Aquaflo Care Ltd

AQUAFLO CARE LIMITED

Inspection report

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London
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29 September 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 and 29 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. This was the first inspection since registration.

AQUAFLO CARE LIMITED is a domiciliary care provider, the registered office is based in Tower Hamlets. This location provides personal care and support to people in four local authorities, Tower Hamlets, Hackney, Islington and Newham. There were approximately 118 people using the service at the time of our inspection.

There was a registered manager at the service. 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.
Although the majority of people using the service told us they were happy with the care and support they received, we identified areas for improvement during the inspection.

Staff recruitment checks were not thorough therefore we could not be assured that care workers were suitable to work with people. Staff files were sometimes incomplete and did not contain appropriate references, application forms were not signed or dated or had gaps in their employment history. Staff supervisions were not carried out in line with the provider's policy on staff supervision. We found evidence that some care workers were being supervised by the office administrator rather than the care co-ordinators as stated in the provider's policy.

We were not able to verify that all staff were given regular training because the IT systems were not working at the time of the inspection and the registered manager said the latest records were not accessible.

We found the provider's risk assessments did not adequately identify assessed risks or guide staff about how to mitigate these. There was an over reliance on risk assessments that had been carried out by other agencies and risks identified in those risk assessments were not always captured in the assessments carried out by the provider. The provider's care plans did not always document identified risks to people.

The initials assessments that were carried out by the provider were not always fully complete. Care plans contained minimal information about people's care and support needs. They were not person centred and did not identify people's preferences as to how they liked to be supported in all the records we saw.

Although complaints were documented and responded to, we found examples where the identified actions for the provider to try and learn from complaints and prevent similar events in future did not take place. These included staff having refresher training or additional supervisions.

The registered manager was not a visible presence at the service. She was not always up to date with changes within the service and quality assurance audits did not pick up the concerns we identified during the inspection.

We found five breaches of the regulations in relation to safe care, fit and proper persons employed, staffing, complaints and notifications. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff recruitment checks were not thorough.

Risk assessments did not contain sufficient information to ensure that people were kept safe.

The provider notified the relevant authorities when safeguarding concerns were raised but did not always act upon the recommended actions.

People told us care workers generally attended on time and if they were late, they were kept informed.

People were supported to take their medicines.

Is the service effective?

Requires Improvement

The service was not effective in all aspects.

Care workers did not receive regular supervision and some of these were not carried out by an appropriately qualified person.

Care records contained basic information about people's health and dietary support needs.

Although people's consent to care was not always recorded, people told us they felt involved when planning their care.

Is the service caring?

Requires Improvement

The service was not caring in all aspects.

Although we received positive comments from the majority of people, care plans were not person centred and did not take into account people's preferences.

People and their relatives said that staff respected their privacy and dignity when carrying out personal care.

Is the service responsive?

Requires Improvement

The service was not responsive.

Complaints were not acted upon.

Care plans were not detailed and in many of the care records that we saw did not include important information about people.

Is the service well-led?

Requires Improvement

The service was not well-led in all aspects.

We did not receive statutory notifications of some notifiable incidents.

The registered manager was not a visible presence in the service and was not fully aware of changes within the service.

Quality assurance checks such as audits and team meetings were not effective in picking up concerns.

AQUAFLO CARE LIMITED

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 took place on 27 and 29 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by one inspector and an expert by experience who carried out telephone interviews with people using the service and relatives after the inspection. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service. We asked the provider to complete a Provider Information Return (PIR) prior to our inspection. The PIR is a report that providers send to us giving information about the service, how they met people's needs and any improvements they are planning to make.

We spoke with nine people using the service, seven relatives and ten staff members including the two operations managers, the registered manager, two care co-ordinators, a HR officer, the office administrator and three care workers. We looked at 13 people's care records, training records, seven staff records, complaints and audits related to the management of the service.

Inadequate

Is the service safe?

Our findings

A person using the service told us, "No issues with safety." A relative of a person using the service told us, "We do not feel our relative is at any risk when the care worker comes."

Despite these comments, we found that people's identified risks were not always effectively captured by the provider which meant that people may have been at risk of receiving unsafe care.

Risk assessments were carried out by assessors before people started to receive care. The information gathered from the assessment visit was then transferred onto the 'Quikplan' system by the care coordinators.

Care records included information from the local authority's care plan assessment which were received prior to support commencing. The registered manager and care co-ordinators told us they carried out their own risk assessments and developed care plans to ensure the information from the local authority was up to date. However, we found that this was not always the case.

In the local authority care plan assessment for one person it stated 'due to high risk of falls, [person] requires supervision whilst transferring and mobilising'. In an occupational therapist report it also stated '[person] can be disorientated at times due to poor memory and bouts of confusion' and 'is very anxious of falling'. However, there was no risk assessment from the provider seen in this person's care record and the risk assessment section of their care plan was empty. This meant that staff may not have had the information they required to ensure that people received safe care and support.

In the care records for another person, there was a local authority's care plan assessment which stated 'undergone videoflouroscopy which shows an unreliable swallow. [Person] has been reviewed by the speech and language therapists' team and is able to tolerate thickened/soft food safely. Requires supervision with eating and drinking and will be at risk of aspiration.' The risk assessment for this person made no mention of the above risk which meant that they may have been at risk of choking if not supported appropriately with their meals.

In another example, the following risks were identified in the local authority's care plan assessment, 'type 2 diabetic and was having difficulties managing it', 'risk of personal hygiene breakdown due to limited range of movement secondary to stroke and osteoporosis', 'partially sighted and at risk of fire and scalding himself/herself when preparing meals and drinks', 'at risk of falls due to right side weakness and history of falls [person] needs supervision when mobilising.' There was no provider's care plan for this person to provide guidance for staff about how to manage these risks.

In a local authority's care plan assessment, the following risks were identified, mobility, falls, carpel tunnel syndrome, cervical myelopathy, schizophrenia and poor balance. There was no written care plan for this person and no mention of the above risks in the provider's risk assessment.

The written risk assessment for one person stated they required assistance transferring to bed and to the toilet with a celling frame. However, this information had not been included in the risk assessment section of the care plan for this person.

The local authority's care plan assessment mentioned a person using the service had a stroke, needed two people to manage their care and a rota stand. It also stated they were at high risk of skin breakdown and pressure sores. These were not identified in the provider's records.

A care worker told us, "[Person] is at high risk of choking. He has asthma problems and needs oxygen. He also needs emotional support." The risk assessment for this person had an action plan in place but it was not fully completed and did not provide any meaningful information. In one example, the action plan required was 'swallow problems', 'cough attack at night' and 'saliva on lungs can cause choking'. However there was no information about how to manage these risks.

The issues identified in the above paragraphs are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We looked at seven staff files, for both care workers and office based staff.

One person's staff file included an application form which listed their previous occupation and two referees to contact, both of which knew the person in a professional capacity. The application form was signed by the applicant on 29 July 2013. The referees that had been contacted included one of the referees which was dated and stamped from their organisation. The second reference was not the person listed on the application form but from a 'good friend' and was signed on 11 August 2016, three years after the date on the application form. We spoke with the staff member from HR about this delay in obtaining the second reference who told us that they had checked the files and had found there was a reference missing and had therefore followed it up afterwards.

In another file, there was one reference from a person in a personal capacity. A second reference was from a previous employer but was not a written reference. The form was titled 'telephone reference check' but it had no comments from the person, no start or end date of employment and was not dated.

Another application form was signed on 19 May 2014 and listed two referees. There was a reference from one person dated 23 July 2015 but there was no company stamp and it was not on letter headed paper so the provider had not verified the reference to ensure it was genuine. A second reference was on letter headed paper from an organisation that stated the person was employed between 15 July 2013 and 02 June 2014. However, this employer was not listed on the person's application form. The application for this person only listed another employer from 10 January 2011.

One file had two references dated January 2015, one was from a previous employer and it was not clear in what capacity the second reference was given in.

The registered manager's staff file was not complete. Her application form dated 03 December 2013 listed two people as referees. Only one reference had been provided and there was no second reference seen.

The 'Aquaflo nursing and domiciliary care agency recruitment nursing/care worker/office personnel policy and procedure' which was reviewed in May 2016 stated, 'verbal references must be recorded on an application form and followed up with a written request in the normal way.' And 'No candidate will be offered employment without 2 acceptable references' and 'failure to give/receive reference must be

investigated.'

There were other records that were not complete in the staff files that we saw. For example, an interview rating form was completed for people where they were given a score between 1-5 based on their appearance/disposition, education, skills/knowledge, personality and special circumstances. These were not present in all the staff files we saw.

Copies of identification documents were kept in people's files. These included copies of passports, national insurance numbers and proof of address. These were date stamped with the date they had been checked. Some of the dates they had been date stamped indicated they were verified after the person had started, for example one person who had joined on 31 July 2013 according to their induction certificate had stamps on their identity documents dated 30 April 2016 and 30 June 2016.
Other files had application forms that were not signed or dated by the member of staff.
The above issues are a breach of Regulation 19 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

We saw evidence that Disclosure and Barring Service (DBS) checks were in place in the staff records that we saw and these had all been renewed recently. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. The registered manager told us they maintained a spreadsheet of all the staff DBS checks. However, we were not able to check the DBS status for all the care staff because the IT systems were down at the time of our inspection and the registered manager told us she could not access this file.

All the people we spoke with told us they felt safe. Comments included, "I don't feel afraid in the presence of the care worker", "I feel very comfortable and safe", "I feel very safe, I have got used to my care worker" and "They are good care workers, I always feel safe"

Care workers were familiar with safeguarding procedures. One care worker told us, "Safeguarding is protecting the individual. If anyone harms them or discriminates against them then we have to report it to the line manager."

We looked at the safeguarding folder containing records of safeguarding concerns that had taken place. We found that the provider was not always following up on the actions identified as a result of safeguarding meetings that had taken place. In one example, where an allegation of neglect had been substantiated in July 2016, the provider was asked to retrain the care workers in how to escalate queries. We asked the registered manager and operations manager for this staff member's file and the only training seen was their induction booklet and induction certificates. In this staff member's supervision records following the incident there was no reference made to this incident.

The majority of people using the service told us there were no concerns with care workers attending on time and if they were late, they were kept informed. They said, "I have no problem at the moment, they turn up on time", "The care worker is always on time. If one is sick, they will contact me and let me know", "No problem at all, they come on time. If they are late due to traffic they always call", "If the same care worker cannot attend, they send someone else", "They always call me if they are late" and "They are on time majority of the time." Some people however stated the following, "I did have problems previously. The care workers have been changed, they are now excellent" and "They just turn up without communicating to me, they are always late, sometimes don't even turn up."

The registered manager told us they monitored the timeliness of care workers through a clocking in and out

system. However one of the care co-coordinators told us they had stopped using this system a few months ago. The registered manager was not aware that this had happened. The clocking in system had been stopped because it was ineffective and was not providing them with real-time information of when care workers were carrying out their calls.

The care co-ordinators told us they were manually calling people up to see if care workers were attending on time. They completed a record book of all the people contacted and recorded their views. A person told us, "I do feel safe, [staff member] calls every month, they check if I am happy and comfortable."

The majority of people said they were supported to take their medicines. Staff told us, "[Person] takes oral medication tablets from their blister pack, we complete that on the communication book." Another said, "We give him his medicines; we have a MAR sheet which I complete."

There was some evidence that care workers had been given training in medicines administration but there were no competency assessments carried out to ensure they were safe to do so in a practical setting.

Requires Improvement

Is the service effective?

Our findings

Care workers told us they received training. They said, "I had an interview, I did my DBS and then my induction training", "I had two shadowing shifts, I did a one hour slot and one 12 hour", "They gave us training before we started. I did learn from it", "They give training every year. Last year I did tracheotomy training" and "He's got a ceiling hoist. I had training on it."

The registered manager told us, "The induction is done over two days. They are given a copy of the induction and Care Certificate training booklet to take home."

Some people had an old induction called 'induction/foundation training programme' booklet in their staff file. This was a booklet in which the following topics were covered, introduction to care, expectations, complaints, whistleblowing, principles of care, dementia and depression, protection of vulnerable adults, safeguarding of vulnerable adults, food hygiene, support, personal issues, personal presentation and training, client report book, timesheets, service users home, health and safety, COSHH, fire safety and emergencies.

There was no evidence that medicines training was delivered as part of this old induction. The registered manager told us a new induction booklet had been introduced in March 2015. It was called 'The new induction and care certificate training booklet'. We checked this induction booklet and saw that medicines training was part of this, however not all of the care workers had completed this induction booklet and their up to date training certificates were not available in their files so we were unable to verify if they had received up to date training. The registered manager said they maintained a training matrix of all staff training but they were not able to access it due to IT problems.

We found that some files contained an induction checklist, but these were not always fully completed. Other records contained no induction training booklet at all. Another staff member's application form was dated November 2014. They told us they had been in employment "For four years." Their induction training programme was dated November 2012 but their induction checklist was dated November 2014. Some staff induction training certificates which were reviewed yearly had expired in May 2015.

Issues discussed at supervision included work related items, review of current performance, objectives and targets, training and development, new developments and action agreed. Performance appraisals were not always carried out annually as expected. They covered a review of performance, improvements, an overall grading, training and action to be taken.

Staff supervision was not taking place at three month intervals as stated in the providers own policy. One staff member who had started in July 2013 according to their application form only had four supervision records dated November 2013, February 2014, March 2015 and June 2015. Only two out of these four records had been signed or dated by both the supervisee and supervisor.

In one staff file for a person who told us they started in 2011, training records were seen from March 2011

and none since then. This person had no appraisal records and only three supervision records in April 2014, January 2015 and May 2016.
The registered manager only had one recorded supervision dated 22 April 2014 that had not been signed by either the registered manager or their supervisor, the operations manager.
Some supervisions and appraisals were being carried out by an office administrator who had only been in post since 18 August 2016 and was not qualified to do so.

A person who had started in April 2015 had three supervision records in place. One in July 2015, one in February 2016 and September 2016. One of these supervisions was carried out by an office administrator who was not qualified to carry out supervisions. One was not signed by the supervisee. This staff member's appraisal was also carried out by the office administrator.

Another person had supervisions in April 2015, October 2015, December 2015, April 2016 and September 2016. The September 2016 supervision was carried out by the office administrator. The supervision done for April 2016 caused us concern. It had not been signed by the supervisee but by the HR officer. However the writing in it was of the office administrator who had only been in post since 18 August 2016. The office administrator told us she had written it but could not offer a suitable explanation as to why the date on it was April 2016 and why she had signed with the HR staff members signature. We asked them if they had been trained to carry out staff supervisions and they said, "I have been told to do it." The registered manager was not aware that this staff member was carrying out some supervisions.

We checked the job description for the office administrator. It stated that one of their roles was to 'maintain a training, induction, appraisal and supervision database.' It did not state that one of their roles was to supervise or appraise the care workers. We asked the registered manager for a copy of the training, induction, appraisal and supervision database but she was unable to produce it due to an IT systems error.

We asked for a copy of the provider's staff supervision policy. It stated that 'All care workers receive regular supervision. Individual supervision takes place every three months. Individual supervision is mandatory as it is a requirement of the post. Failure to attend may result in disciplinary action. The care worker will sign to confirm attendance at the supervision session.' In the section entitled supervision of care workers and supervisors, it stated 'The care staff are supervised by the home care coordinators on a quarterly basis as a group and three months as individuals.'

In the minutes of a quality management meeting that we read, it was recorded that the care co-coordinators were to carry out appraisals for all health staff.

The above identified issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) regulations 2014.

People told us they were satisfied with the support they received in relation to their meals. Comments included, "They help me with the meals. I am happy with the support they give me", "They leave sandwiches for me. I tell them how I want it and they do this", "They give my meals correctly", "They take their time feeding my relative" and "They always do what my [relative] wants. She wants tea they give it to her."

Staff gave us examples of how they supported people in relation to their food and drink. They said, "His food has to be cut up small so he can eat", "I do the shopping for him", "She likes buying microwave meals" and "We go shopping together. We make a list, I ask her if she minds looking in her cupboard and fridge and see what she needs."

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. 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. The application procedures for this in domiciliary care agencies are to be made to the Court of Protection.

The provider did not always accurately record that people had consented to their care plans. Risk assessments and care plans that were completed by the assessor prior to care starting did not always have people's signatures to confirm they had agreed to their content. However, in our discussions with people they said they were involved in their care plans. Comments included, "They go through the care plan with me every two months" and "They always go through the plan with me."

Care workers that we spoke with were aware of the importance of asking for people's consent before supporting them with personal care. They told us, "He makes his own decisions, I give him choices."

Care records contained minimal details in relation to people's ongoing health conditions. Care workers we spoke with were generally aware of people's health conditions and how they would support them. For example, one care worker told us, "She has a kidney dialysis. It's managed by the dialysis nurse and she has a diabetic nurse." Another care worker supported a person with diabetes, "She has insulin four times a day, she does it herself. I just monitor", "She tests her blood and glucose before and after every meal. Sometimes she forgets so I have to remind her" and "She goes to the diabetic nurse regularly."

Requires Improvement

Is the service caring?

Our findings

People using the service had positive comments to make about the attitude of staff towards them. People told us, "Excellent care", "Absolutely caring", "They always do as much as they can for me", "The care worker is always caring to me" and "They always respect me. They are always polite." One person said, "Once they did not treat me with care. The agency changed the person straight away."

Both people and their relatives said that staff respected their privacy and dignity when carrying out personal care. One person said, "My care worker is always handling me with care, always with dignity and respect." Another said, "They close the door, they always treat me with respect." One relative said, "I can see how caring and kind they are to my relative" and another said "They are very caring to my relative. They always shut the door, they always cover my [family member] up."

In the discussions we had with care workers they demonstrated an understanding of the people they supported and also gave us examples of how they respected people's privacy. They were aware of the level of support people required and said they promoted people's independence. Comments included, "[Person] is very independent, we encourage her", "We encourage her to go out and do things independently", "I ask them if they are comfortable. I allow him to wash himself and I shut the curtain" and "I always ask their permission before washing their mouths and hands."

Despite these comments, we found that care plans did not contain a sufficient level of detail to allow person centred care to take place. In a lot of examples, the information against each visit contained one word responses such as 'moving and handling, 'breakfast/tea/coffee', 'repositioning' without going into details with respect to people's preferences and how they liked to be supported. The existing care plans were task oriented and although there was a section entitled 'additional comments' which was sometimes used to provide further information, this was not always completed in the records we saw.

The registered manager told us they were planning on introducing changes to their existing care plans to try and make them more person centred. We were shown an example of the new format. This had a section entitled, 'brief profile of the service user' which could potentially be used to capture this information. It also included sections for culture, ethnicity and hobbies and interests. Because these had not been implemented at the time of our inspection, we were not able to make an assessment on their effectiveness.

Requires Improvement

Is the service responsive?

Our findings

The majority of people using the service told us that the provider listened to their concerns. Comments included, "I had a great problem with a care worker. I spoke to the agency, they changed the care worker immediately", "They have given me a number to call if I am not happy. Never used it as I am happy", "If I ever need to complain I have been given the numbers" and "I have no complaints. They are all OK."

However, we found that the provider did not always take action in response to complaints. A person we spoke with told us they had made some complaints, some in confidence but were not happy that the complaint had been shared with the care worker they had complained against who had continued to come and support them.

We looked at the complaints received by the provider. These were arranged in folders according to local authority. We saw that complaints were recorded and a staff member was assigned to investigate the complaint. Each complaint had an action for the provider to take following the investigation. We saw that in some cases, the required follow up action was not always acted upon. For example, in one complaint it stated that the care worker was to be invited for supervision and given a verbal warning. We asked for the supervision record for the staff member involved which took place after the complaint was raised. There was no mention of this incident in the supervision notes. In the section entitled 'issues or concerns raised; it stated 'no concerns'.

In another complaint the required action was for the care worker to be invited for supervision and to be retrained with an emphasis on recording/reporting awareness of dementia, raising concerns/complaints and safeguarding. The registered manager showed us the care workers supervision record and there was no evidence that this incident had been discussed and in the 'training and development' section of the supervision record the only training mentioned was 'NVQ training to be booked' rather than the specific ones identified above.

In another example the required action was for the care worker to be called in for supervision. This staff file was not available.

We saw a record of one complaint containing an email trail but there was no associated complaint form completed and no resolution documented either.

We saw where people had raised concerns there was not an identified action for staff to follow up. We asked one staff member who carried out calls to people who used the service what they did if people were unhappy. They told us that they passed the information onto the care co-coordinators. However, we saw that where concerns had been raised as a result of speaking with people these were not recorded in the complaints folder neither was there a follow up action for staff to respond to concerns.

These identified issues are a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were separate books in place apart from the communication books that care workers completed. These included medicines administration records (MAR), blood pressure records, equipment operators daily checks, turning charts, activity records, food and fluid balance charts, bowel chats and hair care charts amongst others.

The care co-ordinators told us they each managed a local authority and were responsible for allocating care workers for each person within that area. They said they worked closely with the assessors who carried out initial assessments on people who brought back their risk assessments and care plans to be inputted into the system.

Risk assessments and care planning was carried out by assessors before people started to receive care. These written care plans were then passed onto the care co-ordinators to be transferred onto the care plan system. We found the providers own care plan often contained very basic information and in many of the care records that we saw did not include important information about people.

In one record that we saw, the written care, the section for care required, expected outcome and evaluation were all blank and in another written care plan, the medical conditions, identified need, care required were blank. In another care plan, the information captured in the medical conditions or history was not reflective of that found in the local authority's care plan assessment. In other care records, there was no written care plan from the assessor. We recommend that the provider seeks advice from a reputable source regarding care planning to ensure that records contain sufficient information to enable staff to meet people's needs.

Requires Improvement

Is the service well-led?

Our findings

The provider had not submitted statutory notifications to the CQC relating to safeguarding concerns. We saw records of these concerns in the safeguarding folder and although the provider had taken the correct steps in responding to these concerns, no notifications had been received by the CQC in relation to these as required.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 Care Quality Commission (Registration) Regulations 2009.

The majority of people using the service and their relatives told us the service was well managed and said they were happy with the communication from the office. They said, "I have been using them for two years, I am very happy", "Brilliant service for my relative", "Great service, more organised in relation to time management" and "Generally a good company."

People also told us that the care co-ordinators kept in touch with them. "They always call to check that I am comfortable with the care worker", "The company comes to monitor the care worker. Sometimes they will call me to check I am happy" and "They phone up, ask if I am happy at least twice a month..."

Care workers told us they felt supported. Some of their comments were, "I'm very happy here", "The care co-ordinators are excellent. If I have a problem, they help me" and "They work well with my work life balance. They accommodate my family life."

Despite these positive comments, we found that there were some areas that needed attention.

The registered manager was supported by two operations managers who were based at this location. The office based staff consisted of three care co-ordinators, two assessors, a HR officer and an office administrator. The registered manager was responsible for two locations. She told us she was not based at this location and spent her working week at the other location that she managed. We found that she was not fully aware of how this location was operating. For example, the registered manager told us they monitored the timeliness of care workers through a clocking in and out system. However one of the care co-coordinators told us they had stopped using this a few months ago because the system was ineffective and was not providing them with real-time information about when care workers were carrying out their calls. The registered manager was not aware that this had happened. Although the registered manager was aware that a new system was to be introduced, she was not able to tell us when the decision was taken to stop using the current system. She was also not aware that the office administrator was carrying out some care worker supervisions.

Some quality assurance monitoring did take place, although we found that these were not effective in picking up the issues we identified during our inspection.

The registered manager told us they carried out unannounced observations or spot checks on care workers.

Although we found one or two examples of these in people's care plans, they were not consistently seen in the care plans we reviewed and some of them had no records of any of these visits. There was no system in place for ensuring these were done on a regular, proactive basis as part of continuous quality assurance monitoring.

The provider was supporting 118 people from this location based across four local authorities, 34 in Tower Hamlets, 51 in Hackney, 37 in Islington, and four in Newham. The majority of people were funded through the local authorities. Each client was issued with a folder containing the provider's mission statement and other documents including a complaint/appreciation form, a service user rights information leaflet and contact telephone numbers.

The registered manager told us that evaluations were sent to people using the service to monitor the quality of the service. We saw 12 feedback forms received in 2016 and 10 from 2014. It was difficult to analyse the results of the feedback. The registered manager told us although they analysed the results to see which areas needed to be improved, the records were not available due to problems with the IT system.

Various staff meetings took place. A care workers meeting had taken place over a number of days to ensure care workers had an opportunity to attend. The meeting was held on four different dates in August 2016. Prior to that the last recorded meeting was September 2015. Attendees signed to say they were present in the meeting and issues discussed included safeguarding, communication, refresher training, timesheets, medicines and complaints. Managers meetings had been held between registered managers from various locations in May 2016 and June 2016. Issues discussed included CQC feedback, individual branch updates and recruitment. A quality management meeting was held between the operations manager responsible for quality and the auditor. These were held in December 2015, November 2015 and May 2015.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay of some incidents related to abuse or allegations of abuse in relation to a service user; whilst services were being provided in the carrying on of a regulated activity. Regulation 18 (1) (2) (e).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users of receiving the care or treatment and did not do all that was practicable to mitigate against identified risks. Regulation 12(1) (2) (a) (b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not ensure proportionate action was taken in response to any failure identified a complaint or investigation. Regulation 16 (1).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively. The information

specified in Schedule 3 was not available in relation to each person employed. Regulation 19 (2)(3)(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity did not receive appropriate supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a).