SQ Carers Ltd

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Inspection report

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Date of inspection visit:
16 May 2018
21 May 2018

Date of publication:
19 June 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection visit took place on 16 May 2017 and was announced. SQ Carers Limited is registered to provide personal care to people in their own homes. We returned announced on 21 May 2018 to collect documents we had requested, and to see further records of people's care. At the time of this inspection visit, 23 people received personal care and the service employed 10 care staff.

SQ Carers are located in Stratford upon Avon and provide long and short term care packages with care calls ranging from 30 minutes to one hour. Care calls are provided across Warwickshire and Gloucestershire and SQ Carers also provides a live in service. No one was using the live in service at the time of our visit.

SQ Carers registered with us in May 2017 and this was the first inspection of this service. Before providers are registered, part of our registration process is to check those providing care, are of suitable character and have effective systems and processes to provide people with a service that meets their needs. At this inspection visit we found improvements were needed to their quality assurance systems and how they retained important information that supported their regulatory responsibilities.

The owner was the registered manager and in the report, we refer to them as the 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 requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People who required support to take medicines received these mostly from family members. However, where staff administered medicines, staff were trained and assessed as competent to do so. The provider's recruitment process ensured pre-employment checks were made, prior to staff starting work, to ensure they were suitable to support people who used the service.

People had an assessment of care completed before they used the service to make sure staff could meet people's care and support needs. People felt safe using the service and staff understood how to protect people from abuse and harm.

There were procedures to keep people safe and manage identified risks to people's care, although risk assessments were not always detailed enough to provide staff with the information to manage those risks efficiently. Staff told us they had not always supported people in line with their risk assessments. People said care staff usually arrived around the time expected, but for some people they did not stay for the full amount of time and did not always provide the care outlined in people's care plans. Care plans provided information for staff about people's care needs, but they were not always specific in providing details of what they needed to do on each call.

People and their relatives told us they usually received care from staff who knew them well and from staff

who were kind and caring to their needs. However, some people gave us examples that showed us some staff were not always considerate, such as leaving people without telling them,
or arriving earlier than planned without advanced notice. People said staff treated them with dignity and respect and relatives were confident their relations were safe and looked after.

The registered manager and staff followed the principles of the Mental Capacity Act (MCA). People and relatives told us staff respected their decisions and they felt involved in how their care package was put together.

People's care needs were regularly reviewed. The registered manager and office staff were in contact with people, or their relatives, to check the care provided was what people needed and expected, although they had not identified the issues with the call times and call durations that we found. The registered manager completed observed practices on staff and they completed care calls on occasions which gave them opportunity to speak with people about the service they received.

No written complaints had been raised with the registered manager or office team but when people raised issues, they were actioned. People knew how to complain and information about making a complaint was available for people when they started using the service.

Staff felt supported to do their work effectively and said the managers and provider were approachable and available. There was an 'out of hours' on call system, which ensured support and advice was always available for staff.

The registered manager told us how they worked in partnership with other agencies such as the local authority who commission the services and health care professionals to make sure people's needs were fully assessed and the right care was in place.

The registered manager took responsibility for their own learning and attended meetings within the local area to share ideas and good practice with similar organisations. The office team and registered manager worked well together and were committed to providing a high quality service to people. However, systems to monitor and review the quality of service people received required further improvement and in some cases, were ineffective. The lack of effective and robust governance meant the service people expected did not always match their expectations. Some records we asked for such as copies of care plans, daily records, risk assessments, quality assurance checks were not available and in some cases, were not completed sufficiently to enable us or the registered manager to be confident about the quality of the service people received.

There was a breach of one of the regulations and 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 understood their responsibilities to protect people from the risk of harm. Risks to people's individual health and wellbeing were not always clear and followed by staff to reduce the risks to people receiving care. The provider checked staff were suitable to deliver care and support to people in their own homes. There were enough staff to support people although a lack of call management meant some calls were not always for the required time duration. The provider minimised risks to people's safety in relation to medicines.

Is the service effective?

Good

The service was effective.

Staff were skilled and put their knowledge into practice when they supported people. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and supported people to make their own decisions. People were supported to maintain their health and staff involved other health professionals in people's care when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

The staff knew how to show respect and promote privacy and dignity to the person they supported. However, some people felt staff did not spend time with them because their calls were cut short and some staff left without telling the person, which did not promote dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plan information was not always detailed and for some people, staff did not support them in line with their physical and emotional needs. Staff did not always stay for the required times and some care calls were not always provided at consistent

times which impacted on people's routines.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems to monitor and review the quality of service people received required further improvement. The systems used to monitor the effectiveness of the service provided had not identified the issues we found. Where issues had been identified, limited actions resulted in driving and sustaining improvements. We were assured the provider was committed to putting this right.

SQ Carers 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.

We gave the registered manager 48 hours' notice that we would be visiting their premises on 16 May 2018 to carry out our comprehensive inspection. We gave the registered manager notice of our inspection so they could arrange to be there and arrange for staff to be available to talk with us about the service, and to provide us with the names of people and relatives we could speak with about their experiences of using SQ Carers. The visit on 16 May 2018 was conducted by two inspectors and one inspector returned announced, on 21 May 2018.

Prior to our inspection visit we reviewed the information we held about the service. This includes any information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people, and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law. Following our first inspection visit we received some information that care calls were not always planned to allow sufficient travel time between each care call. There was also information suggesting DBS checks were not always obtained. Our inspection methodology means we would look at these topic areas as part of our inspection process which we did.

Prior to the inspection, we asked the provider to send us a provider information return (PIR). The PIR asked the provider to give some key information about the service, what the service does well and improvements they plan to make. The information provided had not identified some of the issues we found during our visit.

We spoke with four people by phone who used the service and three relatives. We used this information to help us make a judgement about the service.

During our inspection visit we spoke with the registered manager who is also the nominated individual, (this

is the person who makes decisions about the service), two administrators, two care staff and two drivers (drivers take care staff to care calls and they support them as a second care staff member where trained). Following our inspection visit, we spoke with three additional care staff although one staff member terminated the call before we could ask them all the questions we wanted to. We reviewed three people's care records to see how their care and support was planned and delivered. We looked at staff recruitment files to ensure staff were of good character. We also reviewed other records such as staff training records, care call rotas, medicine records, risk assessments and records associated with the provider's quality checking systems.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe using the service and with the staff who visited them. People told us they did. One person told us, "I feel totally safe. I trust the carers and know that I am in a safe pair of hands." A person who required the help of two staff for safe transfers said, "I feel very safe, they listen and make sure I do not fall or hurt myself and staff always arrive together. I have never been left at risk."

Plans and assessments were completed to provide staff with guidance about how to reduce risks to the care people required. People had an assessment of their care needs completed when they started using the service that identified any potential risks to providing their care and risks in the person's home. For example, where people required help to move around, risk assessments detailed how they should be moved, the number of staff required to assist the person and the type of equipment to be used, such as a hoist.

However, we found some risk assessments for supporting people with health conditions such as people who had a catheter, suffering with depression, or people who wore aids to help them with their mobility, were not sufficiently detailed or followed by staff which put some people at risk. A risk assessment for depression did not describe what the potential risks were, especially as this person was at risk of loneliness. Risk assessments for safe catheter care were not in place, so staff did not have information that told them what potential risks there were and what to do, such as checking for a blockage or minimising risk of infection. We told the registered manager about these examples and they assured us this would be addressed with staff and the relevant assessments completed.

We asked staff how they knew about the risks associated with people's care and the actions they needed to take to minimise potential risks. They told us all the information they needed was recorded in the care records kept in people's homes. However, from talking with staff, we found some staff did not always help reduce risks to people when known. For example one person had been identified as requiring a shoulder brace to support them with safe transfers and to help promote their independence. This brace when fitted, also helped to reduce the risk of falling. This person's care plan said staff should help them to fit their shoulder brace. On the day we spoke with them on the telephone they said, "I nearly had a fall this morning…staff caught me." We asked if staff supported them to ensure their brace was fitted properly. They said, "No they have never helped me with my brace. I do struggle sometimes but always manage in the end." One staff member who supported this person knew this person used a brace, but when we asked if they helped put their brace on, they said, "Sometimes." This staff member said they did not check if it was on properly as per the care plan. The staff member knew this person had a stroke and without the brace, was at risk of falling.

We asked people if the care staff were always on time. People had different experiences. Comments included, "They come out and do what they have to do. Usually it takes between 25 and 35 minutes" and, "They are generally on time, occasionally can be up to 30 minutes late but usually within 5 or 10 minutes of the time." The registered manager told us, "I would expect care staff to phone the person if they were going to be late, or they let us know and we call the person." People gave us mixed feedback as to whether they were told in advance or not of their late call.

The registered manager and administrators assured us there were enough care staff to allocate all the calls people required. All care staff we spoke with said there were enough staff to provide the care needed. No care staff raised concerns that there were not enough staff, or that they could not manage their allocated care calls.

The provider's recruitment policy and procedures, minimised risks to people's safety. The provider ensured, as far as possible, only staff of suitable character were employed. Prior to care staff starting work at the service, staff told us the provider checked their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Following concerns raised about the robustness of suitability checks, we looked at a selection of DBS records for staff who were working at the service. All DBS checks were enhanced and recorded no concerns.

Staff knew how to keep people safe and protect them from avoidable harm and abuse. They understood how to recognise signs of abuse and understood their responsibilities to report concerns to the management team straight away. One care staff member said, "Any abuse, we report it." The registered manager understood their role and responsibilities in reporting and dealing with safeguarding concerns to make sure people remained safe. Since registration, no incidents of abuse had been notified to us.

We looked at how medicines were managed by the service. Most people we spoke with administered their own medicines, or their relatives helped them with this. Where people were supported by staff, staff were trained and had been assessed as competent by the registered manager.

People told us their medicines were administered as prescribed. Staff recorded in people's records when medicines had been given and signed a medicine administration record (MAR) to confirm this. MARs were 'spot checked' in people's homes and by the administrator when the MARs were returned to the office. We reviewed examples' of people's MARs. We found the checks had identified unexplained gaps on one record, but there was no record to show what action had been taken. We looked at the corresponding daily records for the dates medicines had not been signed for., These showed that staff had given the person their medicines on these dates, but had not recorded it on the MAR. The registered manager told us they had identified concerns with accurate recording and were taking actions to address this. Staff meetings were used as an opportunity to remind staff about the importance of completing MARs accurately.

People did not have concerns with staff cleanliness and how they left their property. One person told us, "They are very professional and I have no concern over hygiene."

The registered manager recorded accidents and incidents and told us they reviewed each incident to make sure they had taken action to prevent further incidents from reoccurring. Most of the incidents that had been recorded, had taken place prior to staff arriving at people's homes. However, the registered manager said it was important to keep records as it provided information about the person's abilities and needs so they could plan the appropriate level of care to keep them safe.

Good

Is the service effective?

Our findings

We looked at three people's care records. An assessment of people's care and support needs had been carried out prior to people using the service to ensure the person's needs could be met, which included their physical, mental and social needs. People, and, or their relatives confirmed they were involved in the assessment process and felt their care support needs were accurately reflected in their plans of care. People told us care staff knew what care and support they needed to meet their needs and maintain their welfare. One person told us, "They go beyond what I would expect. I know if ever I needed them, they would be there for me."

We asked people if they thought care staff were skilled and competent to meet their needs. Most people told us they were, however one person said, "I had a new one (care staff member) she didn't know anything. I had to tell her what to do and what not to do." This person explained this was more about the staff member not knowing their preferred routines, rather than not being trained.

Newly recruited staff undertook induction training when they first started to work for the service and completed the Care Certificate. The Care Certificate is a nationally recognised set of standards to ensure staff have the right skills, knowledge and behaviours.

We could not be confident staff received training yet staff felt confident in knowing how to support people. Some staff gave us mixed responses about the training they had received. Some staff told us they had completed training which they found helped them care for people, yet one staff member told us they had not yet completed training, then told us they had been trained, but could not remember specifically which training courses they had completed. Another staff member said they had been trained in previous roles, but had not yet completed training with SQ Carers. We asked staff questions about topics covered in essential training areas such as Mental Capacity Act, safeguarding and moving and handling. Staff responses led us to believe staff had knowledge in these areas. The registered manager used a training schedule to ensure staff were trained in key areas but this required updating so it accurately reflected what training staff received.

In addition to the training provided, the registered manager told us if there were any instances were staff did not have experience of a particular health condition, the registered manager put together an information sheet to help staff's knowledge. For example, they had recently put together an information sheet on 'what is a stoma' which guided staff on how to support a person with that specific need. When you have a colostomy, the end of your bowel is brought out into an opening on your tummy. The opening is called a stoma. The registered manager completed observed practice and helped support staff so they were confident staff provided effective care and put their training to use.

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.

Care staff knew they should assume people had the capacity to make their own decisions. One staff member told us people had the right to make decisions even if the decision was thought, by others, to be unsafe. One staff member told us, "It is not for us to decide for someone. We need to respect that person and the choices they make." They told us they had received MCA training and they said, "It was very good." This staff member said if they had concerns about a person's decision making, such as someone refusing their medicines, they would tell the office staff and if necessarily inform the person's family or GP. In the care plans we sampled, people had capacity to make their own decisions. There was one person who had limited family support and varying capacity. The registered manager said a meeting was being planned for this person to use the services of an advocate to ensure decisions were made in their best interest.

People who required assistance with meals and drinks were supported to have sufficient to eat and drink. Most people we spoke with were able to prepare their own food or had relatives who helped them do this. Where people required staff to assist them with meal preparation, this was recorded in their care plan. People who had assistance from staff to prepare their meals indicated they were satisfied with the service they received.

People and relatives told us they arranged their own health appointments, but said staff would support them with this if they needed assistance. The registered manager said they liaised with a range of health and social care professionals including, district nurses, social workers, community mental health teams, occupational therapists and doctors on behalf of people to arrange appointments or seek advice when needed.

Requires Improvement

Is the service caring?

Our findings

People were complimentary of staff and even though some people raised concerns about the length of time staff spent on their care calls, they stopped short of saying staff were not caring. Comments people made to us were, "Staff are very friendly", "Staff are so patient and kind" and, "We are very happy with the service we get." One person told us, "I cannot praise them high enough. They really do care."

The registered manager had a nursing background and told us they wanted to provide good quality care to people. The registered manager gave us examples of how they provided care that demonstrated SQ Carers wanted to ensure people were well looked after and cared for. The registered manager told us it was not uncommon for one person to go without food because they had limited funds and limited family support. The registered manager bought this person food and drink to ensure they had enough to eat and drink to maintain their health. They had also bought this person a fire guard to help keep them safe in colder months because they liked to sit close to the fire to keep warm. A staff member also told us they had purchased food items for some people out of their own money, without re-imbursement from the person they were caring for. The registered manager told us they had raised this with a social worker. It was clear from these actions, that most of the staff team cared for those people in their care.

With these examples in mind and some people's positive comments, we could not ignore how the care scheduling, lack of monitoring and some staff rushing to make their next care call, impacted on the quality of care and time some people experienced. We could not be confident everyone was always treated the same and received the same level of kindness and compassion from day-to-day. This was because staff did not always have the time and support they needed to provide care and support in a compassionate and personal way.

Call schedules and the lack of oversight of making sure staff stayed for the required time, meant practicalities such as allowing for a longer care call, traffic or other unforeseen issues had a knock on effect throughout the day which meant some care calls were cut short. We spoke with one driver who was responsible for taking a care staff member to their call. They made it clear that they were on a fixed schedule and care staff had to fit in with their routes and schedule, rather than the needs of people and care staff being the priority.

The provider's call schedules showed a high number of care calls were completed in less than the agreed times. Some people's care records showed they were at risk of being socially isolated and would have benefitted from the time allocated to them. We asked people and relatives who used the service if they told staff to leave. Most replied, 'no'. Some of their comments included, "They tell me they are very busy. I shouldn't keep them should I… they have other things to do than speak to me?" and, "I do feel they are rushing me sometimes." Another person said, "I say are you going already? They say I am going. Then they just go." They told us sometimes staff had left without them knowing and they only realised when they called the staff member's name and there was no reply. We asked staff why they did not stay for the required time to sit and talk with people, especially those identified at risk of loneliness. One staff member told us, "I hadn't thought of that."

We asked one person who needed support at mealtimes, if they got the help they needed. They said, "They never wait for me to finish my meal. They leave my tray with all of the dirty stuff on and the food I have not finished, go and only clear it away when they do the next call (5pm). It is very embarrassing when I have visitors and things are not cleared away." We found from speaking to this person, the lack of consideration impacted on their dignity and the registered manager, was not aware until we shared this with them.

People's important and personal information was not always kept secured. Each person had a care plan that recorded their personal information and what help and support they needed. This information was accessed by staff electronically, on their own personal mobile telephones. The registered manager had not considered the confidentiality and security implications for people when staff used their own mobile telephones to access these records by using an internet based application. We asked three care staff to show us how they accessed this information. Although staff's mobile telephones had initial security, they were still logged into the application so if anyone bypassed their phone security or their passcode was not activated, people's important and personal information could be accessed unauthorised. The registered manager was looking at ways to purchase business telephones so they had better control of locking and securing important data away from the office.

Requires Improvement

Is the service responsive?

Our findings

The provider's website said, "Our carers will help you or a loved one get on with daily life by providing the right amount of care at the right time." However, people's experiences of care from staff at the times they preferred and for the length of calls they needed, was inconsistent and not in line with the provider's aims and objectives. One relative said they were very pleased with the support and one person told us, "SQ care is absolutely brilliant, I could not ask for more." For other people, especially those at risk of loneliness or becoming socially isolated, they told us staff did not always stay for the required amount of time. One person explained, "I never know when they are going to turn up, and they never stay for the full time, some staff are very quick." We asked what was very quick and they said, "You know five or 10 minutes and they are gone, sometimes they go without saying goodbye. I call out no one answers and I just say to myself oh they have gone then."

From what people told us and from our observations of the provider's care call schedules, we had concerns that call times were not always being provided at people's preferred times and some people did not always receive appropriate levels of support. One person said, "They should come at 10am, 3.00pm and 7.30pm." We asked what time they had come this morning and they said, "Just before 9am, they stayed about 20 minutes…just long enough to make me coffee and breakfast."

Some people told us their call visits were not always when they expected them or for the agreed length of time. For example, one person identified at risk of being lonely, required a 30 minute call three times per day for personal care and for supporting them with getting up and going to bed. We saw one instance during April 2018 where the evening call had only been recorded as one minute long. There were many other calls during April and May 2018 that ranged from four minutes, 17 minutes, 23 minutes and 53 minutes. We noticed some calls lasted over 80 minutes. We spoke with staff about why this happened. One staff member told us this could happen if they had to wait in a person's home for a driver to take them to their next care call. They told us, "We use a driver but I don't think it works really. We can wait up to an hour for the driver to come and we never know where he is. It makes us late for the next call."

Another person required 30 minute calls but we saw call records that showed staff had supported this person regularly for less than 20 minutes. Some people we spoke with said they felt they could not ask staff to stay which gave us the impression, those people worried about the staff rather than staff responding to their needs. One person said, "They (staff) tell me they are very busy. I shouldn't keep them should I as they have other things to do than speak to me?" When we looked at the call log for people who received the service, we found staff members had regularly not stayed for the full allocated times and staff told us they had not. There was no investigation into why this had consistently happened and it was not always known by the registered manager or office staff.

On 22 May 2018 we spoke with a staff member who told us they had got to their 9.00am call that day at 7.47am because of the driver being early. This staff member told us their next care call was 10.30am, yet they had not arrived at this call until 11.15am and the person had not got up or had their breakfast. We asked why they were late, but they did not give us a reason. Throughout our conversations with people that used

the service what they told us about short calls was confirmed by what staff told us. However, this had not been identified through the quality assurance monitoring systems in place where we found a breach of Regulation 17 (Good governance) of the Health and Social Care Act Regulations 2014.

People gave us mixed opinions about the responsiveness of the service. One relative said, "(Person) had never had a call missed and found staff were very friendly." Another relative said, "They get her up every morning and showered and dressed and then ready for bed in the evening. The girls are so nice and friendly and I couldn't ask for more. The notes are all really well laid out."

We were told a copy of people's support plans were kept both in the home of the person who used the service and the agency's main office. However, when we asked to see some people's previous daily records, full care plans or risk assessments, copies were not in the office. When we returned to review more care records on 21 May 2018, we looked at one care plan for a person who had a catheter. The registered manager told us they had provided information about how to provide good catheter care and the importance of recording fluid input and outputs. Information provided within the care plan was not detailed enough, such as when to change the bag and what to do to check for signs of blockage. We checked this person's daily records for April 2018 and found staff had not completed fluid outputs. There was only one record for fluid output recorded in the month which was completed by the registered manager when they visited this person. We would expect the registered manager, senior carer or a person designated to monitor these records for accuracy and completion. There was no monitoring of records to ensure consistent care was provided in line with people's care needs.

Staff told us they had information on their phones that told them what to do at each care call but we found this was not sufficiently specific as it lacked detail. For example records showed us 'Assist getting ready for bed', 'support with transfers' and 'assist with continence needs (changing pads and emptying catheter)', but did not state how this should be done' which meant there was a risk that staff would provide inconsistent care.

People and relatives told us they were involved in making care decisions and what they wanted staff to do. Comments included, "I have had assessments with them and feel involved in my care" and, "I have been involved in some recent assessments of my needs. Fully involved and listened to." Staff said if they saw changes in people they informed the office. One staff member said, "I feel we do our best to respond to people. For example, if we feel someone's needs have changed we contact [registered manager] and things are assessed again." The registered manager said they reviewed care plans at certain intervals but made changes to care plans swiftly when changes were identified.

No written complaints had been made since the service started delivering care although people said, some issues were brought to the registered manager's attention. One person told us they had informed the office verbally about an issue which was addressed quickly and efficiently. The registered manager said because they completed some care calls and did observed practice on staff, issues were dealt with before they escalated, but they had not been aware of the issues we found. We saw people who used the service were issued with a service user guide that informed them how to make a complaint.

Requires Improvement

Is the service well-led?

Our findings

People and relatives were complimentary about the management of the service and felt the provider was approachable and if actions were needed, they were listened to. A relative gave us an example of a situation they raised with the provider. They said, "I had a problem with a member of staff about six weeks ago as they were knocking off early and leaving stuff like towels all over the floor. I reported it to [registered manager] and she has obviously had a word with this member of staff as she has never done it since." People and relatives said the registered manager had done checks on staff when care was delivered and checked with them to seek their views on the quality of care received. One person said, "Management is excellent and it is a really excellent level of service."

Speaking with the registered manager and reviewing their systems, we identified a lack of proactive management and leadership at the service which affected the quality of service provided. For example, the registered manager used a call monitoring system which staff accessed using their own personal mobile telephones. People's personal details such as name, address, key codes and basic care needs could be accessed on these devices. We were concerned about the security of people's important information because if staff had not logged out of the application, there was a risk that if their personal phone was misplaced, an unauthorised person could gain access to people's information. The registered manager had not identified this as a concern but following our inspection they planned to purchase business telephones to better control security and safeguard people's sensitive information.

Systems for the oversight of care plans and risk assessments was in place, but some records of care plans and risk assessments were not kept in the office which restricted what we could see. Daily records were not regularly returned so if events or changes had been recorded, these were not always identified quickly. For example, we checked daily records for a person with a catheter. We found staff failed to record urine outputs. One person required staff to support them with a brace, but staff told us they did not routinely help this person. Effective checks of these records would have highlighted a lack of care being provided so action could have been taken more swiftly to rectify this and improve the quality of care people received.

It was evident from speaking with people and staff that care staff did not regularly check in and check out of each care call. The registered manager and both administrators said this could be because of signal strength issues in certain areas. We checked the provider's call monitoring system and found examples of some care calls lasting one minute, some had not been checked in or out at all, and records also showed some staff checked out close to their own home address which was a distance from their care calls. Knowing the limitations of their systems, there were no effective checks or measures put in place to manage care calls more closely.

The registered manager's audit process did not record what they checked. We looked at a medicines audit that had been completed, but there was no information to tell us what was reviewed and what action had been taken. On one person's MAR we found gaps, but there was no evidence to show why and what they had done to reduce this from happening again.

Training records were not always up to date to record when staff had completed their training. The records, together with the responses from staff, meant we could not be assured that staff had completed all the training necessary. We discussed this with the registered manager who was confident staff knew how to care for people.

The registered manager told us they reviewed daily logs, but there was no record of what they had checked. We looked at examples of daily records and found staff did not record start and finish times. The issues we found during this inspection visit with staff not staying the correct
amount of time or arriving on time had not been identified and investigated. The provider did not have effective arrangements in place to monitor and improve the quality and safety and welfare of people using the service.

This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection visits the registered manager accepted that closer scrutiny and improved governance would help them to deliver good care outcomes to people. The registered manager said they welcomed the inspection and would make the improvements because they wanted to deliver a good service. They told us they were part of a local network of other care providers so they could share and discuss best practice. They also worked in partnership with the local authority that funded people's care and used these networks to seek help and guidance. They said this was helpful to them to learn and improve.

The registered manager told us they had planned to speak with a mobile phone provider to source mobile telephones that they had more control of. They also said they were planning to meet with another call monitoring supplier to see if their system was better suited to their needs. This could give them confidence care calls took place at people's preferred times and records of those calls were made so they had better oversight of what was being delivered.

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 17 HSCA RA Regulations 2014 Good governance Systems or processes were not robust, established and operated effectively to ensure risks to people were reduced and to provide a good quality service to people. Regulation 17(1)(2)(a)(b)(e).