Compassionate Care Team Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection visit took place on 26 September 2018 and phone calls were made to people who used the service on 1 October 2018. The service was last inspected in September 2017, when it was rated 'Requires Improvement'. This is the third time the service had been rated 'requires improvement'. At the last inspection it was found to be in breach of two regulations of the Health and Social Care Act 2008 (Regulations) 2014. At this inspection we found the service remained in breach of these regulations and found a further breach. You can see what action we asked the provider to take at the end of the full report.

The service is a community based service registered to provide care and support to people in their own homes. It currently provides care for 90 people who live in their own home. Not everyone using Compassionate Care Team Ltd, receives regulated activity; CQC only inspects the service being received by people provided with 'personal care' - help with tasks related to personal hygiene, medicines and eating. Where people receive personal care we also take into account any wider social care provided.

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.

The service was not consistently safe. Risks to people were not always identified and risk assessments were not always updated in a timely way. Staff did not always have time to stay for the full call and were often task focused. Sometimes only one staff member attended a care call where two were required. Medicines were generally managed well; however, improvements were required to how the service managed 'as required' medicines. Safe recruitment practice was not followed and some staff were working without all pre-employment checks having been completed. Lessons were not always learnt from incidents or mistakes. Policies were in place for the prevention and control of infection.

The service was not always effective. Not all people who required support to prepare and cook meals, had the meals they preferred. Some staff did not have the skills to support people with specialist diets or who preferred meals cooked from fresh ingredients. Care plans were developed with people and were focused on supporting independence and choice.

The service was caring. Many people told us staff were kind and caring; and promoted their independence and dignity. However, we found some occasions when people did not feel that staff listened to them and they were not happy with changes to their care. On these occasions we found staff had not always respected people's views and preferences.

The service was not consistently responsive to individual needs and preferences. There was no process for capturing people's comments and suggestions and people often felt their views were ignored. Complaints were not processed effectively and some people were left dissatisfied with their care. Feedback was not

used as a learning opportunity to improve people's care experience. Staff tried to support people's cultural needs but found it difficult to engage with some people due to language differences. Where possible, people were supported to remain in their own homes at the end of their life, if they wished.

The service was not well led. Although there had been some improvements in medicines management since the last inspection; there was still no policy for the use of PRN medicines. There had not been sufficient improvement in overall governance and quality assurance. Quality assurance processes were still not effective and had not identified some of the concerns we had. The registered manager said they had recruited to new roles and had been focusing on staff development but now they were fully staffed they would be focusing on improvements to processes and how information was stored and recorded. There had not been sufficient improvement to the governance of the service and improvements were still required. This had impacted on the safety, effectiveness and responsiveness of the service. As this is the third time the service has been rated 'requires improvement' overall, our methodology states we must rate 'well-led' as inadequate.

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 safe.

Pre-employment checks were not always completed before staff were employed and cared for people.
Risks to people were not always identified and records did not always reflect people's current needs.
Information to support staff to administer medicines safely was not always available.
Staff understood their responsibilities to keep people safe from harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always have the time, knowledge or skills to meet people's individual needs.
People were not always involved in decisions about their care.
Staff were supervised and felt supported by the management team.

Is the service caring?

Good

The service was caring.

People told us staff were kind and compassionate and they had positive relationships.
Staff promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider did not always accommodate people's preferences.
People did not always receive a positive response to their complaints.
There was little evidence that feedback from people was used to improve the service and the care people experienced.

Is the service well-led?

Inadequate

The service was not well-led.

Improvements required from previous inspections or audits, had not been made or were not consistently maintained. Quality assurance processes were not effective at identifying areas for improvement. The provider did not always follow their own policies and procedures.	

Compassionate Care Team Ltd

Detailed findings

Background to this inspection

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

This inspection visit took place on 26 September 2018 at the provider's office base. We gave the provider 24 hours' notice because they provide a community based service and the manager is often out during the day; we needed to be sure that someone would be in.

The inspection team consisted of one inspector and one assistant inspector. The assistant inspector telephoned a sample of people who used the service on 1 October 2018, to gather their views on the quality of the service.

Before the inspection visit we reviewed any information we held about the service, including any information the provider had sent us. This included the provider information return (PIR). A PIR is a report that we ask the provider to complete which gives details of how they deliver their service, including numbers of staff and people using the service, and any plans for development. We reviewed any notifications the provider had sent us. Notifications are reports the provider must send to us to tell us of any significant incidents or events that have occurred.

We also contacted health and social care practitioners who work with Compassionate Care Team Ltd to care for people; or who commission services to make sure people have the care they need to live in their own homes. Information they provided was used to inform the inspection planning.

During the inspection, we spoke to 14 people who used the service or their families; as well as the registered manager and 3 staff. We reviewed 3 people's care plans and a variety of associated care records which

included needs assessments, risk assessments and daily care logs. We also viewed management records which included six staff records, policies, audits and evidence of training.

Requires Improvement

Is the service safe?

Our findings

The service was not consistently safe and remained in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 – safe care and treatment. This is the third inspection where the provider has been found to be in breach of Regulation 12.

Risk assessments were in place in people's care records. However, we found them to be basic, lacked clear direction about how to reduce the impact of risks on people and were not always updated in a timely manner. For example, one person had fallen the previous weekend when they were trying to mobilise in their own home and they were taken to hospital to assess them for injuries. Staff told us they were present during this incident and cancelled this person's care for the following day. However, this had not been recorded as an incident and had not led to a review of this person's risk assessment.

Owing to a lack of communication from the hospital, staff were not aware that this person had been discharged home the following day. It was not until the day after that they were informed by a relative of the person, that they were back home; and had been without care since they returned home. Although care was re-instated immediately, this was a potential safeguarding incident as the person had been without care for 24 hours. This had not been reported as an incident and had not been investigated by the registered manager. It was only during our inspection and in response to our questions that information was collated about what happened. Consequently, it was found that a lack of communication from the hospital had led to this person being without care. However, we were concerned that a thorough investigation had not already been started or completed before our inspection. Neither had the risk assessment been reviewed to ensure all options were considered to reduce the risk of this person being without care again. Incidents were not always recorded or investigated thoroughly and did not always lead to a review of risk assessments. We were not assured that the risk assessments we saw, ensured staff were always up-to-date with people's current level of risk and were taking appropriate steps to reduce the risk of reoccurrence.

One person told us they required two staff to care for them, but two staff did not always arrive. This meant they did not always have the care they required. For example, they had to have a wash, instead of the shower they preferred; and sometimes assistance with moving and repositioning was carried out by one staff member instead of the two required. Team meeting minutes confirmed staff had been reminded to ensure that two staff went to calls where this had been agreed. The registered manager told us of a person who was referred to a dietician to assess their nutritional needs and records showed that a soft diet was recommended. However, there was no evidence in the daily records or care plan to advise staff of this and the registered manager could not confirm if this was followed. This demonstrated that known risks to people were not always managed safely.

Poor incident and risk management had been identified at the previous two inspections in 2016 and 2017. It remained a concern at this inspection. Incidents and risks to people were not well managed and they did not always receive care in the way they required it. This put people at risk of harm from known risks. This was evidence of a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some people received support with their medicines whilst others managed their own medicines. We viewed a selection of MAR's for people who had support with their medicines. We found that generally, people received their medicines as prescribed and one person told us, "They always make sure I have my pills."

Some medicines were only administered occasionally for pain relief or to manage other temporary conditions, these are referred to as 'as required' or PRN medicines. At the last inspection, there were concerns raised about poor management of medicines, including PRN. The registered manager showed us improvements to recording and auditing of medicine administration records (MAR) that had been introduced following the last inspection. Whilst there had been some improvements, there were more required for the management of PRN medicines. There were no protocols in place to support staff to identify when a PRN medicine was required, and at what dosage and frequency. This meant staff did not always have information available to support them in administering appropriate medicines for people. The registered manager said this information was on the medicine packaging. However, this did not take into account personal differences to how people react to pain or other conditions that may require PRN.

The registered manager told us they had recently changed the way they recorded PRN medicines. We asked if they had changed their medicine policy to match the new practice. They said they had not. This meant they were operating outside of their own policy which could put people at risk of administration errors.

This was further evidence of a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The information in the provider information report (PIR) stated there had been twelve medicine recording errors and four medicine administration errors in the last 12 months. The registered manager told us how they audited the MAR and daily logs each month once they had been returned to the office. We saw that where errors had been identified they were discussed in staff supervisions or team meetings. However, we found repeated reminders in minutes of team meetings for staff to complete the name of people on the top of each daily log sheet and record start and finish time of calls. This demonstrated that staff did not always follow instruction and meant it was difficult for the registered manager to audit records if they were incorrectly labelled. Lessons were not always learnt from incidents and mistakes.

The provider was not following their own recruitment policy and safe recruitment practices. In the provider information report (PIR) sent before the inspection, the registered manager stated – 'Staff recruited for the company are interviewed through a robust interview. Once a member of staff is recruited a full DBS check is carried out and 2 references are gained.' Their recruitment policy also stated that pre-employment checks must be completed 'with no exception' for all staff.

We checked six staff recruitment records and found they were all missing some information which the registered manager had said they always checked before employing new staff. For example, only two of the six staff files included two written references; and one of these only had references from within compassionate care. Job application forms were not always completed – we found examples of forms that were not signed, dated, or missed dates of employment and education, some did not declare previous addresses. ID was not available in all six staff records and some staff appeared to be working without a valid disclosure and barring check (DBS). One person told us their DBS was transferable but there was no evidence to confirm this; another staff member applied for a DBS during our inspection visit and produced a receipt for this at the end of the day. We asked if there were DBS records stored elsewhere and the registered manager told us, no there were not. Some records did not contain job descriptions or signed job contracts. The registered manager said some staff had not returned their signed contracts.

The registered manager could not demonstrate they had completed all necessary pre-employment checks for staff which meant they could not evidence that staff were suitable to care for people. They told us they could vouch for the suitability of the staff without full references or application forms, as they were previously known to them and they knew them to be of good character. We did not agree this was a robust way of ensuring staff suitability for their role. This left people at risk of harm from unsuitable care staff.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – fit and proper persons employed.

Staff did not consistently arrive on time for care calls and did not always stay for the full duration of the planned call. People had mixed views about whether staff arrived on time and whether staff stayed for the full duration of the call. Some people told us that staff often leave early to get to their next call. One person said, "Sometimes they are late but they can't help it"; a second person said, "Staff have no time for travel – they are constantly late as they are not allowed time for travel." A third person said, "Changes to rota, swapping staff. The person you expect isn't the one who actually comes. When they are late they will say they got held up at the previous call which is frustrating. It should all be rota'd properly and give them time to go from one to the other." Other people were happy with their calls. One person said, "Always on time unless it is unforeseen and they will always ring from the office and say they will be late". Another person said, "Come when they say and do what they are supposed to, and always on time."

Staff confirmed that there was no travel time in the rota and calls started and finished at the same time. This meant it was impossible to arrive or leave on time and for people to receive care for the allotted time, unless there was a break in the rota before and after a visit. One staff member said, "We don't always need the full call time and people often say to us, 'you get off now' when we have finished." Another staff member said, "Lots of the calls are close by each other, so it is easy to get from one to another in a few minutes".

We checked rotas and found that whilst most calls that started and finished at the same time, were close to each other; there were instances where people lived further apart and staff had to travel further to their next call. As rotas were planned without travel time, this meant some people did not consistently receive care for the full duration of the calls that had been agreed. Staff were mainly focused on the completion of tasks and although they gave some examples of sitting and chatting to people, it was clear this was the exception rather than the norm. Some people received social calls where chatting and socialising was an expectation of these calls. However, for those people who only had personal care calls, there was more of a focus on tasks rather than socialisation. Owing to the way that calls were planned back-to-back, some people did not always receive care for the time agreed in their contract. This meant they did not always benefit from the social aspect of their care calls.

We recommend the provider reviews how rotas are planned to ensure everyone receives the care they require, i.e. for the full allotted time.

People were protected from the risk of abuse. People told us they felt safe with staff from Compassionate Care Team. One person said, "I feel safe when they are with me as I can't go out on my own and they use the wheelchair. I use my sticks. They will always hold me if I feel wobbly." They went on to say, "I have grip rails but like them to be there. It makes me feel more secure when they are there. Wouldn't dream of getting in the shower without them."

Staff told us they understood how to keep people safe from harm or the risk of abuse. They described how they would respond to concerns about a person's safety and who thy would escalate any concerns to. We saw there were policies and procedures in place to support staff to keep people safe. The registered

manager told us how they had responded to incidents of abuse and acted immediately to ensure people were safe. Information about potential abuse was shared appropriately with other authorities including CQC and records we saw confirmed this.

People and staff told us they used gloves and aprons when providing personal care to reduce the risk of cross contamination. One person told us, "The girls wear gloves and apron when they helped me with personal care or cooking. I see them washing their hands regularly. Also have antiseptic gel which they use." Another person said, "They wear gloves, they do wash their hands frequently too and they also ask if they can." Staff told us and records confirmed that continence products were disposed of securely in outside bins and staff used hand gel and hand washing to maintain hygiene. Infection control was considered when assessing risks to people.

Requires Improvement

Is the service effective?

Our findings

In the PIR which the provider sent us before the inspection, they said they used NICE guidance to develop their policies and procedures; and used their videos in staff training. We also saw posters and information leaflets displayed in the office for staff to access. This meant staff had access to current guidance which helped them develop their practice, knowledge and understanding of their responsibilities when caring for people. The registered manager told us how they had implemented changes following the new General Data Protection Regulations, which kept people's personal information save and secure. They also told us how they worked closely with other community healthcare services to reduce hospital admissions and provide emergency care to people when they returned from hospital. Care plans were developed with people, family and other healthcare practitioners, where required. This meant they were relevant to the person and helped staff identify individual needs and be clear on expected outcomes.

The provider had an induction process that was aligned to the Care Certificate. The Care Certificate identifies a set of care standards and introductory skills that non-regulated health and social care workers should consistently adhere to. Staff told us they received support during their induction period which included completing workbooks and 'shadowing' experienced staff, before they cared for people. This showed the provider recognised the need to ensure new staff had the necessary training and skills to meet people's needs.

Whilst staff were knowledgeable about the needs of many of the people they cared for, we found some occasions where staff knowledge and skills were insufficient to meet people's specific needs or preferences. For example, one person had expressed support to eat their traditional meals. Staff did not have the skills to assist this person to prepare and cook culturally specific meals. Records did not show that this need was met. A second person told us they were unhappy with the response from staff to their request to prepare fresh meals for them. They told us staff had refused to cook meals from fresh ingredients and on one occasion a staff member had left them with no evening meal, as they refused to cook what the person had asked for. This person told us they needed fresh food to help maintain their health and ready meals did not provide the nutrition they required. This meant this person did not always receive the diet and nutrition they required to maintain their health. The registered manager told us they were not aware of this and would conduct a review of this person's dietary needs.

The registered manager told us the length of calls was set by the local authority who commissioned the service on behalf of people. They said many of the calls were not long enough to cook meals from scratch and this was not an expectation of the commissioners. We asked if they had fed back to the commissioners if they struggled to meet people's needs in the time agreed, but they said they had not. They also told us some staff did not feel confident 'cooking from scratch' and it was difficult to find staff willing to do this. This demonstrated that staff did not always have the skills and knowledge to meet people's individual needs.

Not all people were assisted with their meals or drinks; but where they were, staff heated up 'ready meals' or prepared quick meals. People told us they were offered a choice of the meals available and most were happy with this arrangement. Staff supported people to eat and drink enough food and drinks of their

choice, within the time available. Where this was not possible staff prepared meals ready for people to cook when they were ready to eat.

Communication within the service and with external services was not always good. As the service covered a wide geographical area, care teams were split into smaller locality teams. This ensured people got to know the staff team who cared for them. Some people told us they had the same staff to care for them, which they preferred. Staff from one team told us there was good communication across the smaller staff teams and staff supported each other; especially when arranging cover for absent staff. They told us they checked daily logs to see what care had been given and they were notified by the office staff, if any changes were required.

However, people told us that staff were sometimes late for calls and staff did not always inform them of this. We saw evidence in team meeting minutes that missed calls were discussed. When we asked the registered manager about this, they said it was due to staff not checking rotas for any changes, or people not telling them if their plans had changed. This demonstrated that communication within the service was not always effective.

To assess how well the service communicated with other services to jointly care for people, we asked to see the contact records for other healthcare practitioners. The registered manager advised us they did not keep such records. They said any changes to care were fed into care reviews but other contact was not necessarily recorded. They said it was 'sometimes' recorded in daily logs if it occurred at the same time as a care call, but telephone contact was not necessarily recorded. This meant there was a risk of miscommunication and inconsistent care by staff. It also made it difficult to demonstrate they had acted on advice, or consulted with specialist advisors to support people's more complex care needs. This put people at risk of receiving inconsistent or inappropriate care. Communication processes needed improving to ensure that appropriate information was shared between services that had a joint responsibility to care for people.

Staff told us they supported people to access healthcare services and made referrals to specialist services where required. For example, one person was referred to the district nurses to help manage their pressure care and staff told us how they worked with the district nurse team to manage this person care. People told us staff assisted them to make appointments or order prescriptions if this was required. People were supported to access community healthcare services and maintain their general health.

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 the providers understanding of MCA. The registered manager told us all the people they cared for, had capacity to make their own decisions about care; but some were also supported by family members and professionals, who understood the needs and preferences of the person. A relative told us they had supported their family member and been involved in planning their care with staff from Compassionate Care Team. The provider was following the principles of the MCA.

Good

Is the service caring?

Our findings

People generally told us staff were kind and caring. One person said, "I am getting good care. They are very pleasant and they have time to talk to me. I am quite content with them." Another person said, "They are lovely carers." And a third person said, "They are very friendly people, my carers talk to me. It's like having a friend here if you know what I mean." Staff spoke with kindness and compassion for the people they cared for. One staff member said, "It's lovely to put the service users first" and another said, "When all care is done, we can sit and chat with them, it's lovely." People were cared for by staff who were kind and compassionate.

However, some people also told us they were unhappy with aspects of their care and did not always feel their views and preferences were considered. They told us the care provided did not always match their preferences, for example - time of appointments, choice of food. However, when they voiced this to care to staff they told us nothing changed, and they were not offered an explanation or alternative from staff. One person told us, "They come at 11.30 to do my dinner, but that's too early for me. I have told them just to leave it in the microwave and set the time so I just need to turn it on at the top." The registered manager advised us that many of the call times were set by the commissioners and provided little opportunity for flexibility. They said this was explained to people at the initial assessment and they would revisit this when they reviewed people's care plans.

It was clear people had been involved in the initial assessments and planning of their care, but this was not always evident when care was reviewed. One person said, "My carers are very helpful and will do things for me if I need them to." A relative said, "She is getting the care she wants and will tell the staff what she wants them to do. It's up to her really." People were involved in the initial assessments of their care needs; and their requirements and preferences were recorded in their care plans. Most people felt they were consulted about their care initially and many said they were able to discuss what they wanted to do on a daily or regular basis.

However, one person told us they had not been consulted about changes to their care and were unhappy with decisions that had been made without consulting them. They said their personal care routine had changed following an incident, without any consultation from them or new risk assessment. They said they had expressed their dissatisfaction daily to care staff but did not receive an adequate response. They told us they did not think their feelings were considered at that point. The registered manager said they would review this person's care and ensure they received a satisfactory explanation.

People told us the staff cared for them with respect and dignity, whilst also promoting their independence. One person said, "They help me to get into the chair in a respectful way. I feel at ease as they use a bit of humour which is always nice. They respect my home and are polite." A second person said, "I like to be independent and the staff allow me to be" and a third person said, "They make me feel at ease during personal care and I don't feel nervous or anything." Staff provided examples of how they promoted people's privacy and dignity during personal care and spoke respectfully about the people they cared for. They explained how they promoted independence and encouraged people to do what they could themselves, whilst staying close by if needed.

Requires Improvement

Is the service responsive?

Our findings

Care was not always personalised to individual need and the service did not always respond positively to feedback or suggestions. Some people told us the service was not very flexible or personalised. For example, one person told us staff refused to cook meals for them in the way they preferred. Another person said, "It's the little things that add up, changes to rota, swapping staff, the person you expect isn't the one who turns up…. overall it's alright but they could do better." A third person told us, "They come four times a day but I don't really know what they are supposed to do – don't know if they should help me make my bed and that. No one has sat down and told me what I am supposed to have. They are supposed to stay an hour, but sometimes stay less as they say they have to go to someone else." People did not always feel their wishes and preferences were considered and did not receive satisfactory explanations when care could not be changed to meet their preferences.

Comments, complaints and feedback were not always handled appropriately, or resolved to the satisfaction of the person. People told us they knew how to make a complaint and most people said they would be happy to do so if needed. One person said, "I would be the first to complain, but they are great. I pay my money and I expect good care, and I get it." However, some people were more reluctant to voice their dissatisfaction. One person told us staff come too early to do their lunch but they said, "I don't like to tell the manager as they have other people to see." Another person said, "It's not good sometimes, don't treat you right at times, I don't want to say too much, I don't like to complain and I will say no more, but if it was really serious I would call and I could call you if it's really serious, couldn't I?" This person then went on to say they were happy with their care. People did not always feel comfortable making a complaint or suggestions regarding their care, some people were worried that care would be withdrawn if they complained. This meant they continued to receive care they were not entirely satisfied with.

There was a complaints policy in place and we saw that written complaints had generally been processed in accordance with the policy. However, we found examples of complaints that had not been responded to positively and had not been resolved for the people making the complaint. For example, one person told us they were considering changing their care provider as they were unhappy with the response from the registered manager to their complaint. We saw the written response to this person's complaint and found the registered manager had not accepted responsibility or given a satisfactory explanation for the decisions the person was unhappy with. The complaint had not been resolved to the person's satisfaction. Another person told us they had complained to staff daily, about changes to their care they were not happy with and it was not resolved until another healthcare practitioner complained.

We asked how people's comments and suggestions for improvement were recorded. The registered manager told us these were resolved verbally by the staff and not necessarily recorded as a complaint. The process for processing complaints and feedback was unsatisfactory as it only focused on written complaints and did not capture comments and suggestions from people on aspects of their care they were not happy with. Some people felt dissatisfied with how staff responded to their comments or suggestions. Although it may not have been within the power of care staff to make all the changes people required; by not acknowledging people's concerns or offering satisfactory explanations, people felt ignored and dissatisfied.

This then led to people not wishing to voice their opinions and disengaging with any consultation process. Comments and complaints were not used as an opportunity to learn more about people's individual needs and preferences or to improve people's care experience.

We recommend the provider reviews how they manage comments, feedback and complaints and consider how they can use such information to improve people's care experience and involve them in developing the service.

The registered manager told us how they had tried to meet the cultural needs of a person where English was not their first language. They said there was a staff member who spoke the same language, but once they had left it had been difficult to recruit staff with the required language skills, from their local area. They had suggested the person join local community groups but this had been declined. Staff told us they 'got by' using signs and the limited vocabulary of the person. They also supported them to access shops that sold their preferred foods. This demonstrated that staff tried to accommodate people's cultural and personal preferences, where possible.

There was no one receiving end of life care at the time of our inspection. However, the registered manager told us that where possible, they worked with district nurses and community health teams to support people to remain at home, if this was their wish.

Inadequate

Is the service well-led?

Our findings

The overall rating for this service is 'requires improvement'. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding.' Good care is the minimum that people receiving services should expect and deserve to receive. This shows that effective systems were not in place, or consistently applied, to ensure the quality of care was regularly assessed, monitored and improved.

This service has now been rated as 'requires improvement' on three consecutive inspections and consequently we have rated well led as 'inadequate' as per our methodology.

At this inspection we found there had not been sufficient improvements in leadership, management and governance of the service and the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not always follow their own policies. For example, the registered manager had not followed their own recruitment policy. They had not always ensured that pre-employment checks had been completed before new staff started work and could not assure us that all staff were suitable to care for people. This has not been identified by the registered manager or provider during quality assurance checks of the service.

Concerns about medicines management had been raised at previous inspections and they had not been completely resolved by this inspection. The registered manager had previously been advised that a PRN policy and procedure was required to support staff to make safe decisions about the use of PRN medicines. However, this was still not in place when we inspected. We also found they were not consistently followed their medicines policy. For example, the manager had identified the policy was not effective and asked staff to amend their practice but had not updated the policy. This meant they were encouraging staff to work outside of policies and procedures, which were in place to support staff to provide safe and consistent care for people.

Concerns regarding ineffective quality assurance systems had been identified at our last inspection in September 2017. The local authority had also identified this in their April 2018 audit of the service. They said the provider had not achieved the requirement to have 'a robust quality assurance policy that ensured people received a high-quality service, first time'. However, they had acknowledged some improvement in the systems and said the provider was 'working towards' this goal.

We found the systems in place were still not effective at ensuring people received a high-quality service, first time. The monitoring was inconsistent and did not always identify when improvements were required or lead to the desired change. Although improvements had been made to auditing of medicines records, there were other areas of quality assurance that required improvement. For example, the systems in place had not identified the concerns we had regarding recruitment, management of risks and incidents, continued absence of PRN protocols and poor recording of information generally. Neither did they provide an effective analysis of comments and feedback from people who used the service. The registered manager could not

provide evidence of how information from quality assurance processes had led to improved care for people.

We found ineffective quality assurance systems remained a concern at this inspection. This information was considered when we formed the judgement following this inspection, that overall leadership and management of the service was inadequate.

Display of current ratings must be conspicuous and legible. However, we found the information provided to the general public about the providers previous CQC rating was confusing and inconsistent. The provider had displayed the rating from the last inspection in their office, as they are required to do. However, their website had a confusing message on its home page which stated, 'This service is no longer registered with the CQC'. The registered manager could not explain why this message was there and assured us this would be removed immediately. When we checked the following week, this statement had been removed. However, it had been replaced by a message that said, 'CQC do not currently have any information about this service'. There was a link through to the CQC website and the last 'Requires Improvement' report from September 2017, but the initial message was confusing and inaccurate, with no clear rating displayed on the website. The provider had not consistently met the requirement to display their last CQC rating.

Staff told us they understood their roles and responsibilities; and these were discussed during team and individual meetings. However, we found concerns about poor record keeping and medicine errors were repeated at each team meeting, which implied staff did not always follow advice or instruction. The registered manager informed us they would use the disciplinary procedure where staff consistently failed to perform. However, we found no evidence that this had been effective at bringing about the improvements required from staff who were consistently not following advice or instruction.

The provider was unable to demonstrate how they used incidents and feedback from people as opportunities for learning and development. At this inspection we found some processes had been improved. However, they had not always been effective at identifying areas for development or bringing about the necessary improvements to people's care. For example, when errors on medicine administration records were found they were noted in staff records but not service user records. This meant it was not possible to identify if there had been any impact on the person of not receiving their medicines as they were prescribed.

Although people were consulted about the service, there was no analysis of the results and no indication of how this information had been used to develop the service. The results had been presented in a pie chart and there was no detail to explain people's responses. For example, people were asked how the provider could make the service more effective; the pie chart indicated that 20% of people replied positively, 20% replied negatively and 60% of the chart was labelled 'other'. There was no explanation of what 'other' meant and how this had been analysed or how it had led to more effective care for people.

A lack of analysis of survey results meant that feedback was not used constructively to improve people's care. Feedback we received from people, indicated that good care was not consistently provided; whilst some people had a positive experience other people told us they were dissatisfied with aspects of their care. For example, some people remained unhappy that their care calls were 'cut short' as staff had to rush off to the next call. This had been identified at previous inspections yet it was still causing concern for some people. The registered manager told us the rota 'worked well' and said they could not change it, as they were not paid for staff travelling time only the length of the visit. Poor responses to complaints meant people remained dissatisfied with their care, which could have a negative impact on the service's reputation. Care plan audits had not been effective in identifying issues in relation to risk management. Audits and feedback had not been used to continually evaluate and improve the service.

This was evidence of a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Although there were processes in place to engage people and staff it was not always clear how this feedback was used to develop the service and improve people's care experience. Most of the people we spoke with said they were happy with how the service was managed. One person said, "I have no involvement with the manager as everything is running smoothly, but I know I can call them if anything changes." Care was planned weekly to ensure there was enough staff available to meet people's needs. People received a rota through the post on Monday morning, informing them of the time of their daily calls and which staff would be caring for them. Whilst most people were happy with this, one person said, "This means we don't know who's coming on Monday".

Although there had been no recent staff surveys, staff felt involved in the development of the service and said they were able to contribute to team meetings and individual supervision meetings. Staff said they would like more notice of their rotas but understood it was difficult to plan too far in advance, as they had to accommodate people's changing needs and staff holidays.

Staff told us they had good relationships with key healthcare partners. For example, district nurses, occupational therapists and GP's. The registered manager confirmed this and quoted an example of how a district nurse had rung the office to ask for a person to be on their bed for their next call, so they could examine their skin. However, contact with other services was not always recorded which made it difficult to demonstrate they had acted on advice, or consulted with specialist advisors to support people's more complex care needs. This put people at risk of receiving inconsistent or inappropriate care.

Staff told us they enjoyed working for Compassionate Care Team and they worked well together across all teams and office based staff. One staff member told, "I love working here, the manager trusts the staff. It's a big thing to be trusted." The service covered a wide geographical area which was also rural with dispersed communities. The registered manager had developed the service to cover each of these geographical areas and had recruited staff for specific locality teams. Staff from one team told us this worked well, staff supported each other and were able to arrange cover or accommodate last minute changes within their team. They said the recently introduced locality team meetings were good as they were more relevant and easier for staff to attend.

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 People did not always receive care and treatment in a safe way. The provider had not always assessed the risks to people's health and safety, or taken action to reduce the likelihood of harm from known risks. Medicines were not consistently managed safely. Incidents were not always shared with relevant services, that also had responsibility to keep people safe.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not effective at ensuring compliance with the regulations and did not ensure people received safe, effective and responsive care. The provider had not responded effectively to previous requests to improve and could not demonstrate how feedback was used to improve people's care experience.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not followed their own recruitment policy and had not completed relevant pre-employment checks before people carried out a regulated activity.

The provider could not provide the evidence to demonstrate that at the commencement of employment, staff employed to care for people were of good character, had sufficient knowledge and skills and did not present any risks to people.