Eternal Care UK Limited

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Inspection report

11 The Mound
William Barefoot Drive
London
SE9 3BA

Tel: 02083043818
Website: www.eternalcare.com

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

About the service: Eternal Care UK Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats. The service provides personal care to adults some of whom have dementia. At the time of the inspection there were 59 people receiving personal care from the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

People's experience of using this service:
At our comprehensive inspection of 28 June 2016, we found the provider had not acted to make sure medicines were managed safely. We took enforcement action. At our inspection on 12 and 13 December 2016, we found that the provider had addressed the breaches of regulation, however at the 2 and 3 August 2018 inspection we found that these improvements had not been sustained and we took enforcement action. At this inspection, we found the provider had not made sufficient improvements for managing medicines since the last inspection. Medicines were still not always being managed safely.
At the inspection on 2 and 3 August 2018, we found staff did not always attend people's care calls as required. The provider sent us an action plan and told us that they would complete all required actions by 5 October 2018. However, when we returned to the service on 28 and 29 March and 2 April 2019, we found this was not the case.
At the inspection on 2 and 3 August 2018, we found there was no risk assessments for people using bedrails and risk assessment reviews were not completed for people who had come out of hospital. At this inspection we found there was no risk assessments and management plans for people with challenging or complex behaviour at times.
At the inspection on 2 and 3 August 2018 we found when people lacked the capacity to make important decisions for themselves the provider had failed to maintain a record of decisions made in their best interests, in line with the Mental Capacity Act 2005. At this inspection we found the provider had not made improvements, when people lacked capacity to make important decisions for themselves to ensure that their rights were protected.
At the inspection on 2 and 3 August 2018 we found two people's care plans did not reflect people's current needs. The provider sent us an action plan and told us that they would complete all required actions by 5 October 2018. However, when we returned to the service on 28 and 29 March and 2 April 2019, we found improvements had not been made.
At our last comprehensive inspection on 28 June 2016 we found that effective systems were not in place to monitor and improve the quality and safety of the service provided to people. At the inspection on 12 and 13 December 2016, we found that the provider had addressed the breaches of and were compliant with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.However, at the inspection on 2 and 3 August 2018 we found the provider had not always ensured that they monitored people's calls to check if they were attended as per their scheduled time through an electronic or a manual call monitoring system.
At this inspection we found call monitoring was not effective. The electronic call monitoring system did not provide accurate records of staff visits.

A people's satisfaction survey carried out in July 2018 was not analysed and an action plan was not developed to drive any improvements. The provider had not ensured that people's information and their records were maintained safely.
People's needs were assessed to ensure these could be met by the service.
The provider trained staff to support people and meet their needs. Staff told us they felt supported and could approach the new manager at any time for support.
Staff supported people to eat and drink enough to meet their needs.
People were protected from the risk of infection. The provider had a system to manage accidents and incidents to reduce the likelihood of them happening again.
The provider worked with other external professionals to ensure people received effective care. People were supported to maintain good health.
The provider completed home environment assessment and made referral to external professionals for their support.
Staff supported people and showed an understanding of equality and diversity. People and their relatives were involved in the assessment, planning and review of their care. People were treated with dignity, and their privacy was respected. The provider had a policy and procedure to provide end-of-life support to people.
People told us they knew how to complain and would do so if necessary.
The new manager and staff worked as a good team. The service had an on-call system to make sure staff had support outside office working hours and staff confirmed this was available to them.
The new manager encouraged and empowered staff to be involved in service improvements through periodic meetings. People and their relatives were involved in the planning and review of their care and support.
The new manager completed checks and audits on accidents and incidents, complaints, staff training, and safeguarding. The senior staff carried out spot checks of staff to ensure care was provided as planned.
The new manager and the provider remained committed to working in partnership with other agencies and services to promote the service and to achieve positive outcomes for people.

Rating at last inspection: Inadequate (report published on 17 October 2018).

Why we inspected: This was a planned inspection based on the last inspection rating.

Enforcement: Action we told provider to take (refer to end of full report)

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another

inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: We will continue to review information we receive about the service until we return to visit as part of our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Eternal Care UK Limited

Detailed findings

Background to this inspection

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

Inspection team:
Two inspectors visited the service on 28 and 29 March 2019, and on 2 April 2019, a member of CQC's medicines team, returned to complete the inspection. Two assistant inspectors made phone calls to field staff and two experts by experience made phone calls to people to seek their views about the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise is in older people and a family carer.

Service and service type:
Eternal Care UK Limited is a domiciliary care agency. It provides personal care and support to people living own homes. It mainly supports older people and people with a learning disability.

The registered manager left the service in February 2019 and a new manager started at the service on 1 March 2019. The new manager's application to be the registered manager was being processed by the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because the new manager was often out of the office supporting staff. We needed to be sure that they would be in.

The inspection site visit was carried out by two inspectors on 28 and 29 March 2019, and on 2 April 2019, by a member of CQC's medicines team; to see the director, new manager and office staff; and to review care records and policies and procedures.

What we did:
Before the inspection: We looked at all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law. Due to technical issues the provider was not able to complete a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the commissioners and the local authority safeguarding team for their feedback about the service. We used this information to help inform our inspection planning.

During the inspection:
We spoke with the director, the new manager and four office staff members. We looked at 14 people's care records, and 11 staff records. We also looked at records related to the management of the service, such as the complaints, accidents and incidents, medicines management, safeguarding, and policies and procedures.

After the inspection: We spoke with seven people and nine relatives, and 13 members of field staff on the phone. We requested additional evidence to be sent to us in relation to medicines management and quality assurance. This was received and the information was used as part of our inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

• At the inspection on 2 and 3 August 2018, we found there were no risk assessments or management plan for people using bedrails and reviews of risk assessments had not been completed for people who had come out of hospital to check whether there had been any changes in their needs.
• At this inspection we found there were no risk assessments or management plans for people with challenging or complex behaviour. There was no risk assessment in place to identify how their behaviour manifested nor was there a suitable risk management plan in place to mitigate the concerns. Therefore, there was a risk that staff may support people in an unsafe manner, or not in line with their preferences.
• For one person their care records showed that an urgent occupational therapist (OT) referral was required for toileting support following an accident that took place. This need was identified on 26 September 2018. There was no record to show that this had taken place. The new manager confirmed that an OT referral had not been completed by the service. Therefore, no action had been taken to address this known risk.
• The field supervisor told us that the service users' risk assessments and their management plans were neither accurate nor up to date. The new manager and the field supervisor said they were aware of this situation and had developed a new holistic tool to carry out the risk assessment and develop management plans. However, at the time of this inspection, only nine of the 59 people receiving personal care had up to date risk assessments. Therefore, we could not be assured that risks were adequately mitigated to ensure people's safety.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We reviewed two updated risk assessments and their management plans and found they reflected people's current risks and there was guidance for staff about how to manage these risks.

Staffing and recruitment
• At the inspection on 2 and 3 August 2018, we found staff did not always attend people's care calls as required. There was no communication record to show that the office staff had informed people when staff were running more than 15 minutes late to their scheduled home visits. Records showed that for some people, the provider had not always allowed enough time for travel between calls.
• At this inspection we found that the provider had not made sufficient improvements. For example, one relative told us, "Staff can sometimes arrive a bit late which can sometimes affect us as my [loved one] has a health condition and needs to have their breakfast. So, in the event I will call my [family member] and they will pop up and give us our breakfast." One person said, "I like to be up and ready by 10.30 but if it's not regular one [staff] it can be 11.40." Another person commented, "If it's my regular one [staff] they will call if

held up, but the relief one [staff] will come whenever."
• Staff told us travel time between calls was not sufficient to meet people's needs. Their comments included for example, "I haven't got a car myself, a little more travel time would be good." Another member of staff said, "It's a real problem. One client has to be done at 4pm, so I can get to the most important client at 5pm. I'm on the bus, it doesn't matter how much time you tell them (office staff) and every week it is the same thing." A third member of staff commented, "No not always. so, you'd end up getting there late. We did tell them (office staff) about that but they never changed."
• The provider did not consider people's preferences and agreed time of visits in the staff roster. For example, a person's care plan showed their agreed visit time for Monday to Sunday as from 8am to 9am, however their rota showed on 28 February 2019 from 9am to 9.45am, and for 1 March 2019 from 8.20am to 9.20am, and on 5 March 2019 from 7.20am to 8.05am. Another person's care plan showed their agreed visit time as from 7am to 7.30am Monday to Sunday. However, the rota showed for example, on 28 February 2019 from 10.50am to 11.20am and on 1 March 2019 from 9.05am to 9.35am. For a third person the rota showed that their visits were also taking place significantly outside of the agreed times.
• Staff rostering records showed that for some people, the provider had not always allowed enough time for all staff to travel between calls. For example, on 28 February 2019, one staff member was rostered to do a call from 6.00am to 6.45am and then another call from 6.45am to 7.30am for another person at a different postcode. On 17 March 2019 another staff member was rostered to do a call from 3.30pm to 4.00pm and then they were rostered to attend a call from 4.00pm to 4.30pm for another person at a different postcode. A third member of staff on 5 March 2019, was rostered to do a call from 7.30pm to 8.00pm and then another call from 8.00pm to 8.30pm at a different postcode. This meant calls were rostered back to back with no travel time allowed.

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

• People were informed when staff were running late for more than 15 minutes to their scheduled home visits.
• The service had an on-call system to make sure staff had support outside office working hours. Staff confirmed this was available to them when required.
• We confirmed through our discussions with people using the service there had been no missed calls. .
• The provider carried out satisfactory background checks for all staff before they started working. These included checks on staff member's qualifications and relevant experience, their employment history and consideration of any gaps in employment, references, and criminal record checks and proof of identification. This reduced the risk of unsuitable staff working with people who used the service.

Using medicines safely
• At our comprehensive inspection of 28 June 2016, we found the provider had not acted to make sure medicines were managed safely. At our inspection on 12 and 13 December 2016, we found that the provider had addressed the breaches of regulation, however at the 2 and 3 August 2018 inspection we found that these improvements had not been sustained and we took enforcement action.
• At this inspection, we found the provider had not made sufficient improvements for managing medicines since the last inspection. Medicines were still not always being managed safely.
• Information was not available for people using the service in assessments or care plans to ascertain who was responsible for ordering, transporting or returning medicines from the community pharmacy to ensure people received their medicines as prescribed.
• Staff members had incorrectly transcribed how and when to give time sensitive medicines from the dispensing label to Medicine Administration Records (MARs) designed by the provider. This meant people were not always given their medicines as prescribed.

• The provider had audited the MARs monthly. However, the audits had failed to identify the issues we found during this inspection.
• During our previous inspection we had found staff had not been competency assessed to handle medicines. At this inspection we saw evidence that staff members had received training to handle and administer medicines. However, they were still not being competency assessed to ensure they could handle medicines safely.
• There was limited guidance available to help staff give people their medicines prescribed on a when required basis.
• Some people were prescribed high risk medicines such as anticoagulants. Anticoagulants are medicines prescribed to help prevent blood clots. These medicines can have side effects such as risk of bleeding and bruising. Guidance was not always available for staff to monitor side effects of high-risk medicines in people's care plans.
• People's care plans did not always have information about all their current prescribed medicines. Some people were prescribed time sensitive medicines. However, people's care plans did not always have information about when and at what intervals these medicines should be given.
• There was a medicine policy in place which had been reviewed in August 2018. However, as highlighted during the last inspection in August 2018 it did not have sufficient information for staff to handle and administer medicines and we found this had not been addressed at this inspection.

This demonstrates a continuous breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• At our last comprehensive inspection on 28 June 2016 we found the provider had not taken action to support people when allegations of abuse were raised and the appropriate bodies had not been informed of the incident to reduce the risk of similar future incidents. At the inspection on 12 and 13 December 2016, we found that the provider had addressed the breaches of regulation, however, at the 2 and 3 August 2018 inspection the improvements had not been sustained.
• At this inspection we found the provider had made improvements. People and their relatives gave us positive feedback about their safety and told us that staff treated them well. One person told us, "I feel safe and they [staff] are nice to me." Another person said, "Yes, I do feel quite safe because I know they are from the company and wear uniform." One relative commented, "Yeah my [loved one] is safe, and seems to be very happy with them [staff]."
• The provider had a policy and procedure for safeguarding adults from abuse. The new manager and staff understood what abuse was, the types of abuse, and the signs to look for. This included reporting their concerns to the new manager and the local authority safeguarding team. Staff completed safeguarding training. Staff knew the procedure for whistle-blowing and said they would use it if they needed to.
• The service maintained records of safeguarding alerts and monitored their progress to enable learning from the outcomes when known. The service worked in cooperation with the local authority, in relation to safeguarding investigations and they notified the CQC of these as required.

Preventing and controlling infection
• People were protected from the risk of infection. Staff understood the importance of effective hand washing, using personal protective equipment (PPE) such as aprons and gloves and disposing of waste appropriately, to protect people and themselves from infection and cross-contamination.
• The service had infection control procedures in place and records showed that staff had completed infection control training to ensure they knew how to prevent the spread of infection.

Learning lessons when things go wrong

• The provider had a system to manage accidents and incidents to reduce the likelihood of them happening again. Staff completed accident and incidents records. These included action staff took to respond to and minimise future risks, and who they notified, such as a relative or healthcare professional.
• The new manager monitored these events to identify possible learning and discussed this with staff.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. A regulation was not met.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA.

• At the inspection on 2 and 3 August 2018 we found when people lacked the capacity to make important decisions for themselves the provider had failed to maintain a record of decisions made in their best interests, in line with the Mental Capacity Act 2005.
• At this inspection we found the provider had not made improvements, when people lacked capacity to make important decisions for themselves. The provider had failed to maintain a record of decisions made in their best interests, in line with the Mental Capacity Act 2005. For example, the daughter of a person who lived with dementia and lacked mental capacity had the Power of Attorney (PoA) for finance only and therefore did not have legal authority to make health and welfare decisions on her mother's behalf. No best interests meeting had been held and the daughter had signed the medicines authorisation form. In addition, the boxes were not ticked to show what was being consented to.
• Another person's risk assessment showed that a mental capacity assessment had been carried out for them on 5 June 2018 by the provider. However, the specific decision required was missing. The most recent risk assessment in the care record stated that the person was "unable to make own decisions [this person] lives with parents." The MCA questions were not decision specific as required.
• When asked the new manager about this who confirmed that a best interests meeting should have happened for this person. The field supervisor told us that this person's family had informed them of a best interests meeting scheduled at the local NHS Acute Trust for the following month.
• The provider's policy for mental capacity was not in date. When asked the new manager provided us with a document titled, "Mental capacity: In depth" edition three which was last updated October 2017, with a review date of October 2018. This document did not have the term 'policy' in its title nor did the document provide guidance for staff about how to meet their responsibilities in relation to the MCA. The manager confirmed that this not in fact an MCA policy. There was also another document which they provided. This second document was titled, "Service Users Who Lack Mental Capacity to Take Decisions Policy" edition three which was last reviewed October 2017 with a review date of October 2018.The new manager told us

the policy was not fit for purpose and required updating, as it lacked descriptive actions and had no appendices to show what mental capacity form should be used.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed to ensure these could be met by the service. Staff carried out an initial assessment of each person's needs to see if the service was suitable to meet them. This looked at people's physical and mental health; mobility, nutrition and social activities.
• Where appropriate, staff involved relatives in this assessment. Staff used this information as a basis for developing care plans to meet each person's needs.

Staff support: induction, training, skills and experience
• The provider trained staff to support people and meet their needs. One person told us, "They [staff] seem quite well trained in washing me and how to handle me when they take me to the bathroom, I don't feel like they will let me fall." One relative said, "My [loved one's] carer has been trained to give [them] lunch as my [loved one] has a condition which may cause [them] to choke so the carer is aware and trained to know how to deal with that." Another relative commented, "My [loved one] never felt unsafe when they [staff] use the hoist so I assume they must be well trained."
• Staff told us they completed comprehensive induction training and a brief period of shadowing experienced staff, when they started work.
• The senior staff told us all staff completed mandatory training identified by the provider. Staff training records confirmed this. The training covered areas such as food hygiene, health and safety in people's homes, moving and handling, administration of medicines, infection control and safeguarding adults.
• Staff told us the training programmes enabled them to deliver the care and support people needed. The provider supported staff through regular supervision and onsite spot checks.
• Staff told us they felt supported and could approach the new manager at any time for support.

Supporting people to eat and drink enough to maintain a balanced diet
• Staff supported people to eat and drink enough to meet their needs. One person told us, "They [staff] don't have to do much for my meal just heat up something I have taken out, they do me a drink and check if I can manage my drinks in between carers." One relative said, "I will leave out the food for my [loved one] and the carers will warm it up, it might be pancakes for breakfast and then microwave dinner, my [loved one] never complained so I assume it's all okay."
• People's care plans included a section on their diet and nutritional needs.
• Staff told us people made choices about what food they wanted to eat and that they prepared those foods so people's preferences were met.

Staff working with other agencies to provide consistent, effective, timely care
• The provider worked with other external professionals to ensure people received effective care.
• We observed a member of staff sharing concerns regarding a person's declining mobility. The registered manager in response arranged to carry out a mobility assessment at the person's home and to follow up with an occupational therapist referral.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to maintain good health. People's health needs were recorded in their care plans and any support required from staff in relation to this need.
• Relatives coordinated people's health care appointments and health care needs, and staff were available

to support people to access healthcare appointments if needed.
• Staff told us they would notify the office if people's needs changed and if they required the input of a health professional such as a district nurse, GP or a hospital appointment.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

• People's care plans included details about their ethnicity, preferred faith and culture. Staff showed an understanding of equality and diversity.
•Staff told us they would always seek to support people with any needs they had with regards to their disability, race, religion, sexual orientation or gender.

Supporting people to express their views and be involved in making decisions about their care
• People and their relatives were involved in the assessment, planning and review of their care.
• People told us they had been involved in making decisions about their care and support.

Respecting and promoting people's privacy, dignity and independence
• People were treated with dignity, and their privacy was respected. One person told us, "As far as my privacy and dignity is concerned they [staff] all make sure that the door is closed." Staff described how they respected people's dignity and privacy and acted in accordance with their wishes. For example, staff told us they ensured people were properly covered, and curtains and doors were closed when they provided personal care.
• People were supported to be as independent in their care as possible. One person told us, "I can manage to wash myself but if I call them they will come in and help with my back." Staff told us that they would encourage people to complete tasks for themselves as much as they were able to.
• The provider trained staff and had policies and procedures which promoted the protection of people's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. A regulation was not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• At the inspection on 2 and 3 August 2018 we found two people's care plans were not updated to reflect change in their needs. The provider sent us an action plan and told us that they would complete all required actions by 5 October 2018. However, when we returned to the service on 28 and 29 March and 2 April 2019, we found that improvements had not been made.
• At this inspection we found care plans were not person centred and did not reflect people's current needs. For example, for one person there was no mention of their medical history, including tablet controlled diabetes, high risk of falls, depression and hearing loss. The new manager told us that this person should have a diabetes management plan in place but this had not been completed.
• Some care records were inaccurate. For example, in one person's care records there was contradictory information about their mental health. In one section it stated that they had no mental health conditions but later in the care record it stated that this person lived with long-term depression for which they received medicines. In another document 'Eternal Care Needs and Risk assessment' dated 19 April 2018, which was the latest record, we read that this person had postural hypertension (which would make them at even higher risk of falls) but this was not mentioned in their care plan. This person also received healthcare support from the district nurse for their leg ulcer treatment but this was not reflected in their care plan.
• For another person they had no care plan in relation to a behaviour which may have required action by staff. The most recent care review was incomplete. This meant staff may not have had the information they required to meet this person's needs.
• There was no guidance for staff on how to manage and respond to the needs of someone living with dementia and the periods of disorientation they had. The care plan had not been reviewed and updated since 23 July 2018, and so it may not have reflected their current needs. Although the review date was meant to be January 2019.
• We brought these issues to the attention of the new manager. The new manager told us that they had started care plan reviews and updates. Of the 59 people receiving personal care, the provider had already reviewed and updated nine of them at the time of this inspection.

This was a continuous breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We reviewed two updated care plans and found they were person centred and reflected people's current needs.

Improving care quality in response to complaints or concerns
• People told us they knew how to complain and would do so if necessary. One person told us "If I had to complain, I'd ring the office like I always have done and they have responded." Another person said, "I had

to complain once about a carer who didn't arrive on time, and they never came back."
• The provider had a clear policy and procedure for managing complaints and this was accessible to people and their relatives.
• The service had maintained a complaints log, which showed the registered manager had investigated and responded in a timely manner when concerns had been raised. We noted that the complaints related to call times, late visits and behaviour of a member of staff.

End of life care and support
• The provider had a policy and procedure to provide end-of-life support to people. The new manager was aware what to do if someone required end-of life care. Staff received training to support people if they required end -of life support. However, no-one using the service required end-of-life support at the time of our inspection.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• At our last comprehensive inspection on 28 June 2016 we found that effective systems were not in place to monitor and improve the quality and safety of the service provided to people. At the inspection on 12 and 13 December 2016, we found that the provider had addressed the previous breaches. However, at the inspection on 2 and 3 August 2018 we found the provider had not always ensured that they monitored people's calls to check if they were attended as per their scheduled time through an electronic or a manual call monitoring system.

• At this inspection we found the provider had maintained a record of phone calls to people when staff were running late but they had not carried out an analysis of late call and/or early call alerts routinely to identify patterns and address these.

• Call monitoring audits carried out for some areas were not effective, because not all areas had been audited to identify the extent of any problems. For example, two of the four localities were not covered.

• The provider's call monitoring audit was 'limited in scope' to service users living in two localities, which covered aspects of how many calls were logged in and out by staff of the total calls they made. The provider had not taken any action despite a significant deterioration in staff logging in. For example, records showed that for two staff members in March their log ins had reduced by almost 20% but this had not been addressed.

• There were issues with the accuracy of the provider's Electronic call monitoring (ECM). For example, the ECM record for 14 staff we looked at showed that 11 staff had missed calls between 28 February and 27 March 2019. For example, one member of staff was recorded as missing 16 scheduled visits, another staff member missed six visits and the third member of staff missed five visits.

• The director told us that these visits had taken place, we then cross referenced with the care logs for the above staff and found that staff had undertaken these visits and there were no missed calls. Therefore, ECM was not always providing an accurate picture of calls taking place and the management oversight of this was ineffective and therefore we could not be assured that there was adequate monitoring to ensure that people's visits took place as scheduled.

• During our inspection of 2 and 3 August 2018, we identified a breach in relation to person centred care. The provider submitted an action plan and told us that they would complete all required actions by 5 October 2018. However, when we returned to the service on 28 and 29 March and 2 April 2019, we identified a continuing breach of this Regulation. Therefore, the systems and processes for assessing, monitoring and improving the quality and safety of the services provided for carrying on the regulated activities had not been operated effectively.

• A people's satisfaction survey carried out in July 2018 was not analysed and an action plan was not

developed to drive any improvements.
• The provider had not ensured that people's information and their records were maintained safely. We saw log books stored in a backroom and not in a locked cabinet. There was no archiving and records management policy. The new manager told us they were in the process of ordering archiving boxes and said the new office they planned to move to in the near future had suitable facilities, with locked cabinets in a locked room.
• Quality assurance systems were in place to monitor the quality of the service being delivered. However, the provider had not always identified issues that we had found at this inspection and acted upon them in a timely manner.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The new manager and staff worked as a good team. There was a clear staffing structure in place and staff understood their roles and responsibilities.
• The service had an on-call system to make sure staff had support outside office working hours and staff confirmed this was available to them.
• There was a positive culture in the service, where people, their relatives and visiting professionals' opinions were sought to make service improvements.
• The new manager encouraged and empowered staff to be involved in service improvements through periodic meetings. Areas discussed at these meetings included internal auditing of care plans, risk assessment procedures, staff training, medicines management, staff supervision and spot checks, satisfaction surveys, and coordinating with health and social care professionals to ensure continuity of care.
• We observed staff were comfortable approaching the new manager and their conversations were professional and open.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their relatives were involved in the planning and review of their care and support.
• Staff meetings were held to share learning and good practice so staff understood what was expected of them at all levels. Records of the meetings included discussions of any changes in people's needs and guidance to staff about the day to day management of the service, coordination with health care professionals, and any changes or developments within the service.

Continuous learning and improving care
• The new manager completed checks and audits on accidents and incidents, complaints, staff training, and safeguarding. As a result of these checks and audits the provider made improvements, for example, care plans and risk management plans were updated, complaints were investigated and daily care records improved.
• The senior staff carried out spot checks of staff to ensure care was provided as planned.

Working in partnership with others
• The new manager and the provider remained committed to working in partnership with other agencies and services to promote the service and to achieve positive outcomes for people.
• They worked closely with local authority commissioners and healthcare professionals.
• Feedback from a social care professional stated that the new manager continued to make improvements.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and did not reflect people's current needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent When people lacked capacity to make important decisions for themselves. The provider had failed to maintain a record of decisions made in their best interest, in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was no risk assessment and management plan for people with challenging or complex behaviour at times.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes for assessing, monitoring and improving the quality and safety of the services provided for carrying on the regulated activities had not been operated effectively.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider did not consider people's preferences and agreed time of visits in the staff roster. Staff roistering records showed that for some people, the provider had not always allowed enough time for all staff to travel between calls and some calls were roistered back to back

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not made sufficient improvements for managing medicines since the last inspection. Medicines were still not always being managed safely.

The enforcement action we took:

Positive conditions