to be delivered. However, care plans contained contradictory information and there were gaps in essential information which meant unfamiliar staff might not have sufficient recorded information to care for people appropriately.

The service had a complaints policy in place and complaints were handled appropriately to ensure a satisfactory outcome for people using the service. A record was kept of all compliments received and when these related to staff, these were published in the company newsletter to acknowledge staff achievements.

Staff spoke highly of the registered manager and the organisation and told us they were supported in their role. They enjoyed their caring role and showed great pride in their work and the feedback they received from the people they cared for.

The registered provider had a clear vision in place to develop the service. There was robust monitoring in place in areas such as people management and staff training. However, we found audits to monitor the quality of service provision around for example, the safe administration of medicines, and care plan audits had not been effective in addressing shortfalls in these areas.

We found three breaches in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in Regulation 12; Safe Care and Treatment, Regulation 11; Need for consent and Regulation 17 Staffing; Good governance.

You can see what action we told the provider to take at the back of the full version of the 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.

Staff we spoke with demonstrated a good understanding of how to recognise abuse and ensure people were safeguarded. They knew the procedure to follow to report any concerns.

Generic risks to people were identified. However, specific measures to protect people were not always evident and moving and handling care plans did not include detailed methods for staff to follow.

Medicines were not always recorded as administered safely and gaps in records where people had not taken the medicines had not been explored.

Records showed recruitment checks were carried out to ensure suitable staff were employed to work with people at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider had not understood their responsibilities under the Mental Capacity Act 2005 and no capacity assessments or best interest decision had been recorded.

Staff did not have a good understanding of the principles of the Act although they could describe how they supported people to make decisions.

Staff had received training to ensure they had the knowledge and skills to perform in their roles and were supported to develop through supervision and appraisal.

Is the service caring?

Good

The service was caring.

Staff knew how to ensure privacy; dignity and confidentiality were protected at all times.

Staff knew how to maximise people's independence to help them to live fulfilled lives.

People using the service spoke highly of their permanent staff and people told us staff were caring and went over and above to meet their needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were person centred and referenced people's views, preferences and choices, and people were provided care in a way that reflected their wishes.

There was a discrepancy in what was recorded in people's care plans against the daily journal, and the care plans lacked the detail to evidence how staff were to support people in some areas.

The service had an effective complaints policy and process in place to ensure concerns about the service were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service was continually striving to improve and had monitored what they did well and what they could do to improve and had plans in place to improve the delivery of the service.

Some audits had not been effective in resolving issues around the safe management of medicines, and incomplete care plans.

Staff told us the registered manager was supportive. We found staff were motivated and supported to provide good care and had great pride in their work.

Town & Local Care

Detailed findings

Background to this inspection

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

The inspection took place on 8 and 27 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service.

The membership of 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.

Before the inspection we gathered and reviewed information from statutory notifications. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted Healthwatch to see if they had received any information about the provider. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team and reviewed all the safeguarding information regarding the service. The local authority shared their recent contract monitoring visit in relation to their commissioned service. The Commission sent out questionnaires to people using the service their relatives and to staff to seek their views on the service provided. 50 people who used the service were sent a questionnaire and 19 people responded. We sent out 70 questionnaires to staff and 14 were returned. We sent out 50 to relatives and five were returned.

We reviewed seven care records and daily journals. We reviewed three staff files and associated recruitment records. We spoke with ten people who used the service and one relative.

We spoke with the registered provider, the Group Operations Director, a registered manager from another of the registered provider's services who provides cover in the absence of the registered manager, the registered manager by telephone, two coordinators, three staff, and the training manager. We reviewed the

records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service whether they felt safe with the care staff who supported them. One person said, "Yes. I just feel safe. I'm not on my own here anyway. I trust them." Another told us, "Oh yes. The girl that's coming is so nice and caring. She's a good girl. Yes, she's great." Another person said, "Absolutely. I'm very comfortable with the ones I am getting." We also received the following comments, "They're all very good. I'm quite capable of telling them what to do. If they're new, instead of them needing to read the book, I'll tell them what to do and what I need.", "Yes, I trust them all. They're all very efficient who come." "Oh yes. They help with anything I want to do, in any way they can."

People were less complimentary about new and unfamiliar staff. One person said, "The two that I get, yes I do. But when I get different ones, it's horrendous. When they're on holiday or away [regular staff] I get really nervous." Another person said, "If you get someone and they're here all the time they know what to do, but if you get someone new, they don't, and that happens a lot, especially in holiday times."

We received 19 responses to questionnaires sent out to people using the service and 100% of people told us "I feel safe from abuse and or harm from my care and support workers." Staff we spoke with had a good understanding of how to identify abuse and act on any suspicion of abuse to help keep people safe. They were able to describe the type of abuse you might find in a community setting and the signs of abuse. They all told us the steps they would take if they suspected abuse. Staff also knew the principles of whistleblowing, the duty by a staff member to raise concerns about unsafe work practices or lack of care by other care staff and professionals. They assured us they knew the whistleblowing process and would not hesitate to report any concerns. One of the coordinators described a safeguarding incident they had been involved with and what steps they took to reduce the potential for further abuse. This demonstrated they were aware of their responsibility to ensure people were safeguarded against abuse.

The service had a general risk assessment tool which covered environmental risks at the property, personal safety of staff, and household equipment. In addition to the generic environmental risk assessments, we were told risks to people using the service were also assessed and reviewed at least every six to twelve months or sooner if required. One coordinator told us "I update risk assessments every time a carer says something has changed." We saw risk assessments in people's care files around moving and handling, choking, showering, respiratory difficulties, weight loss, hydration, stoma care, and medication. In four care plans the risk of choking had been identified, but there were no measures in place to reduce this risk and on discussion with the care coordinators, although this had been highlighted on the form, there was no risk of choking for these people. One record stated there was no risk in relation to tissue viability, yet on reading this person's records they had a pressure cushion which required staff to ensure was turned on. We also found no dates on the risk assessment form or review date. One person had been identified as not having moving and handling needs, yet on reading the care plan, staff were assisting the person to lift their legs into bed and to wheel this person into the bathroom. These were moving and handling tasks that required assessment and care planning to ensure staff undertook these manoeuvres safely.

Prior to the inspection we had received information from staff regarding the lack of training in the use of

moving and handling equipment for individual people. We checked and found that staff had received comprehensive office based training and had been assessed as competent with specific moving and handling tasks. A member of staff had told us prior to our inspection that one person had been provided with a hoist and they received no training or instructions on how to use this. The Group Operational Director told us staff were only paired up with experienced staff to support people who required assistance to move. However, we found as the method of moving and positioning people was not clearly described in people's care plans and staff were reliant on learning how to move people from other staff, this posed a risk of inappropriate care provision. This was raised with the registered provider who agreed to improve practice in this area.

Staff were all able to confidently describe to us what they would do in an emergency situation such as if they found a fallen person or could not get an answer at the door. This demonstrated the service had systems in place, which staff were aware of, to deal with emergencies as they arose.

Records showed us staff had been trained in how to administer medication appropriately. We looked at four people's care records to check staff were putting their knowledge into practice and administering medicines safely. We found errors in the way medicines administration was recorded in all four care records. For example, we found discrepancies in one care plan when compared to the Medicines Administration Record (MAR) in the amount of medicines to be taken. For example, the care plan stated, the person required 10 mg of a medicine and the MAR sheet recorded 40 mg. We found a typed entry on the MAR sheet which stated one tablet am pm (blister) which had the pm crossed out and x2 handwritten against it without any explanation for this change. On some dates one tablet had been recorded as administered and others two had been recorded as administered. Another medicine required half a tablet to be administered and the record showed some staff had recorded one tablet administered and some days half a tablet. Some other medicine records contained gaps where nothing had been recorded and no reason recorded. The inaccurate recording of medicines demonstrated a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service employed between 70 and 80 care staff to support people in the Kirklees and Calderdale area. We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) checks, reviews of people's employment history and two references received for each person. The Group Operational Director told us recruitment and retention of staff had been a problem in the area with a high turnover of staff. They told us they recruited a lot of students from the university and they naturally left the service when their studies ended. People we spoke with told us the high turnover of staff meant they did not always get consistent staff supporting them. The service was actively working to improve staff retention and the engagement officer telephoned each person who had left to determine why staff were leaving. The recruitment team were holding open days and we were told recruitment into the care role was steady but was replacing leaving staff rather than expanding the number of care staff.

The service used a web roster system to monitor calls and to rota staff support calls. Rotas were sent to staff mobile phones and staff were required to use an application on their phone to scan a barcode when they arrived at a person's home, which alerted the office they had arrived to support the person. The coordinating staff monitored people's calls on a daily basis. The coordinator told us any call which was half an hour late was considered to be a missed call and they monitored all missed calls. The people we spoke with generally confirmed staff arrived within half an hour of their expected time frame. Comments included, "The only times they run a bit late can be at the weekend – they're not much later than 10am" [should be 9.15-9.30] "but I don't mind that because I can have a bit of a lie-in." Another person told us, "Odd times, if they've been rushed, I've said they can go five minutes before time. Some of them are walkers and have to

walk to the next job. They always do what they're supposed to do for me." And one person said, "Yes, usually. Sometimes if there's traffic, they can be five or 10 minutes late."

The registered manager told us that staff were provided with personal protective equipment which enabled them to carry out their caring duties safely. Supplies were kept in the office and in people's homes. Community equipment such as hoists and slings were provided through local community equipment arrangements.

Requires Improvement

Is the service effective?

Our findings

We asked people using the service whether the staff who supported them had the knowledge, skills and training to care for them. One person said "As far as what I need, yes." and another person told us, "Oh yes, I do." Another person said, "Some of them are. A lot of them have just started and I don't think they get much training." A further person said, "Oh yes, I do, yes. My regular girl just knows. I don't have to repeat anything, she just does it." Other comments included, "They come from everywhere. It's not the same person every time." and One person said "Er yes. There's odd ones, new ones like, but they soon get used to it. Some are very experienced, but the young girls what come, they're not experienced; they have to learn as they're going along."

People told us they felt less confident in the skills and knowledge of new or unfamiliar staff. Comments included "I had a carer who came; she'd only been on the job 4 days, so not at all. It was uncomfortable for me. My usual carer does a thorough job; she's incredible. She knows exactly what I need." Another person, told us, "The majority are [trained]. It's only when the new ones start; they panic a bit. I do think the girls, especially at the weekend, are very rushed. It's always more chaotic. One of the girls has told me that she has 22 people to see in a day. And I don't think she's the only one. That seems to be the 'norm' at the weekend." A further person told us "Well, one thing I have noticed, with me being one of the lower priority, they seem to send me a lot of new ones. I do get a regular one but she's on holiday at the moment and in those nine days she's away, I might get six or seven new faces. I've seen five already and she's only been away since [five days]."

We looked to see how new members of staff were supported in their role. The registered manager told us all new staff received an induction into the service and this included five days introduction to care training and a minimum of two days shadowing. We were told if staff required further shadowing this would be provided. Following this they were observed and shadowed during the first 12 weeks of employment by the coordinators with feedback sought from people using the service and from colleagues. If further training was identified to ensure they were competent to perform in their role, this was provided. The service utilised the Care Certificate to map their induction process and staff have to be observed to meet the competency criteria of the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. The registered provider employed an Employee Engagement Officer to provide regular contact with new staff within their first three months of employment, as they told us they recognised the importance of supporting new staff to develop into the role. We saw in the minutes of a team meeting the Employee Engagement Officer had attended and informed staff about their role to improve communication and engagement with staff to support retention. The minutes of the staff meeting recorded the officer handed out their information to enable staff to contact them if required.

Staff received ongoing training which was refreshed in line with company policy. The group training manager told us they had a training matrix and when it was identified a member of staff was due to attend they would send the care coordinator and the registered manager a date for the person to attend. In addition to mandatory training additional training was provided if audit showed an area required

improvement. For example, staff had attended additional training in record keeping in October 2015 as an audit had highlighted this was an area that needed to develop.

Staff were provided with an employee handbook which detailed the philosophy of care and aims of the service, policies and procedures and information about working for the company. Regular supervision of staff is essential to ensure that the people at the service are provided with the highest standard of care. Records showed staff had received supervision and an appraisal. Staff we spoke with as part of our inspection process told us they had received supervision, an appraisal and a direct observation of their care. This demonstrated the service was providing staff with the opportunity to develop in their roles through ongoing training, development, supervision and appraisal.

Prior to our inspection the Commission sent out 50 questionnaires to people using the service and 19 responses were received. 84 % of people told us "My care and support workers have the skills and knowledge to give me the care and support I need." One person did not share this view and told us, "A small number of the staff are skilled. The majority don't have the skills needed. They don't understand that my condition means I move slowly and freeze, a few of the carers have told me I need to hurry up as I am taking too long." One relative who responded on behalf of their relation commented, "There are members of the team who display great skill. There are however some do not have the skills required to deliver effective care and appear to lack training. They have made judgements which they do not have the clinical skills to make." Another relative said, "Generally I am happy with the care which Town & Local provide. For the most part the carers are consistent and timely. I have good contact with the management of the company."

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 reviewed the service's Mental Capacity Act Policy. This described the Mental Capacity Act 2005 and the principles of the Act but did not guide staff on the application of the Act in their role on a day to day basis. Staff knowledge of the Act and the principles was limited although our discussions with care staff demonstrated they were supporting decision making in practice.

We also found a lack of understanding about capacity to consent in the medication policy. For example, the policy referred to covert medicines and stated "Where a service user is unable to give consent due to the nature of his/her illness or disability, consent must be sought from the next of kin and GP. A written risk assessment must be completed." The policy made no reference to acting in accordance with the mental capacity legislation, including the requirements to undertake a capacity assessment if there was evidence to suggest they person lacked the capacity to consent, and if the person lacked capacity following the best interest process.

The group operations director told us "We don't conduct capacity assessments ourselves. We get our packages from social services and we would expect the assessment to be conducted by them. If there were none in place, we would be asking for this to be done." They also said, "It's an area we would like more guidance and incorporate this into what we are doing." By our second day of inspection they had put plans in place to ensure this shortfall was addressed and to ensure people's care plans reflected capacity to consent was in line with legislation. However, this demonstrated a breach in Regulation 11 and 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to obtaining and recording of the consent in line with legislation.

People told us staff supported them to remain healthy and had involved other professionals when necessary or when they were unwell. One person said, "Absolutely. She wouldn't leave me. She'd go above and beyond, even if it made her late." Another person told us, "Oh yes, no messing. I've had to have the District Nurse in and things, but it was their idea to get her in." We saw evidence in people's care files where other people were involved in a person's care to inform staff who this was and how they could be contacted.

Good

Is the service caring?

Our findings

All the people who used the service told us the care staff were kind and compassionate. One person told us, "Yes. The girls that I've had have always been caring. The carer I've got at the moment is very good and when other carers come in, when she's off, like over the weekend or something, they're good to me as well." Another person told us, "Oh yes, the girls are really good I must admit. If I run out of anything at lunch time, they'll pop to the shops and pick me something up." A further person told us, "Oh absolutely. They think about you. They're concerned about you all the time. They're carers but they're also caring." My usual carer is unbelievable. 'Fantabitosy'. She's incredible. Others that come don't know my ways, but they still care." Another person said, : "Yeah, I do actually. They're always asking if I want this or want that." And we received the following comment, "If she finishes early, she always asks if anything needs doing. She's more likely to stay over a few minutes; she never rushes off."

One relative we spoke with told us, "I find them extremely pleasant and they're always very good with [name]. [Relative's] always laughing with them and has a good rapport with them." Care staff told us they received positive feedback from people they cared for and their relatives, which affirmed they were caring and compassionate when supporting people.

People told us staff respected their dignity and privacy when carrying out personal care. Comments included, "Yes. They ask me if I'm alright. If I'm getting showered, they give me towels and stuff. They close the curtains, doors and everything." Another person said, "Yes, I do. They make sure I've got a towel round me all the time and that, when I get out of the shower." One person told us, "Oh yes, they do. I get embarrassed easily, but they respect my wishes."

People told us staff involved them when providing personal care. One person said, "Oh yes, she does. She asks me beforehand if it's alright to do. She always makes sure I'm quite happy with her doing it." Other comments included, "Oh yes, yes." "On the whole, yes." "I do, yes. I've had no problems along those lines at all." I have a half an hour allowance, but sometimes they've finished before this. Sometimes they'll chat; they're a friendly bunch. They're never in a rush enough to not do what I ask them."

The registered manager told us people were encouraged to remain independent. They told us this was recorded in people's care plans. For example, they said, "When the care worker is making a meal for a person, they encourage them to make a cup of tea if they can. If a person can wash part of themselves during personal care, they are encouraged to do that whilst the carer supports the task." The registered manager showed us the records of one person to demonstrate how this was recorded and we could see this encouraged the person to remain as independent as possible during the provision of support. People's sensory impairments were recorded in their care plan with a record of equipment required to ensure the impairment was minimised such as whether the person used a hearing aid or visual aids.

We asked the registered manager whether anyone at the service was using an advocate. We were told that there was no one using an advocate but if this was required they would refer back to the person's social care worker. The service had a policy on advocacy explaining to staff about advocacy to support people to make

difficult decisions or those who had no one to act on their behalf.

Requires Improvement

Is the service responsive?

Our findings

People told us they received care that met their needs, choices and preferences. One person said, "I have the breakfast I want. Whatever I want, they give. It's not a case of what they're prepared to do for me; it's always what I want." Another person said, "If I say I'll not have a shower, I'll not have a shower." Another person told us "If I say 'do something' they do it. If you get someone and they're here all the time, they know what to do, but if you get someone new, they don't, and that happens a lot, especially in holiday times."

The registered manager told us once a referral had been received by a local authority the care coordinator or registered manager would carry out an assessment which was titled, " Person Centred Care Plan and Comprehensive Risk assessment (PCP)." A new role had been created at the service and in future one care coordinator would undertake this assessing role to improve consistency in the quality of care plan recording. They were new in post and this role was developing.

A copy of the care plan was kept in the person's home and a copy kept in the office. The personal care plan contained information about the person, detailed other agencies involved in supporting the person, a section on the person's life history, their family situation, and how they communicated. There was information about the person's medication history, a list of medicines and how to support the person to take their medicines. There was a section on the outcomes the person would like to achieve and specific care plans such as maintaining a healthy balanced diet, how to support personal care, mobility and consent to care.

We reviewed seven care plans as part of our inspection process. We found the records were person centred and detailed people's needs, choices and preferences and how they wanted their care to be provided. They included details in relation to what people liked to eat, how they mobilised, whether they liked to bath or shower and how to support decision making. For example, one record we reviewed stated, "Please ask me what I would like to wear by give me a choice of 2/3 outfits". And "I usually have two Weetabix with warm milk and no sugar, a pot of tea, milk and no sugar, but please ask if I would like anything different."

Care plans also advised the care worker what the person could do for themselves to ensure the worker maintained the person's independence by doing tasks with the person rather than for the person. However, when we cross referenced the care plan to the person's daily journal which provided a chronology of the tasks provided, we found people had needs (which staff were meeting) which were not referenced in the care plan. People also had equipment which staff were using but was not referenced in either the risk assessment or care plans. It was clear the outcome was being achieved and care provided but there was no accurate record to detail this care provision had been assessed, and all risks recorded as reduced to the lowest acceptable level.

The care coordinator told us they reviewed care plans whenever people's needs changed and at least yearly. The PCP did not have a review or assessment date on each section so it was not clear when the care plan had been reviewed. We discussed this with the registered provider who assured us this had been on the form in the past and could not explain why this was no longer evident.

The service had a complaints policy and procedure in place. We reviewed the recent complaints to check they had been resolved to the satisfaction of the complainant. The registered manager told us if a person was not satisfied with the outcome the registered manager would visit the person to try and resolve the matter. We asked people who used the service how easy people found the complaints process to use and whether they were happy with the way their complaint was handled. People told us they would ring the office in the first instance, and made the following comments, "I have no complaints." Another said, "I'd go to the company first, but if they didn't do anything, I'd go to my social worker." Another person said, "Well, one of the co-ordinators. I'm sure they would act on it. I've not complained yet. Only about being late and not turning up, that's all." One person told us they had made a complaint in the past. They told us, "I've only had one complaint in 4 years." They explained how this had been dealt with and they were satisfied with the outcome. This demonstrated the service had an effective system in place for dealing with complaints and improving the experience of people using the service as a result of effective complaint handling.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who had been registered since 9 March 2016. They were not at the service on both days of our inspection. However, we interviewed them over the telephone on the second day of our inspection. All the staff we spoke with told us the registered manager was supportive and they were able to go to this person if they had any concerns. People who used the service, who knew who the registered manager was, spoke highly of their ability to resolve issues. However, some of the people we spoke with were not aware who the registered manager was and often referred to the coordinators as the 'manager'. Staff and people who used the service were less complimentary about this level of management. The registered provider told us there had been a recent change in the coordinators' role and people using the service should find an improvement in this aspect of service delivery.

The registered provider told us they kept up to date with best practice they were on the Board of the United Kingdom Homecare Association Ltd (UKHCA). This is the professional association of home care providers from the independent, voluntary, not-for-profit and statutory sectors. They told us they wanted to develop their service into an outstanding service and embrace new models of service delivery, utilising technology to make it easier for staff to record care provision and provide office staff with up to the minute information in relation to people using the service. They told us the registered manager attended the local registered manager forum which assisted them to keep up to date with local initiatives.

The Group Operational Director told us their vision for the service, "As a group it is all about quality. We don't stand still. We want to develop what we do. It feels like we have the coordination team right now. There has been a lack of consistency in the past. We have invested in staff and their wellbeing. We now have an employee engagement officer to communicate with staff, produce newsletters. Our latest employee survey demonstrated an improvement and evidenced we listened." The Employee Engagement Officer had three key objectives to improve engagement, communication and staff retention The registered provider had been awarded the Workplace Well-Being Charter. The Workplace Wellbeing Charter demonstrates a business's commitment to the health and wellbeing of its workforce.

We found the registered provider had recognised the importance of training and development of staff to recruit and retain staff with the values and behaviours required for the caring profession. The Group Operational Director told us they were implementing a management development programme for management and office staff to develop the staff at this level to ensure they had the knowledge, skills and behaviours required of them to lead, manage and develop people effectively. They told us one of their trainers received the Care Trainer award from the Great British Care Awards. The award recognised the person's enthusiasm for training and development and ability to enthuse and energise staff to attend and request training.

The service had a quarterly service user/staff newsletter and we were shown the latest copy of this. This contained positive feedback comments from people who used the service about their carer and provided information on topics such as healthy eating and how to minimise the risk of dehydration. People we spoke

with and care staff told us they had received the information. The service had sought feedback from people using the service. We saw the 2015 Service User Survey Results 2015. 187 surveys had been sent out and 49 returned. People were asked whether their care worker came at a time that suited their routine, whether they were happy with the continuity of care workers, whether the care worker arrived within 30 minutes of the time expected, whether they stayed for the allocated time, were treated with dignity, respect, caring and kindness and whether staff encouraged people to do as much as they could for themselves. There was a mixed response to the questions, but overall 100% of people were satisfied with the care provided. The registered manager had completed an action plan to address areas where people were less satisfied. This demonstrated the service was actively seeking the views of people using the service and using the results to improve their service delivery.

During our inspection we found areas where quality of service provision had not been managed effectively and audits had not driven up improvements. For example, we found medicines management audits had not been completed or had not found the issues we had found in the safe management of medicines. Care plan audits had not picked up the discrepancies between what was recorded in the care plan and what had been recorded in the daily journal in relation to the delivery of care. Not all the policies had been updated to reflect up to date legislation and the Mental Capacity Act Policy referred to the incorrect Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to consent. This policy described the Mental Capacity Act 2005 and the principles of the Act in detail but did not guide staff on the application of the Act in their role on a day to day basis. We found no capacity assessments in the care plans we reviewed and a lack of awareness amongst assessing staff and management on their responsibilities in relation to mental capacity legislation, although staff could tell us how they acted within the principles of the Act which ensured peoples human rights were respected. We discussed this with the registered provider who agreed to act on these findings immediately.

Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. We were shown evidence the service was having meetings at the different levels of service provision. We were shown minutes from the latest staff meetings. Not all staff had attended these meetings and we asked staff whether they received the minutes of meetings if they were unavailable to attend. The staff we spoke with were not sure they received minutes to meetings but the registered manager confirmed these were emailed to staff who were not in attendance. The Group Operations Director told us they held fortnightly operations meetings and human resources meetings. They told us the registered manager completed their own report on how their service was delivered and we were given a copy of this report which detailed information on staffing issues, absence levels and compliance on supervisions. They told us they received reports from human resources on recruitment and people management information, plus a report on training. This demonstrated the service had systems in place to robustly monitor the quality of this aspect of service delivery.

This evidenced the registered provider had failed to effectively assess and monitor the quality of the service provided to people. Records relating to people who used the service and staff employed were not accurate enough to withstand scrutiny. Systems and processes and were not robust enough to ensure full compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This evidenced a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 11 HSCA RA Regulations 2014 Need for consent Where individuals might lack capacity to consent, the legal process to obtain consent had not been followed.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The inaccurate recording of medicines and the lack of individual risk assessment and risk reduction plans demonstrated the service had breached this regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been robust in improving practice. Records such as mental capacity assessments and best interest decisions were not in evidence.