Mears Care Limited

Mears Care - Richmond

Inspection report

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

Summary of findings

Overall summary

The inspection took place on 21 March 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

The last inspection took place on 15 November 2016 when we found breaches of Regulation in relation to safe care and treatment, person centred care, receiving and acting on complaints, staffing and good governance. We rated the service requires improvement. We found that the service was not safe and rated this domain inadequate.

At the inspection of 21 March 2017 we found the provider had made improvements. In particular there had been improvements in the way in which the service was managed leading to some improvement in all areas. However, we found that the provider was not always keeping people safe. We noted improvements in other areas but these were not always enough to meet the Regulations.

Mears Care – Richmond is a domiciliary care agency providing personal care and support to people living in their own homes within the London Borough of Richmond upon Thames. The majority of people had their care funded and organised by the local authority. As part of the provider's contract with the local authority they provided the care and support to people who lived within two extra care schemes in the borough. They also provided short term care and support alongside the treatment provided by the health authority to people moving back home after an accident, hospital admission or operation. This type of support is known as reablement and is designed to help people to regain skills and confidence so that they can return to the lifestyle they had previously. The number of people who used the service changed regularly because the agency was one of the main providers used by the local authority. At the time of the inspection the agency was delivering approximately 3,000 hours of support a week. Mears Care Limited is a national organisation and has branches in different counties and London boroughs. The Richmond branch was located in an office with a number of other branches.

The registered manager left the organisation in 2016. Since this time three different service managers had been employed to run the service. The current service manager was appointed in February 2017. They had not yet applied to be registered for the Mears Care – Richmond branch, but had previously been the registered manager at another one of the provider's locations. They told us they would be applying to add the Richmond branch to their registration with the Care Quality Commission. 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 and associated Regulations about how the service is run.

People did not always receive their medicines in a safe way and the provider had not taken sufficient steps to ensure medicines were managed safely in the future.

People were sometimes placed at risk of harm and the provider had not taken enough action to minimise this risk.

There had been improvements in the way in which the staff were deployed but there were still instances where people did not receive the care and support they needed because the systems for deploying and organising staff were not always sufficient.

The provider had not always acted within the principles of the Mental Capacity Act 2005 because they had not assessed people's capacity to make decisions or followed the correct processes for making decisions in people's best interests.

People did not always receive care visits at the time they were planned and expected, or for the amount of time planned, and this resulted in some of their needs not being met.

Records were not always up to date, accurate or well maintained.

The provider's systems for monitoring the quality of the service had improved. But these did not always identify when things had gone wrong or were not being done properly. Therefore improvements had not always been made when they were needed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

There had been improvements in the way in which people were cared for and in all aspects of the service. Whilst we identified problems with the way in which medicines and risks were managed, we also saw that there had been improvements since the last inspection and the provider had systems in place to ensure improvements continued. In particularly they had improved the way in which they monitored how people were being cared for so they could identify and act on any problems swiftly.

People had good relationships with their care workers and felt they were kind, supportive and caring. Their privacy and dignity was maintained. People told us they had seen improvements in the service. People felt the staff met their needs and followed care plans. People felt involved in planning and reviewing their own care and told us the provider had been responsive to requests for change.

The staff told us they felt the service had improved. They felt better supported and told us they had the information and training they needed to help them carry out their roles. The recruitment procedures ensured that checks on the suitability of staff were in place. The staff told us their work was better planned and they were told about who they would be caring for in advance. This was a significant improvement since the last inspection and meant that the care workers were able to meet people's needs better. People were supported by the same regular staff rather than lots of different staff, which had been a problem in the past.

There had been improvements in the way in which the service was managed. This included improvements in team work, systems and processes for monitoring how well the service was working. The provider had demonstrated a commitment to continuous improvements and was acting on problems as they identified these or were made aware of them. They had responded to complaints, accidents and incidents appropriately and were working with the local authority to develop the service.

The overall rating for this provider is 'Requires Improvement' and the key question of safe has been rated 'Inadequate' at this inspection and at the previous inspection of the service. This means that it has been placed into 'Special Measures' by CQC.

The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve • Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

People did not always receive their medicines in a safe way or as prescribed. The provider had taken some action to prevent future mistakes and improve the way in which people received their medicines.

The provider had not always assessed or mitigated the risks to the health and wellbeing of people using the service. They had made some improvements in this area, but people were still being placed at risk at the time of the inspection.

The staff were not always deployed in a way which met people's needs and kept them safe. There had been significant improvements in this area, which improved deployment and monitoring of care visits. However, further improvements were needed.

The provider had procedures for safeguarding vulnerable people and these were being followed, but not all the staff were aware of their responsibilities.

The recruitment procedures included checks to make sure the staff were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider was not always acting within the principles of the Mental Capacity Act 2005 because they had not always assessed people's capacity to make decisions about their care and treatment. They had not always evidenced that they had followed the correct processes to make decisions in people's best interests if they did not have capacity to consent. But they had obtained consent from people who had capacity. The provider was also taking steps to improve the skills and knowledge of the staff to enable them to make appropriate assessments.

People were cared for by staff who were well trained and supported.

Is the service caring?

Good

The service was caring.

People were cared for by kind, polite and caring staff.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The provider had made improvements to the timing of visits so that more of these happened at the planned time. However, this was not experienced by everyone and some people's care visits took place much later or earlier than planned. Some people did not receive care visits for the full allocated time, including some visits which were so short no care had been provided.

There had been improvements to the way in which care was delivered and people felt that this was a better reflection of their care plan. People were involved in planning and reviewing their own care.

There was an appropriate complaints procedure and people had more confidence that their complaints would be taken seriously and acted on.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Records were not always complete or accurate.

The provider had introduced systems for monitoring the service and improving quality. However, some of these systems were not working effectively. Whilst improvements were noted in some areas, there were still people whose needs were not being met and problems which had not been addressed or resolved.

Mears Care - Richmond

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 21 March 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to make sure someone would be available.

The inspection visit was conducted by an inspector and an inspection manager. Before and after the visit we contacted people who used the service, their relatives, staff working for the agency and external professionals for their feedback. Some of this contact was made by a second inspector and some was made by an 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 supporting this inspection had personal experience of caring for older relatives who used care services.

Before the inspection visit we looked at all the information we held about the service. This included the last inspection report, the provider's action plan which they sent us in response to the last inspection report, information from the local authority about the service and other information which we held about the provider which included notifications of significant events and safeguarding alerts.

We spoke with 19 people who used the service and five relatives of other people who used the service by telephone. We also received written feedback from two relatives who had contacted us independently of the inspection to tell us about their experiences. We spoke with 20 care workers employed by the agency. We also spoke with the quality manager at the London Borough of Richmond upon Thames for the local authority's perspective.

During the inspection visit we spoke with the service manager and Mears quality manager, who was supporting the branch at the time of the inspection. We also spoke with the deputy manager, five care coordinators and one visiting officer.

We looked at the care records for 12 people who used the service and the electronic call monitoring data for February and March 2017 for 16 people. We also looked at the staff recruitment, training and support records for 12 members of staff and the rotas for February and March 2017 for 10 members of staff. We looked at additional related records when case tracking specific people's care. We looked at other records which included the provider's own quality monitoring records and audits, records of complaints and service concerns, records of safeguarding alerts and investigations, meeting minutes and information shared with people using the service and staff.

Inadequate

Is the service safe?

Our findings

At the inspection of 15 November 2016 we found the service was not safe. This was because people did not always feel safe and gave us specific examples about where they had been placed at risk. In addition, people did not always receive their medicines in a safe way.

The provider supplied us with an action plan on 17 January 2017 stating that all actions would be completed by 31 January 2017.

During our inspection of 21 March 2017 we found that some improvements had been made. The provider had improved the way in which they monitored and managed risks. However, we found that there were still risks which were not being appropriately managed.

People did not always receive their medicines in a safe way. We looked at a sample of records relating to people's medicines, including the record of medicines they were prescribed, the administration records and authorisation for administration. We found the records for one person stated that they administered their own medicines. There was no risk assessment or care plan relating to medicines. The person had signed an authorisation to state that they administered their own eye drops, which were the only recorded medicine for this person. There were no details about the actual eye drop medicine or the administration. However, we found that the log books for this person for January, February and March 2017 repeatedly stated that the staff had administered the person's eye drops, with comments such as, ''Put eye drops in [the person's] eyes'' and ''Eye drops administered as required.'' In addition, one log entry in January 2017 stated, ''Put eye drops in eyes and ointment as prescribed.'' Whilst another entry in March 2017 stated, ''Applied oil balm to shoulders'', another entry stated, ''gave all medicines as prescribed in boxes'' and a third entry stated, ''Assisted with blister pack [medicines].'' There was no record to state what these additional medicines were or to indicate whether the staff should be administering these. A log in March recorded that the person had two different types of eye drops and that one of these had been opened for more than 28 days and the member of staff had disposed of this medicine. There was no information about whether a new supply of this medicine was available or had been administered.

We found that another person's care plan and medicine authorisation stated that their family carer administered some of their medicines, but that staff should administer the person's morning medicine each day. The medicine administration records and daily logs for this person did not include any details of the medicines the person took in the morning and only included medicines they took at lunch time. There was a record to show staff had administered these, which did not reflect the care outlined in the care plan, risk assessment or medicine authorisation record.

The provider's procedures included collecting medicine administration records (MAR) and auditing these each month, so that any errors could be identified and acted upon. However, we found this was not always the case. One person's file included a MAR from December 2016. There were eight gaps where no administration details had been recorded, the staff responsible for administering the medicines, had recorded a reason for three of these incidents. However, there was no recorded reason for the other five

missing entries. The MAR had not been audited and therefore the gaps had not been explored or acted upon. There was no recorded MAR for this person in their file for 2017. In another person's file we found MAR sheets for December 2016 and January 2017. Both of these included gaps where no administration had been recorded. There was no evidence these had been audited or action taken to investigate why the errors had occurred. The MAR for February 2017 was not in the person's file. A third person's file contained MAR sheets for November and December 2016. The November MAR included 15 gaps where no administration had been recorded and the December MAR included 16 gaps, four of which had been explained. There was no evidence these MAR had been audited and there was no MAR for 2017 in the person's file. We saw that a forth person's MAR charts for December 2016 and January 2017 had been audited by the provider. The person auditing these had recorded, ''[Named care workers] spoken to and will be monitored'' for the audit of the December 2016 MAR and, ''Spoke to [care workers] about missing logs and explained the importance to complete, will be monitored'' for the audit of the January 2017 MAR. One named care worker had made errors in both December 2016 and January 2017. We looked at this care worker's file. There was no evidence that the medicine errors had been discussed with them, they had not received any additional training around medicines and there was no evidence of formal supervision, spot checks or checks on their competency at administering medicines since this time. In addition there was no evidence the provider had sought advice from the person's GP or pharmacist about the potential effects of them not receiving their medicines as prescribed.

We found that another person had MAR sheets for November and December 2016 indicating the staff had been administering their medicines. However, there were no details about these in the person's care plan and no medicine authorisation form. In addition there were gaps in the MAR for both months, which had not been explained. There were no MAR sheets for 2017 for this person. In another person's log book a member of staff had recorded that there was no MAR charts available to use at the person's home for their prescribed medicines. There was no evidence this had been acted upon or explanation about what action had been taken. In addition there were no MAR in the person's file in the office to indicate that this issue had been resolved.

Therefore people were at risk because they did not always receive their medicines as prescribed or in a safe way.

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

People who we spoke with who were supported with their medicines were happy with this support, as were relatives of people receiving support. Although one person said, ''If the [care workers] are running late I take [my medicines] myself and they don't check that I have.''

The provider was able to evidence they had taken some action to improve the way in which medicines were managed. They had a record to show they had written to care workers responsible for medicine recording errors. They also had introduced a way to monitor whether audits of MAR sheets were taking place and to track where problems with medicine administration or recording had occurred. In addition they had designed training based on specific case scenarios about medicines administration and recorded and were planning to provide this to all care workers involved in medicines incidents. The care workers had all received training in medicines management when they started work at the service and there was evidence of annual checks on their competency in relation to this.

We found that some of the records relating to medicines had been appropriately completed and there was clear evidence that people had received their prescribed medicines. In addition their care plans, and

associated risk assessments recorded details of their medicines.

The majority of care files we looked at contained evidence of clear risk assessments, which included information for the care workers on how to keep people safe and minimise the risks of harm. These had been regularly reviewed and changes in people's needs had been recorded in the reviews.

At the inspection of 15 November 2016 we found the staff were not always deployed in a way which was safe and met the needs of people who used the service.

The provider supplied us with an action plan on 17 January 2017 stating that all actions would be completed by 31 January 2017.

At the inspection of 21 March 2017 we found that there had been significant improvement but there were still incidents where people were at risk because of the way in which the staff were deployed. For example, there were still a number of care visits which did not take place as planned. The provider recorded there had been 24 missed visits in January 2017. We looked at the provider's record of missed calls and incidents. Whilst there was evidence that these had been investigated there was not always evidence that action had been taken, for example additional supervision, monitoring or other action regarding the staff responsible.

We looked at a sample of staff rotas for February and March 2017. These recorded the planned care visits for the member of staff. Whilst the majority of rotas did not include discrepancies, we found that some staff had been assigned care visits which clashed with other visits, and also visits scheduled with no travel time allowance. For example, one member of staff was scheduled to carry out four care visits at the same time on one day, one visit from 15.30pm until 16.00pm, one visit at 15.40pm until 15.57pm, one at 16.00 until 16.30pm and another at 16.14pm until 16.29pm. Two days later the same member of staff had been assigned visits with no allocated time to travel between the people, with one call visit scheduled to end at 15.00pm, the next to start and 15.00pm and one scheduled to end at 15.30pm and the next visit scheduled to start at exactly this time. The member of staff had scheduled visits on a third day which overlapped by 15 minutes, with one call scheduled to end at 16.00pm and the next call scheduled to start at 15.45pm. A second member of staff had a regular schedule where each day they were assigned to finish one care visit at 11am and start the next at the same time, with another care visit scheduled to start at 7.00pm, the time their previous care visit was scheduled to finish. A third rota we looked at included a regular schedule where there was no travel time allocated between two visits in the middle of the day.

One member of staff we spoke with told us that they regularly did not receive their rota until very late at night. This had been a problem we identified at the previous inspection, which resulted in the staff not always being aware of the care visits they were scheduled to complete in enough time. However, the majority of staff we spoke with told us this had improved and they now received their rotas in better time. They also commented that there had been improvements in allocated travel times, although some care workers told us this was still a problem. Some care workers told us they had long periods of time between calls which they were not paid for, whilst at other times they had a high concentration of calls back to back which they could not achieve in the allocated times.

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

There was evidence that the provider had taken steps to improve the way in which staff were deployed and the situation was much better than it had been in November 2016. The provider had restricted the coordinating teams so that the allocations were based on smaller geographical areas. They had improved

the way in which rotas were generated and the timing of when these were sent to the care workers. Further improvements in this area were planned. The service manager told us that they were now managing to send out rotas twice a week well in advance of the scheduled visits for each care worker. In addition, systems for communicating changes to the rota had improved. The office staff had all received additional training and support to understand the computerised planning and monitoring systems so that they could allocate work in a more appropriate way. The system generated alerts when care visits were not carried out and all office staff had live access to the system to track whether care visits were taking place as planned.

The provider had recruited more care workers so that they had greater flexibility with staffing levels and as a result they had reduced their reliance on agency and sub contracted workers.

At the inspection of 15 November 2016 we found that the staff were not always aware of their responsibilities in keeping people safe from abuse. We found that this continued to be the case, because some of the staff we spoke with had very limited understanding of different types of abuse or what they would do if they suspected abuse. We discussed this with the service manager who agreed to have additional information and training for staff in this area. There was evidence that all the staff had received relevant training and completed written tests about their knowledge at the time of training. The staff were issued handbooks which included information about safeguarding procedures. However, some of the staff told us they had not looked at the information since they were given it and were not able to tell us what was discussed in the handbook.

The provider had a procedure for safeguarding adults. There was evidence that they had acted appropriately when they had been made aware of allegations of abuse. They had notified the appropriate authorities and worked with the local safeguarding authority to investigate concerns and protect people.

The majority of people who used the service and their relatives told us they felt safe with the agency. One person said they were concerned that too many different care workers visited and this meant they did not feel safe. One person told us, ''I would feel safer if I knew who was coming.'' Another person told us the staff did not always show their identify badges to prove who they were. Other comments from people included, ''I feel safe, I have no complaints'', ''I feel very safe'', ''Most definitely feel safe'', ''I have no problems'', ''Absolutely safe'', ''Safe – very much so'' and ''Now I have got to know them I feel safe.''

The provider had contingency plans for different emergency situations and these included actions on how to deal with different scenarios. They had risk rated each individual using the service according to their vulnerability and needs, for example, people who lived alone or had significant health concerns were rated at high risk. The contingency plans for managing emergencies and monitoring if care visits took place were designed to help protect the most vulnerable people.

The provider's procedures for recruiting staff were appropriate. Staff were invited for a formal interview. There was evidence of this in staff files. The staff completed application forms, with employment histories. The provider obtained evidence of identification, eligibility to work in the United Kingdom, Disclosure and Barring Service criminal record checks, references from previous employers and evidence of literacy and numeracy skills. All the staff files we examined contained the required information.

Requires Improvement

Is the service effective?

Our findings

At the inspection of 15 November 2016 we found that the staff did not always have a good understanding of their responsibilities under the Mental Capacity Act 2005.

At the inspection of 21 March 2017 we found some improvements had been made and there were plans for further improvements. However the provider was still not meeting all their responsibilities under the Mental Capacity Act 2005.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Where people lacked capacity this had not always been assessed or clearly recorded. We found that care plans referred to people's dementia, confusion or other disabilities, but there was no specific assessment of their capacity to make decisions. For example, where people had varying levels of capacity and could make certain decisions, but not others, this had not been recorded. Some care plans, consent to medicines authorisations and risk assessments had been signed by a representative of the person using the service. There was not always clear evidence of why this representative had been asked to sign the documents rather than the person using the service. Representatives do not have the authority to consent for people using the service unless this has been agreed by law, for example, they have Lasting Power of Attorney for someone. People's next of kin and other representatives may be consulted to help ensure that care is provided in someone's best interest, however this should be clearly recorded and we found it had not been.

In addition, the majority of care workers we spoke with were not able to tell us about their responsibilities under or understanding of the MCA. For example, when we asked the care workers about the MCA and what the term capacity meant some of their responses included, "The MCA is the ability to make full and wise decisions otherwise the power of attorney is authorised to make decisions'', ''[The MCA is] how to handle people with mental problems'', ''[Lack of capacity is] if the client is not behaving normally", "When medication is locked away or people aren't allowed to move" and "When people don't understand you or start acting strangely."

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

People using the service told us that the care workers did ask them for consent before they provided care. They said that their choices were respected and they did not feel restricted by the service.

The provider had introduced new documentation for the visiting officers to use when assessing people's needs to specifically assess their capacity. They had provided training for these staff about the MCA and making assessments. We spoke with one visiting officer who was able to describe the new documents and how they would use these when assessing people.

We found that where people did have capacity they had been asked to sign their consent to their care plans, risk assessments and authorisation to administer medicines.

At the inspection of 15 November 2016 we found that not all of the staff had the opportunities for training and support they needed and this meant they did not always understand parts of their roles. However, the majority of care staff had received relevant training which they told us was useful.

The provider supplied us with an action plan on 17 January 2017 stating that all actions would be completed by 31 January 2017.

At the inspection of 21 March 2017 we found that the provider had made the necessary improvements. Staff working in the office and care workers all reported that they had the training they needed. They were able to describe comprehensive inductions and list training courses they had attended. They also told us that they took part in training refreshers when needed. All the office staff and the majority of care workers told us they felt better supported by the agency than they had at the last inspection. They said they had opportunities for formal meetings with their manager and that they could raise concerns or ask questions and these would be dealt with. Some of the comments from the staff included, "When I first joined it was a real mess but it's so much better now", "The flow of information could be better – you only get a very brief description of the client and their needs before your first visit," "The training was excellent. It was agreed that I only needed half a day shadowing. I was told that I could do more if I wanted but I felt confident enough after half a day."

The service manager told us that they were in the process of organising individual supervision meetings with all care workers. We saw evidence of this in care workers' files and in the provider's own monitoring systems. Half of the staff we spoke with told us they had taken part in an annual appraisal and most of these found this useful. Some care workers told us that the agency did not carry out spot checks or observations of them at work. This reflected our findings when looking at individual staff files, when some staff had not been assessed in the work place for over six months. This meant that the provider could not assure themselves that the staff were providing care and support in an appropriate way.

People's healthcare needs were recorded in their care plans. There was evidence the provider had worked with other healthcare professionals to meet people's needs, for example liaising with occupational therapists about equipment people needed and contacting GPs when people had become unwell.

Some people were supported by staff who prepared their meals. People we spoke with told us that they were generally happy with this support.

Good

Is the service caring?

Our findings

People who used the service and their representatives told us that they had good relationships with their regular care workers. They said they were polite, caring and respectful. Some people told us that sometimes they felt the care workers did not always understand the type of English or phrases they used and this could cause misunderstandings. But most people felt the care workers tried to understand and support them how they wanted to be cared for. One relative told us that they felt the care workers did not talk with the person they were caring for and this increased their sense of isolation. This was echoed by one person who told us their care workers did not speak with them and just ''rushed through the tasks.'' This feedback showed that some people felt the service was not caring, but they were in the minority and most people felt that the caring nature of the care workers was one of the most positive aspects of the service. Some of the comments from people using the service and relatives included, ''[My relative] gets on well with the staff, they have a cheeky banter and [they] like the care workers coming'', ''The carers are all very kind and polite'', ''I have no complaints regarding the carers'', ''They are very good indeed'', ''They are pretty good'', ''The people are all very nice, they just don't come on time'', ''Absolutely wonderful, nothing is too much trouble for them'', ''They are so careful and gentle'', ''Very sweet girls we have lovely chats'', ''Amazing, helpful and attentive'' and ''Some of the carers are very good.''

People using the service and their relatives told us the care workers respected their privacy and dignity. Some of their comments included, ''I am quite able to take care of my own washing and dressing, the carers will knock if I am in the bedroom/bathroom'', ''The carers are always polite and never interrupt if I am talking to someone'', ''They are all very respectful'', ''They never discuss other people and always keep the door closed when they are washing [my relative]'', ''They are careful when handling me, they never talk to me about other clients'', ''They are warm and clean and they close doors and keep [my relative] covered'', ''They are very discreet when changing my pad'', ''They treat [my relative] with great respect and protect [my relative's] dignity'' and ''They are very polite and careful.'' Only one person felt their privacy was not always respected and told us they did not like it when the care workers left them undressed whilst they attended to other tasks.

The care workers who we spoke with demonstrated a good understanding of maintaining people's privacy and dignity. They had received training in this and were able to tell us that they should keep doors and curtains closed, cover people when they were supporting them, offer them choices and talk in a respectful way towards people.

Requires Improvement

Is the service responsive?

Our findings

At the inspection of 15 November 2016 we found that people did not always receive care which met their needs or reflected their care plans. The care visits were not always on time and sometimes did not take place.

The provider supplied us with an action plan on 17 January 2017 stating that all actions would be completed by 31 January 2017.

At the inspection of 21 March 2017 we found improvements had been made and some people were receiving regular care visits at the right time. They reported the staff met their needs and stayed for the right amount of time. However, this was not the case for everyone and further improvements were needed.

Half the people using the service and their representatives we spoke with told us the care workers did not always arrive on time or when expected. Some people said that care workers did not stay for the allocated time. One person told us, ''They are supposed to be here at 9.00am but on two occasions they have been as late as 12pm.'' Another person said, ''They rarely come on time. They appear to have their own times and they never stay for the whole time.'' Other comments included, ''They come in early and don't always stay for the whole time, I spoke with them but there is no real improvement'', ''They try to squeeze too many calls in, they whizz around'', ''We often have to wait, [my relative] needs two carers and they do not arrive together'', ''They are always in a rush, they do what is necessary and then leave'' and ''They do not arrive on time, it should be 9am but often it is 10am or 11am and they never stay for the full hour, they rush around, I have told them not to but they do not respond.'' However, other people told us that they did not have any concerns about the timing of visits. Their comments included, ''I am fairly flexible and they are open, it suits me, I have no complaints'', ''They are usually on time and stay for as long as necessary'', ''They are practically always on time and they stay for the time required'', ''They have it down to a fine art'', ''They are pretty much on time and do everything which is needed'' and ''We are lucky we have regular carers and they are mostly on time, they never rush [my relative].''

We looked at a sample of log books where care workers recorded the time and details of the care visits they had carried out. We also looked at a sample of the electronic monitoring records which electronically recorded the actual time the care workers arrived and left someone's home. From these we identified that people did not always receive their care visits at the planned time. For example, one person's care plan stated that they should receive a daily visit at 8am each morning. The records for February and March 2017 showed a variation in the time staff arrived, with some calls as early as 7am and some after 9am. The person was also scheduled to receive a lunch time visit at 12pm. However their calls varied from between 11.31am and 14.30pm. Another person's morning visits were planned for 9.15am, however the log of their calls showed a variation between 11.15am start on one morning and then an 8.37am the following day. The person's afternoon visit was scheduled for 18.00pm. One day the care worker arrived at 17.37pm and they arrived at 19.30pm the following day. Some care visits regularly took place a lot later than planned. For example, the records for one person showed that within one week in March 2017, one visit was one hour and 37 minutes later than planned, one visit was one hour and 29 minutes late, one visit was one hour and

23 minutes late and three visits were over 50 minutes late. Another person's visits for one week in March 2017 included a visit which was one hour and four minutes late and a visit which was 53 minutes later than the time the person expected their care workers to arrive.
Whilst some variations in the timing of visits are expected these were examples of significant variations when the people receiving care did not know when care workers would arrive. Some of these care visits were to provide meals and medicines, and big variations could cause people discomfort or distress.

The timing of some people's actual visits meant that some of these visits were close together with long gaps of time between other visits. For example, one person's planned visits included assistance to bed at 9.15pm. However, logs of the visits which had taken place indicated that the staff regularly arrived for this visit at 19.00pm, only half an hour after the person's dinner time visit had finished. Another person's logs of calls indicated that one visit regularly ended at 17.15pm and the next visit started at 18.30pm. The actual planned start and finish times of these visits allowed for a two hour gap.

We also looked at the call times for people who required the support of two care workers working together. We saw that for some of these people there were big differences between the time one care worker arrived and the time the next care worker arrived. Often people required moving using a hoist, and this could not be performed by one care worker alone, which meant the person's needs could not be met until both care workers had arrived. For example, one person's call monitoring showed that there was regularly a gap of up to 25 minutes between one member of staff logging in and the next member of staff logging in. Another person's log we looked at showed that the second care worker sometimes arrived half an hour later than the first care worker.

The electronic monitoring records showed that some people did not always receive care for the allocated time. For example, one person had a schedule of two different hour long visits each day. The log of calls showed that the care worker was regularly at their home for less than 10 minutes when they should have been providing one hour's worth of care. We saw that during February and March 2017 another person had received 31 visits which lasted less than 10 minutes and 48 visits lasting less than 20 minutes for a call which was scheduled for one hour, with one visit lasting only three minutes. The only visits which had been recorded for the full hour had been manually inputted by office staff and were not a true reflection of the actual time the care worker was at the person's house. Similarly seven of another person's care visits during March 2017 lasted less than 10 minutes with a further 13 lasting less than 20 minutes. Again the shortest visit for this person was three minutes for a call which was supposed to last one hour.

Therefore people were not always receiving the care and support which had been planned for them. Their needs were not always being met.

Some of the care workers who we spoke with told us that care visits did not take place at the planned time because they did not have enough travel time between visits. One care worker said, ''I definitely do not have enough travel time. I have to get from Twickenham to Hanworth with no allocated travel time between calls.'' Another care worker told us, ''It is impossible and it upsets the service users.'' A third member of staff commented, ''[The provider] is disorganised regarding the time allowed between calls and geographical distance.'' However, some staff said that there had been improvements with the planning of visits and allocated travel time. For example, one care worker said, ''It's been much better since the new manager joined.'' Another care worker told us, "It's been much better recently and more reliable for clients."

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

The provider had made some improvements in this area. The way in which care visits were planned and organised had improved and this meant that more visits took place on time. There was evidence with the logs we looked at that care visits for some people did take place at the same regular, planned time each day, and that the care workers stayed for the allocated time. People usually had the same regular care workers which meant they felt safer and built up relationships with these care workers.

People told us the agency did not always let them know if care workers were going to be late or there was a change in care workers. One person said, ''They have missed quite a few calls but when you phone the office they have no idea and nothing changes.'' However, one person told us, ''Things are improving, it is being sorted out.''

At the inspection of 15 November 2016 we found that there were care plans with information about people's needs and the majority of people felt their regular care workers followed these. However, some people had experienced care which was not appropriate and their preferences were not considered or met.

The provider supplied us with an action plan on 17 January 2017 stating that all actions would be completed by 31 January 2017.

At the inspection of 21 March 2017 we found improvements had been made. People using the service and their relatives told us they had been involved in planning their own care. They were aware of their care plans and said that these were regularly reviewed. They told us the care workers followed these care plans and met their needs in a way in which they wanted and expected.

The logs completed by care workers at each visit indicated that care plans were being followed and that people received the care and support they needed.

At the inspection of 15 November 2016 we found that there was a complaints procedure but not everyone had confidence in this and some people had experienced situations where they felt their complaints were not listened to or taken seriously.

The provider supplied us with an action plan on 17 January 2017 stating that all actions would be completed by 31 January 2017.

At the inspection of 21 March 2017 we found that improvements had been made. People who had made a complaint told us they felt confident this had been responded to. People also told us that they felt informal concerns were listened to. Some people still felt communication from the office staff could be improved but most people felt able to discuss any concerns they had. People knew how to make a complaint and told us they had information about this.

We looked at the provider's records of complaints. There was evidence that each complaint had been investigated and the provider had written to the complainant explaining the outcome and apologising for the issues which led to the complaint. There was an allocated member of the senior staff team who was responsible for meeting with and telephoning people after complaints to make sure they were happy with the outcome and to find out whether there were any continued problems.

Requires Improvement

Is the service well-led?

Our findings

At the inspection of 15 November 2016 we found that records were not always accurately or appropriately maintained.

The provider supplied us with an action plan on 17 January 2017 stating that all actions would be completed by 31 January 2017.

At the inspection of 21 March 2017 we found that some improvements had been made. In particular there had been improvements in the way in which some records were audited so that any problems could be identified and acted upon. However, we found that some records were still incomplete or being used inappropriately. For example, we saw one person's care plan had not been completed. There was no information about the person's needs, their social history, preferences, daily routine, the support they needed and no recorded outcomes for their care. Another person's care plan gave detailed information about a night time visit and the care the staff should provide at this time. However, the person's communication log recorded that the person received an additional visit at lunch time each day. This was not included in the care plan and there was no information about the time or tasks which needed to be completed at this visit. Another person's care records did not include any assessments of risk.

In one person's care file we found that the communication log was missing entries when care had been provided on specific days but the care worker had not recorded this. Additionally, the care workers had run out of space in the book and used pieces of small paper which they had stapled into the log book. In this person's and two other people's log books we found the staff had recorded information about care visits on pages designated for recording financial transactions because they had completed the book and run out of space. Some communication logs were illegible and therefore it was not clear what care the person had received. One person's communication log included a stapled receipt for a grocery purchase. There was no reference to this in the communication log itself and the financial transaction had not been completed, therefore it was not clear why this had been saved or whether the care worker had made a purchase on behalf of the person. One person's care file included a medication administration chart for a different person.

Communication log books were completed at the person who used the service's home. The provider's procedures were that log books would be returned to the office for auditing and storage when completed. However, we found that there were no log books in the care files for some people. This included one person who had been using the service four times a day since June 2016, two people who had started using the service in October 2016 and one person who had used the service since November 2016 with three visits each day. In addition we found that one person's most recent log was dated October 2016. The provider's other records showed that this person had been involved in an incident leading to injury since this time. There was no evidence to show their logs of visits had been collected or audited to identify any changes in their need or concerns leading to the incident. Using other similar people's records as a bench mark, each log book contained on average between one and two months' worth of entries, meaning that there may

have been at least two or three completed log books for these people. The log books are evidence of the care provided and also may identify if there are any concerns or changes in need. Collecting and auditing these logs was important for the provider to monitor how people's needs were met and failure to do so could mean problems were not identified.

The provider told us they had mistakenly archived some of the records we requested during our inspection. They were taking action to retrieve these which contained information about staff employed at the service.

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

At the inspection of 15 November 2016 we found that there were audits and checks but these did not always result in positive changes for people.

The provider supplied us with an action plan on 17 January 2017 stating that all actions would be completed by 31 January 2017.

At the inspection of 21 March 2017 we found that improvements had been made. In particular the provider was making contact with people who used the service and their relatives by telephone and in person to ask about their experiences on a regular basis. This contact was recorded and there was evidence that concerns were acted upon. However, the audits were not always robust enough to ensure that the service was meeting people's needs. For example, the provider did not always accurately audit people's medicine administration records, or check logs of the care provided.

The provider used an electronic call monitoring system for the care workers to log in and out of people's homes when they arrived and left care visits. We looked at a sample of these and found that some staff had not logged in or out of calls. For example, when people required two carers working together, there were regular incidents when only one care worker had logged in. The record of electronic logging in for one person for February and March 2017 included 44 times when no information had been recorded and a further 56 times when a member of the office staff had recorded a reason why there was no information (for example, the member of staff forgot to log in or the member of staff was a temporary contracted worker). The log for another person's visits in March 2017 included eight gaps with no information and a further 20 where the office staff had recorded a reason. The provider told us that there had been a problem with the computerised system and this had now been resolved. In addition they carried out their own monitoring of how the system was being used. They had recorded approximately 50% compliance rate with the system, although they found most non-compliance was from temporary or subcontracted workers. Failure to use the system properly meant that the provider was not able to ensure people were receiving care at the right time. However, they had introduced new procedures to alert the coordinating staff when care workers did not use the electronic logging in system so that they could act on this immediately.

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

At the inspection of 15 November 2016 we found that people using the service, their relatives and staff had experienced problems with communication within the agency.

The provider supplied us with an action plan on 17 January 2017 stating that all actions would be completed by 31 January 2017.

At the inspection of 21 March 2017 we found that most people felt the agency had improved in this area. Some people felt further improvements were needed but most people we spoke with were generally positive about the service and their comments included, ''Everything is hunky dory. I have a relative who is a nurse and she says she is happy with them, can't get a better opinion than that'', ''They have empathy and make him laugh'', ''They are reliable and everything is just right'', ''It is very good, the simple things are right, they are gentle'', ''it's a great help to me'' and ''They are quite good.''

Some of the people who we spoke with told us they felt the service needed further improvements. Their comments included, ''They don't allow the people enough time, they could help more with my cleaning and keep me better informed'', ''More travel time for the staff, they have a rough time trying to fit everything in'', ''They could speak to their staff about how to talk to people and not to ignore us'', ''Timing is a big issue, they are too erratic'', ''They always come too early for lunch'', ''They don't know how to wash up'', ''There are not enough carers and too many clients, they are pushed from pillar to post'', ''There are occasions when they do not turn up for a long time and [my relative]'s pad gets very wet'', ''The staff do not always have good English language skills and don't understand the simple things like the difference between custard and horseradish'' and ''Communication and timing.''

Some people did not feel the service needed any improvements. One person told us, ''I think I have picked a winner'' and five other people told us there was nothing that could be improved on with one person saying, ''They are very very good.'' One person commented, ''I would certainly recommend them'' with another person telling us, ''They are amazing, excellent care.''

Since the last inspection a new service manager had been appointed. All of the office staff we spoke with told us that this appointment had led to positive changes for the branch. In addition we saw evidence of improvements, which included better organisation, monitoring systems and a proactive approach where the service manager looked at potential problems and tried to act before these developed. Some of the feedback from the office staff included, "The whole service is working better. There is improvement and this is down to having a decent manager'', "There have been improvements since the new manager came" and "The new manager understands us better – they understand the pressures. Our new manager will support us if we have too much to do."

The staff said the new service manager had addressed the need for more care workers by working very closely with the recruitment team. This had resulted in lots of new staff being appointed and starting work which had eased pressures on rotas. One co-ordinator said this had made their job easier and this meant they did not have to stay very late to get rotas covered any more. It was also stated that the branch had managed to drastically reduce its' use of agency workers and that some agency workers had even wanted to come and work for the location directly. One member of staff said "the rota system still needs to be worked on, but this is happening already." Another staff member said that communication still needed to improve amongst the office-based team. They said "Things still get missed but I feel it will get better". They went on to say "Not everyone is working on the same page yet. But the manager is working on making things better.''

Care workers told us they felt the management support at the service had improved with prompt and effective response to their queries. A small number of staff raised concerns about the out of hours on call support team. We discussed this with the service manager who was already aware of the concerns and working with the on call team manager to resolve the issues. The care workers felt the service was improving and they said that they felt the service manager had made a difference. One care worker told us, ''The new manager has really made a difference. If you have any issues she addresses it immediately." However, some care workers told us they still felt their direct line managers were not always supportive. Some of their comments included, "I was told when I called in unwell that I would be prosecuted if something happened

to the client, "They've got a very poor attitude, especially if you're sick they tell you that you still have to work'' and ''The coordinators really don't care.'' Some care workers told us they felt communication from the office staff needed to improve. One care worker told us, "It's very frustrating – I recently had a service user who was admitted to hospital but no-one told me and the call was still in the rota.'' Another care worker said, "I was recently called to attend a call when the scheduled time had already passed – they're very poor." However, some of the care workers told us they received better support from all the senior staff. Their comments included, "Before it was a nightmare – now they treat you with courtesy, they're much more professional and it's a pleasure to work for them" and "They're very helpful – always there to support you when you need it."

The provider worked closely with the London Borough of Richmond quality assurance team. They told us the local authority had been supportive and helped suggest improvements. The quality manager from the local authority told us the new service manager had made a difference at the service and that they were open to suggestions and wanted to make things better. They said the service was ''Moving in the right direction.'' They told us they had confidence in the abilities of the new manager to bring about all the changes needed at the service.

The provider had created an action plan which outlined areas where improvements were needed. This was regularly reviewed and updated. The plan included feedback from complaints, incidents and other concerns. The provider had developed systems to monitor different aspects of the service. These were not yet fully embedded, but we saw how they had started to work and improvements in most areas were measurable.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure that the care and treatment of service users was appropriate, met their needs or reflected their preferences. Regulation 9

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not always acted within accordance of the Mental Capacity Act 2005. Regulation 11 (3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always have or operate effective systems and processes to assess, monitor and improve the quality of the service. Regulation 17(1) and (2)(a) The registered person did not always maintain accurate and contemporaneous records of the care provided to each service user. Regulation 17(2), (c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure that there was always sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. Regulation 18(1)