Nestor Primecare Services Limited

Allied Healthcare London North

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 18, 19 and 23 May 2016. At our last inspection of the service on 28 April and 7 May 2015 we identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Regulation 12 (safe care and treatment). After the inspection, we asked the registered provider to take action to address these concerns and they sent us an action plan informing us that the required improvements would be made by November 2015. This inspection was planned to check whether these improvements had been made and that the registered provider was now meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Allied Healthcare London North is a large domiciliary care agency in North London providing personal care and support to people in their own homes in the London Boroughs of Barnet and Islington. At the time of the inspection there were 514 people using the service and 240 care staff.

The service is run by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider did not adequately assess risk for all people using the service. We identified seven instances where a risk assessment had not been carried out for people with identified risks. Risk assessments were a lengthy tick box format and did not provide staff with enough guidance on how to recognise risk, actions to take or how to mitigate identified risks.

Medicines were not managed safely and effectively. There were inconsistencies between what consent forms, care plans and medicines risk assessments stated as to what medicines support people required. Daily records completed by staff in relation to medicines support people received differed from what instructions were given. Medicines audits were inconsistent and areas for improvement were not always identified. Staff were not receiving a yearly medicines competency check.

The provider did not always adhere to the Mental Capacity Act 2005 (MCA). Many consent forms were signed by relatives with no authority. There were no best interest decisions or mental capacity assessments highlighting that people did not have capacity to sign their care plan consent forms. Not all staff had received training in the MCA 2005 and staff did not always understand how this legislation impacted on the lives of people they were working with.

Care planning varied. Some people had new style care plans which were well designed and comprehensive. Other care plans were less thorough. We found that some care plans had not been reviewed for many months, and in some cases this meant that significant changes in a person's condition had not been recorded. We found two instances of where there was no care plan in place and, in other cases, care documents were inaccurate or did not contain important medical information.

Staff did not receive regular effective supervision or annual appraisals. The provider did not always ensure robust recruitment practices by following up on references and during the interview process.

Staff received an induction, although, post induction meetings and support arrangements for staff did not occur.

The provider had quality assurance systems in place, but this was not always effective. The leadership of the organisation had identified issues but appropriate steps to address them had not been taken. Managerial audits of peoples and staff files were not carried out.

The provider had a complaints process and written complaints were investigated and responded to. However, verbal complaints were not always responded to. Feedback received from people was not analysed for trends and concerns were not followed up.

Most people told us staff were caring and kind. However, many people told us they experienced late visits and staff were rushed. Some people told us that they were not consulted about changes to their carers or informed when their carers were going to be late.

Staff had received training on safeguarding adults and staff we spoke with had a good understanding of abuse and how to raise any concerns.

Overall, we found significant shortfalls in the care provided to people. We identified breaches of regulations 9, 11, 12, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

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. Medicines were not always administered, recorded or monitored safely.

Risk assessments did not always provide information needed to protect people from harm. In some instances risks to people had not been assessed at all.

People experienced late or missed calls on a regular basis and were not always kept informed by the office.

The provider did not always operate a robust recruitment procedure.

Staff were knowledgeable around safeguarding and whistleblowing.

Is the service effective?

Inadequate

The service was not effective. Supervision and spot checks for staff were not consistently documented or carried out.

Staff training, which included medicines, safeguarding, basic first aid and life support, fire prevention, infection control and food hygiene was carried out every three years with the exception of moving and handling on a yearly basis.

Most people gave their consent for their care and support. However, there was a lack of records relating to the legal arrangements in relation to decision making. Not all staff had training in MCA 2005 and two thirds of staff we spoke with lacked knowledge of MCA and consent.

People who were supported to eat and drink told us they had no concerns.

Is the service caring?

Requires Improvement

The service was not always caring. Some people spoke highly of

their carers. However, other people commented that they often received care from different carers who did not know them or understand their needs. The service failed to ensure that people received consistent care.

People told us they were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not always person centred. Some people did not have a care plan and other care plans contained inaccuracies or lacked important medical information.

A complaints policy was in place and written complaints were investigated and responded to. However, verbal complaints were not always followed up.

Feedback was obtained from people and relatives, however this was not analysed to drive improvement.

Is the service well-led?

Inadequate

The service was not well led. Quality audit systems were not sufficiently robust.

Staff were generally positive about management and the support they received, however some staff told us they found the manager and office staff unsupportive.

Allied Healthcare London North

Detailed findings

Background to this inspection

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

The inspection was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

This inspection was carried out by two inspectors, three Specialist Advisors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience supported this inspection by carrying out telephone calls to people who used the service and their relatives.

Before the inspection we reviewed the information we already held about the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications, and safeguarding alerts. We also spoke with local authority commissioning and adult safeguarding team and the local Healthwatch team.

During the inspection we reviewed 23 people's records, including care plans and risk assessments. We also looked at 17 staff files, complaints information, and quality monitoring and audit information.

As part of this inspection we visited two people using the service. We spoke with 24 people using the service and eleven relatives. We also spoke with the registered manager, a senior co-ordinator, three field care supervisors, a senior coordinator and 15 care staff.

We sent out 50 surveys to people who were using the service and relatives. We received surveys feedback from nine people and two relatives.

Inadequate

Is the service safe?

Our findings

At our last inspection on 29 April 2015 we found that people were not protected against risks, because of inconsistent risk management. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager sent us an action plan telling us that risk assessments would be reviewed and updated to ensure that people using the service were not at risk. At this inspection we saw that care plans and risk assessments still did not consistently evidence that risks were effectively managed.

Care files contained risk assessment documents which included skin integrity, nutrition, emotional wellbeing, allergies, slips, trips and falls and environmental health and safety. Risk assessments were a tick box format which required the assessor to answer yes or no on whether a risk existed. Risk assessments did not provide information on what signs staff should look out for, what staff should do if the risk occurred and how to mitigate the risk. Risk assessments should provide clear guidance to staff and ensure that control measures are in place to manage the risks a person may experience.

Some people had health conditions, such as epilepsy, diabetes and mental health conditions. However, risk assessments did not identify the signs and symptoms a person may display when they became unwell due to these conditions or what action staff should take to keep the person safe. A Field Care Supervisor (FCS) told us that the service implemented a diabetes risk assessment tool in February 2016 which we saw appropriately completed for one person. However this had not been implemented for all people with diabetes.

One person did not have a risk assessment in place for the risks associated with the use of oxygen, such as fire and skin irritation, despite their care plan stating that they required oxygen overnight and three to four hours per day. Their care plan stated that they had respiratory problems.

We saw that one person required the use of bedrails, however there was no bedrails risk assessment in place to guide staff on the risks associated with the use of bedrails such as the person becoming trapped in a gap or climbing over the bedrail. This placed people at risk of harm as risk assessments failed to provide enough information for staff to adequately understand or mitigate risks posed to people they cared for.

One person had developed a pressure sore at home which had been appropriately reported to healthcare professionals. The person was admitted to hospital. However, following the person's discharge from hospital back to the service, their care plan or risk assessment had not been updated to include what care and support the person needed in relation to the pressure sore and associated risk management.

Care plans did not always contain accurate information about people's medical diagnoses. One care plan did not mention that the person suffered from seizures despite carers recording in daily notes that the person was prescribed an anti-seizure medicine. Another person's care documentation incorrectly stated

that the person had epilepsy when they did not. This meant that people were placed at risk of harm as their care plans contained inaccurate information.

People who were supported to take medicines did not always have a medicines risk assessment in place, despite the assessing FCS identifying the requirement for a medicines risk assessment. People were not adequately protected from risks associated with their care. This meant we could not be certain that staff had sufficient information to guide them on how to reduce or eliminate the risk so that the people were kept safe.

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

The provider supported some people to take medicines. Comments from people and relatives were mixed with one person telling us, "I'm taking a lot of medicines. [My carer] sets it out every morning, takes it out of the blister pack and gives me my medicines." Another person told us, "Yes, they give me my pills on time." However, a relative told us, "It's rare that I visit [my relative] and the whole blister pack has been issued. Generally teatime medicines are not given. I have mentioned it in the past and reiterated that [my relative] takes medicines."

Training records showed that staff received medicines training every three years. In addition to this, staff were also supposed to have a medicines competency assessment by a FCS on a yearly basis. The registered manager told us that the yearly medicines competency checks were not taking place as the FCS who were undertaking these checks had not been trained to do this task by the provider's clinical team. Three FCS received medicines training following the inspection. This meant that people were placed at risk as staff supporting people to take medicines had not had their competency assessed on a regular basis.

The provider had a comprehensive medicines policy in place and staff told us they had access to the policy. Staff demonstrated an understanding of safe medicines management. One member of staff told us, "If someone missed their medicine, I would inform manager immediately and then contact GP to find out if it was safe to give medicines now or what we can do." Another member of staff told us, "If we are reminding them we don't have to write on the MAR chart. If we are administering, we write it on the MAR chart like district nurses do. We write it in the daily log if it's just reminding people."

Support plans were not clear whether staff were assisting or administering medicines and records were incomplete. For example, one person's care plan stated that the person needed assistance with medicines; the medicines risk assessment stated that the person needed physical support in opening boxes or bottles whereas staff were recording in the persons daily notes that sometimes they were administering medicines. Another person's care plan consent form which listed the level of medicines support the person using the service required, stated that staff were to provide full administrative support with their medicines. However, the person's medicines assessment stated that the person lived with family and carers were to provide physical assistance when family were not around and the person's care plan did not mention medicines. This meant that staff did not always have clear guidance about how they were to support people to take medicines safely.

Some people that used the service were taking high risk medicines. One person had been prescribed a high risk medicine to be taken once a week. Staff were recording in daily notes that they were administering this medicine to the person, however there was no Medicines Administration Record (MAR) chart in place for this medicine. MAR charts are the formal record of administration of medicine within the care setting.

The provider's medicine policy stated, 'Care workers must not leave a dose of medication that has been removed from its packing for later. In exceptional circumstances this may be assessed as appropriate and explicit details must be recorded in the customers care plan.' However, staff were documenting that they were leaving medicines out for one person to take later. This meant that this person was placed at risk of harm as staff were not ensuring the person had taken their medicines as prescribed.

The provider's policy stated that, 'Medication can only be disposed of with the person's consent and medication no longer required should be returned to a pharmacy for safe disposal'. However, one week's worth of medicines for one person been taken from their home and brought to the office by a carer. These medicines had not been administered to the person. We also found that a medicine prescribed to this person to be taken in the evening had not been administered between 30 March 2016 and 3 May 2016. We discussed with the registered manager and we highlighted that this was a safeguarding matter. We submitted a safeguarding alert to the local authority. The registered manager also subsequently alerted the local authority.

Medicines audits were carried out, but they failed to identify issues. The registered manager completed an audit of a MAR chart in May 2016. The audit noted that a carer on 2 March 2016 had entered code 'D' on the MAR chart which referred to the person being away from home. However, when we checked the persons daily notes, the carer had recorded that the person was at home and the carer washed dishes. We also saw in the same MAR chart that carers were noting that the person using the service was taking medicines before the carers arrived. The person did not have a care plan in place. This was not recognised as a concern and no action was taken.

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

Staff files showed that the provider's recruitment process was not always followed. The registered manager told us that the provider's central personnel department managed the application and decision process for new staff and only passed information for staff who were suitable for interview to the agency local office. The local office then arranged interviews. Applicants were required to complete a pre-interview questionnaire and then underwent a face to face interview. However, in one pre-interview questionnaire a question relating to people's safety was not answered appropriately. There was no indication of this having been discussed at the face to face interview. A score sheet was also used to rate the applicants performance at the face to face interview but we saw this had not been completed on any of the score sheets we viewed.

We looked at the recruitment and induction records for ten of the 69 staff recruited since our previous inspection in April and May 2015. We found that the necessary background checks, including disclosure and barring service (DBS) had been undertaken and verified. However, in one case there had been no verification that a worker who was not a British Citizen had confirmation of Home Office permission to work in the UK. We asked the person responsible for overseeing staff recruitment processes at the local agency office and they told us that this was checked by the provider's central personnel department but they could not provide evidence that it had in fact been verified.

The provider's procedure for obtaining relevant references and then verifying the validity of references was not being adhered to. Only one reference for a single member of staff had been verified as valid by telephoning the referee in question. In three other cases, no reference was received from the person's previous or most recent employer.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The registered manager told us that the service had recently implemented an electronic call monitoring system called CM2000. The registered manager told us that this had significantly reduced the number of late calls. We checked the system during the inspection and we saw that there had been two late calls logged on one morning. The co-ordinator monitoring the mobile phone told us that this had been followed up with the carers involved by phoning them.

Although the registered manager stated that there had been a reduction in late and missed calls, ten people told us they experienced late calls on a regular basis. Comments from people included, "Someone has always turned up. But they can be very late", "I don't know who is coming and at what time" and "Sometimes they do [come on time] and sometimes they don't. I understand."

When asked if they were contacted when staff were late, one person told us, "Not really and I am not happy about that." Another person told us, "It's the duty of the office to contact me. They should be doing it." Another person told us, "They are okay, they come late so often though and I try and ring the office but nothing really changes."

Three people we spoke to told us they had experienced missed calls. One person told us, "It has happened now and again. I haven't said anything about it." Another person told us, "Once or twice no one has turned up and the agency didn't tell me until the next day." A relative told us, "It happened not too long ago. First time I had to phone the next day to complain as no one told us anything about it. It happened again the week later. This time I had to keep phoning them on the day, the staff in the office didn't handle it well and really understand then what was going on. The next day [staff member] phoned back and said it was the carer fault. They couldn't get hold of her and will be disciplined and won't be coming back."

The registered manager told us that there had been ten missed calls in the past two months. The registered manager told us that once they had been made aware of a missed or late visit, they followed up immediately with a call to the person using the service and the details are entered onto a centralised Complaints Incidents Accidents Monitoring System (CIAMS) where data was reviewed by a centralised audit department at the providers head office.

A local authority commissioning team told us that they have an action plan in place with the provider to improve how their electronic call monitoring system is used and how they rota their staff for visits.

The registered manager told us that it was not possible to monitor all calls electronically as some people did not have a landline phone. Some people were using their own phone when the carers arrived and others did not consent to carers accessing their landline phones. The registered manager confirmed that 416 people using the service had their calls monitored electronically which meant that 100 people did not have their visits electronically monitored. There were also instances of where calls failed to log due to technical problems. Carers were required to complete a timesheet on these occasions where electronic call monitoring was not possible for the reasons stated above. When completing quality checks, people and relatives were asked to comment whether carers attended on time.

People told us they felt safe. Comments from people included, "They are very good. I am well satisfied", "Honestly I've never thought about it. I never felt unsafe at any time" and "They are alright. I am happy with them." 100 per cent of people who responded to the survey indicated that they felt safe with their care worker.

There was a safeguarding policy in place. Staff had received training in safeguarding adults. They were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. One staff member told us, "Protecting the people we look after, if I have any concerns I would report it to my manager." Another member of staff told us, "I'd go straight to my coordinator then my manager and if they did nothing I'd call CQC."

The provider had a whistleblowing policy and staff had a good awareness of whistleblowing. One staff member told us, "If someone did something wrong. I would complain to CQC. I have the number." The service had arrangements in place to deal with emergencies, whether they were due to an individual's needs, staffing shortfalls or other potential emergencies. The service operated an out of hours on call service and there was also a provider emergency call line that operated nationally. This information was contained in the information provided to people using the service which was seen in the homes we visited during the inspection.

Inadequate

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "Some of them are very good." Another person said, "[My carer] is good at what he does and he does his job." Another person told us, "The carer is amazing he can look after him without any issues. He is reliable and very helpful and he can use the hoist." A relative told us, "[The carer] is a little diamond."

New staff had undergone a classroom-based induction for four days and shadowed a more experienced carer for twelve hours. One staff member told us, "Yes, we had induction for one week. We shadowed staff and also looked at care plans." It was policy for carers to have a telephone call with a FCS after their first day working alone. New staff were also supposed to have a four and eight week meetings during their probationary period. However, we found that the service had not adhered to its own policy for any member of staff whose recruitment records we viewed. This meant that newly appointed staff were not fully supported to provide high quality care in their first weeks and months of their new job.

We received mixed responses from staff in relation to training and supervisions. Most staff felt the training they received was adequate for their role and in order to meet people's needs. Some staff we spoke to told us they had regular supervisions, spot checks and appraisals. However, other staff told us they did not have regular supervisions, spot checks and appraisals. One member of staff told us that since commencing employment within the past year, with no prior experience in working in this sector, they had not had a spot check or a supervision session. Another member of staff we spoke with told us that they had only one supervision session in the past two years.

The senior co-ordinator was responsible for overseeing staff training told us that mandatory training, which all staff were required to complete, took place every three years and included medicines management, moving and handling, infection control, fire prevention safeguarding adults and basic first aid. The provider's database flagged up when a member of staff was overdue for this training. However, when we asked how the service managed specialised training to equip staff with key skills for the people they supported the service was unable to provide details of how or if this took place. Records showed that only three staff had received training in diabetes and 10 staff had received epilepsy training.

In relation to supporting staff, we were told that staff were contacted regularly by telephone and email if they were not visiting the office frequently. The provider's policy and staff told us that three monthly spot checks and supervisions should be carried out on an alternate basis meaning staff were required to have at least two of each in every year. However, this had not been recorded in staff files. There was no more than one spot check recorded in the previous year in the staff files we looked at. No one to one supervisions were recorded on any staff record we looked at.

The provider's policy stated that appraisals should take place each year and a review and update of objectives should be recorded every three months during supervision. We found that no staff appraisals had taken place within the last year for any worker whose records we looked at. Staff were not being adequately supported to carry out their role.

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

People told us that staff generally requested consent when delivering care. Most staff told us how they gained consent from people before providing care and support. One staff member told us, "I have to ask permission before starting to do something." However, when asked about obtaining consent, one member of staff told us, "Not regularly. They have been quite happy to go along."

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.

Most care records contained a care plan consent form. Some people had signed their care plans to indicate their consent for carers to provide care. However, in several cases consent forms had been signed by relatives. Care files did not contain details as to why the person receiving care had not signed their care plan. Consent forms did not note whether this was a best interest's decision. A best interest's decision is made on someone's behalf where they are unable to make decisions for themselves. Consent forms did not indicate whether the relative who signed their consent form had a power of attorney (POA) giving them the legal authority to act on the person's behalf. A POA is someone who is nominated to make decisions on a person's behalf where they are unable to do so. It is important to be aware when a POA is in place so that decisions are made by the right person. This information is essential to ensure that decisions made on behalf of people are lawful. We discussed this with the registered manager and a FCS who advised that sometimes relatives were very involved in care planning and insisted on signing people's care plan consent forms. This meant that the provider was not acting in line with MCA if the person had capacity to consent for their own care. The provider had personalised individual memory needs assessments and best interest decision making screening tools but these were not being consistently used.

Some examples of this included a care plan consent form signed by a niece of a person using the service despite there being no information on the persons care documents to indicate that the person lacked capacity. Another person's consent form was signed by their daughter. However, the mental capacity assessment stated 'able to make decisions'. The provider did not obtain consent from this person in line with MCA. Another person's care plan consent form was not signed at all.

Records showed that approximately half of staff had received MCA training and this was reflected in staff knowledge of MCA and capacity. Comments from staff included, "It [MCA] is where people who are unable to make decisions so we have to step in or we have to get other people involved like the GP, family and the office", "People who had mental disorder and cannot decide for themselves. If someone has dementia and they cannot decide, we contact their family to make a decision," and "If someone can make a decision on their own. If they cannot make a decision, I will look at care plans to see if there are any changes and I will notify manager." We spoke to 15 staff and we found that 10 staff did not demonstrate an understanding of MCA and how to implement this in their day to day work with people they provided care for.

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

Some people told us that they were supported to access health services. However, many people and relatives we spoke to did not require assistance from the provider to access healthcare services as

domiciliary care agencies do not generally support people with healthcare appointments as they provide care such as washing, dressing, medication and food preparation. One person told us, "[My carer] phoned the doctors and arranged an ambulance." Staff told us that they knew how to contact emergency services, such as the ambulance service, if necessary.

For more routine healthcare access, the FCS requested an appointment with the appropriate healthcare professional when they were completing a review or assessment of needs. For example, an assessment highlighted that a person was displaying signs of injury when being hoisted. The FCS immediately contacted the district nurse team and occupational therapy team to request a review which was promptly followed up. We saw another example of where a FCS saw that the person using the service was had difficulty in accessing their bathroom. The FCS immediately contacted the district nursing team to request a continence assessment. However, it was only because of the FCS was completing a review that these concerns were escalated and not as a result of carers raising concerns. Carers were not always raising concerns on an on-going basis.

People's needs in relation to support with eating and drinking had been assessed during the initial assessment and recorded. Many people we spoke did not require assistance from carers to prepare food. People who required it did not raise any concerns as regards the assistance they received. One person told us, "[My carer] will make me a slice of toast and a cup of tea in the morning."

Requires Improvement

Is the service caring?

Our findings

Most people told us that most staff were generally caring and kind. Comments from people using the service included, "Yes very good. [My carer] is always polite and friendly", "[My carer] is really nice. I went through four other carers before I got her and she is very good to me" and "Yes she is wonderful. She never gets angry no matter what I do and she is always nice. Don't have a bad thing to say about her."

However, some people told us that at times staff were rushed and abrupt. Comments received included, "Can be a bit rushed", "They rush it" and "Some are very nice and some are grumpy." A relative told us, "We have had a lot of issues with carer time keeping. Issues with carers not doing their jobs and complaining a lot."

We received mixed feedback from people and relatives about the continuity of care provided. Some people we spoke with told us that the same carers consistently visited and they were happy with the care provided. When asked in the survey if they receive care and support from familiar, consistent care and support workers, 50 per cent of respondents agreed and 50 per cent disagreed. Some people told us that they did not know their carers well and often did not know who would be visiting to provide their care and support. One person told us, "I see so many different people. They don't know much about me." A relative told us, "When you get a new carer they don't know how to treat him so they end up having to learn everything all over again. It can be inconvenient." A member of staff told us, "Hopefully if your rotas are similar, you get to know them." 56 per cent of people surveyed told us that they were not always introduced to their care workers before they provided care and support. This meant that people sometimes received care from staff that were not always familiar with the person or their care needs which could have caused people anxiety or distress.

People told us their dignity and privacy was respected. One person told us, "They are very respectful. They always draw the curtains on the ground floor." Another person told us, "I do get help with the bath and I feel comfortable with them." Another person said, "[My carer] ask me if I'm ready to have a shower and [my carer] talks to me about everything that is going on." We asked staff how they respected people's privacy and dignity. One member of staff told us, "I have to cover them in terms of personal care, when I am supporting them."

People's care plans included information about their cultural and religious heritage, communication and guidance about how personal care should be provided. We asked staff about their understanding of person centred care. One staff member told us, "People that I support are different. I always ask them what they would like to eat or how they want their personal care. I always give them a choice." Another member of staff told us that she spoke with the person she supported in their own language. She told us, "One of my clients, I speak to her in French. She is amazing. I really enjoy it. You adapt to different clients."

We asked staff how they would respect people from a different cultural background. One member of staff told us, "We have to respect their culture but also respect our policies and procedures." When asked about this, the staff member told us that it is the provider's policy for staff not to remove their shoes when entering

a person's home or wear shoe covers unless they are in the bathroom. The staff member told us that sometimes people using the service do not agree to this. However, this policy was implemented following an incident where a member of staff slipped down the stairs in a person's home whilst wearing foot covers. A person using the service told us in their survey response, "Would like them all to wear protective clothing and shoes to keep carpets clean."

People told us they were supported to be independent. One person told us, "I used to be very independent and they discussed with me how I could do it now. I do push myself to go downstairs. [My carer] helps me with whatever I want."

Requires Improvement

Is the service responsive?

Our findings

The service had implemented a new style care plan earlier this year. Although not all people had their care plans updated in line with the new style. New care plans that had been completed were detailed, person centred and contained people's likes and interests. For example, one care plan contained photographs, was in an easy to read format and included people, places and people important to the person, likes and dislikes and hopes and dreams for the future. Care plans contained an 'About Me' document which included a summary of people's individual needs and care planning. This document also contained information about people's life history and family members. New style care plans contained an emotional wellbeing and social inclusion care plan was completed. This supported staff to improve the emotional wellbeing of the person using the service by providing information on befriending and advocacy support, suggesting a daily newspaper delivery and suggesting hobbies.

People's care plans were not consistently person centred. Despite the progress made by implementing new person centred care plans for people using the service, we found that care plans were not always up to date and did not always contain accurate information. The older style care plans were in use were much briefer in format and lacked personalised information about people.

Of the 23 care records we looked at during the inspection, we found that the service had not completed care plans at all for two people using the service. In one example, the person had been using the service since 2014. We saw that in the person's individual demographic information document, which contained basic personal and health information stated that the person had epilepsy. There was no risk assessment in place that gave staff information on the person's risk of seizures and how to mitigate the risk. When we queried why there was not an epilepsy/seizures risk assessment in place, the registered manager confirmed that after making enquiries with the persons social care professional, it was established that the person did not have epilepsy but a different medical condition. This incorrect information on care documents meant that if the person required urgent medical attention during a care visit, incorrect medical information could have been given to the emergency services. During the inspection a FCS visited the person using the service and completed a care plan, however the information recorded as regards their medical history was vague, for example, the care plan referred to the person having a 'stomach problem', and the new care plan did not contain up to date medical information. This meant the care plan did not describe what staff needed to do to make sure the person received personalised care and support.

Care plans were not always reviewed when people's needs changed. We visited a person using the service during the inspection. The care plan in place at the time of the visit was dated 23 June 2015 and referenced two daily visits and a lunch call four days per week. The care plan was not updated in light of increased care needs which at the time of the inspection was four daily visits and the care plan did not address the person's current health condition. The care plan stated that the person could walk with assistance. However, during the inspection we saw that this person was bedbound and required full assistance with all aspects of care. This was discussed with registered manager and FCS and a new care plan was completed prior to the conclusion of the inspection. Although the new care plan stated that this person was bedbound and unable to do anything for themselves, it also stated that the carer is to support this person with getting medication

out of the box. This was contradictory information.

Care plans were reviewed on a yearly basis. However, the registered manager and FCS told us that that there was a backlog in reviewing care plans. It was identified in May 2016 by the provider's compliance officer that 64 care plans were identified as due for a review. The provider had been taking on approximately three new people every week. The FCSs were targeted to complete five care plans per week. There were five FCSs employed to undertake the review of care plans. FCS also had other responsibilities which included spot checks, supervisions and audits which took priority over care plan reviews as their system blocks staff who have not had a spot check or supervision. People who required a review of their care plan due to changing care needs were not being assessed in a timely manner.

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

The provider had a complaints policy which provided details of the complaints process and escalation process if complaints were not dealt with effectively. People were given a copy of the complaints procedure when they started to receive a service and told us they called the office if they had problems. A relative told us, "The problem was staff were always coming in late. But since I talked to them [the office] the staff have been on time. Only time will tell if it stays like this." Some people and relatives told us that they have in the past requested that their carer was changed due to concerns about attitude and the level of care provided. One person told us, "I complained about not liking the other carers. They changed them until I found one that I liked." However, some relatives told us that the office complied with their request for a short time period and then the carer started to attend to visits with people again, which caused distress to the people and relatives involved. One person told us, "I have asked them twice not to send [a particular carer]." One relative told us, "[My relative] has to clean up after the carer. [The carer] leaves a mess on the bathroom floor and I nearly slipped once. I have to complain to them again." Another relative told us, "This [carer] who came around. She just wanted her book signed."

There had been 21 complaints recorded as investigated since January 2016. Of these, 20 complaints were from the two placing authorities and one directly from a relative of a person using the service. We saw that complaints were raised in relation to missed calls, single carers attending for a double visit, incorrectly logging calls, carers not following a care plan and medicines errors. We saw that complaints were investigated with statements obtained from the staff involved and a response provided to the local authority who initially made the complaint. Where the complaint was received from the local authority, a complaint response was sent to the local authority but not to the person using the service. From speaking with people and relatives, we found concerns had recently been raised verbally in relation to a number of issues such as the attitude of carers, missed medicines and late/missed visits. However, these were not logged or analysed for trends.

Inadequate

Is the service well-led?

Our findings

Most people told us that they did not know the registered manager but generally told us that they could contact the office if they needed to and speak with a co-ordinator or FCS. People told us, "They try their best. They are so pressed" and "I think it's well run. It's very busy." However, one person told us, "No, I would not recommend this place. [The] carers seem to be running late and are rushed off their feet." Of the people we surveyed, 56 per cent indicated that they would not recommend the service to another person.

Most staff we spoke with us told us they found the manager supportive and the office environment friendly. Comments from staff included, "A very good manager and very supportive", "She is a very good manager and always listens." However, some staff told us that they found the office staff unhelpful and at times rude when they tried to contact them. One staff member told us, "When you go to complain, nothing gets done about it. The manager shouts, all she does is shout and then starts speaking in her own language." Another staff member told us that they did not call the office regularly as they had the impression that office staff were not interested and were at times rude to people and carers tended to resolve issues themselves.

There was a registered manager in post. The office was split into five teams, each of which had oversight of a specific geographical area with approximately 100 people who used the service and approximately 30-40 carers. A senior care coordinator supported the manager in a deputy capacity and provided managerial cover when the registered manager was absent. This person had the overall responsibility for the effective management and supervision of care teams, care workers and supporting the registered manager, oversight of recruitment and staff training. The senior co-ordinator was also responsible for allocating carers for visits for one of the five teams. Each team had a FCS, care coordinator and an administrator. The FCS had responsibility for completing all assessments and care plans, care plan reviews of people using the service, supervising staff, completing spot checks and auditing daily records and MAR charts. The care coordinator was responsible for first line management of carers, scheduling visits, staff rotas, alerting FCS to new people using the service, monitoring call times, and management of staff sickness and absence. In addition, care coordinators assisted with supervisions and appraisals and staff recruitment. Job descriptions for staff were clear and described the responsibilities for each role. One FCS we spoke with told us they worked extra hours and weekends without additional pay to try to catch up on their workload. However, the numerous responsibilities allocated to each FCS and care co-ordinator combined with the number of people and staff they had oversight for resulted in inadequate monitoring of care delivered to people, instances of poor quality care plans, delayed care plan reviews and inconsistent supervision and appraisal of care staff.

The service's quality assurance system was not always effective. A branch action plan, dated July 2015, identified a number of issues to be addressed and was due for completion in November 2015. Actions for completion in this audit included updating customer files, audits of daily records, MAR charts and nutrition and hydration assessments. The action plan also included auditing staff files and monitoring appraisals and supervisions and ensuring FCS were signed off to complete medicines competency assessments. We saw that the last recorded update on the action plan was in January 2016 where with the exception of medicines audits, all other action areas were either not actioned at all or were 40 per cent non-compliant.

Audits were not always being carried out on a regular basis and were not always effective. No audits were made available to inspectors during the inspection. Following the inspection the registered manager submitted an undated 'self-audit', which we were told was started in May 2016. This audit identified deficiencies around how consent was obtained from people, specialist training for staff, medicines management, staff competency checks and staff supervisions and appraisals.

It was identified in the May 2016 visit by a compliance officer from Allied Healthcare's regional team that out of five care plans reviewed, one care plan was detailed, one care plan was detailed with areas for improvement identified and three care plans were not detailed with quality issues such as incorrect assessment of risk and incorrect person's name on the care plan. The action taken as noted in the report was that the concerns were discussed with the registered manager and FCS. However, no action had been taken and no action plan had been developed.

The system for returning MAR charts and daily records made by staff was not always effective. Audits that had been completed in relation to medicines did not always pick up the concerns in respect of medicines management noted by the inspection team. There were not enough trained staff to carry out yearly medicines competency checks despite this being identified as an action in July 2015.

There was no system in place to monitor how the Mental Capacity Act 2005 (MCA) was applied when obtaining consent from people prior to care being provided. Staff lacked knowledge of MCA how this applied to their work.

There was no system in place to review if the risks posed to people had been properly identified, addressed and mitigated when risks were initially assessed.

Staff did not receive regular effective supervisions and appraisals.

Recruitment systems in place were not robust and deficiencies in the recruitment process had been identified by the inspection team. It was noted that some of the recruitment process was completed by a central recruitment team, although the recruitment stages completed by staff in the branch office was not adequately monitored to ensure completeness.

Overall, we found a lack of managerial oversight in relation to care planning, risk assessments, obtaining consent, medicines management, staff supervisions and appraisals and aspects of staff recruitment.

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

The service carried out bi-monthly customer quality monitoring reviews where a selection of clients were surveyed, usually by telephone. Comments varied widely from people being usually satisfied with the service to others where people had raised comment about the attitude of workers. People told us that they received telephone calls from the office to ask about their experience of using service. One person told us, "[Feedback], once a couple of months ago." Another person told us, "The office phones me all the time and asks me about my carers and their behaviours."

The feedback received from people was recorded on a feedback form. However, the forms detailing the feedback obtained were not fully completed, action was not always taken on negative feedback and no action had been taken to identify trends. In one example, a relative indicated that carers were not punctual and did not stay the allotted time. However, the person assessing the feedback recorded that no further

action was required despite the concerning feedback received.

Staff meetings were held at regular intervals in the office and on one day of the inspection three staff meetings were taking place at various times throughout the day to promote staff attendance. During the inspection we observed one meeting. Minutes were not taken at these meetings. Staff were provided with an agenda listing the main messages. Staff were not given the opportunity to add items to the agenda for discussion. The meeting comprised staff receiving updates and new procedures.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1)(a)(b) The provider did not ensure care plans contained accurate and up to date medical information for all people who used the service. Regulation 9(3)(a) The provider did not ensure care plans were in place for all people who used the service.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 14 June 2016.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) Care and treatment was not always provided with the consent of the relevant person as the registered provider was not always acting in accordance with the Mental Capacity Act 2005. The registered provider did not ensure that staff were familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 14 June 2016.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)

	The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. The registered manager did not ensure the safe management of medicines.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 14 June 2016.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) The service did not have effective systems in place to record and monitor the quality and safety of service provision in order to improve, learn and develop.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 14 June 2016.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19(1)(a)(b) The registered provider did not ensure a robust recruitment procedure by ensuring staff employed were of good character and had the skills and experience which were necessary for the work to be performed by them.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 14 June 2016.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(2)(a) The registered provider did not ensure regular and consistent staff supervision and appraisals which meant that staff performance was not being effectively monitored and reviewed.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 14 June 2016.