First Choice Homecare & Employment Services Limited

First Choice Home Care & Employment Services Limited - Hackney

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 10, 11 and 12 January 2017 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

At the last inspection on 24 and 25 May 2016 and 1 and 3 June 2016 we found multiple breaches in relation to person-centred care, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, complaints, good governance, staffing, the employment of fit and proper persons and notification of incidents. The service was rated inadequate and placed into Special Measures as a result. We imposed a condition on the provider's registration restricting them from providing personal care to any new Service User from First Choice Home Care and Employment Services Limited Hackney without the prior written agreement of the Care Quality Commission. The provider sent in an action plan to tell us what they were going to do to make improvements. However during this inspection we found that insufficient improvements had been made.

First Choice Home Care and Employment Services Limited Hackney is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our previous inspection the service was providing support to 429 people in the London Boroughs of Hackney and Camden. The majority of the people using the service were either funded by the local authority or the NHS. After the inspection the local authorities arranged for people to be transferred to alternative care providers and at the time of this inspection, there was only one person being supported with personal care by the service.

There was a manager in post at the time of our inspection who had worked for the provider since October 2016 and had applied to be a registered manager. The previous branch manager had left after the last inspection and the last registered manager in place left in April 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People who lived with specific health conditions had not had the risks associated with these conditions properly assessed and care plans were not developed from these to ensure their safety and welfare. Risk assessments were not detailed and did not provide staff with information or guidance on how to minimise the risk.

Appropriate policies and procedures were not in place to ensure that people received their medicines safely and effectively. People's medicines were not being recorded correctly or checked. There was also no evidence that staff had received regular competency training to ensure that they were able to prompt and administer medicines safely.

Safeguarding incidents had started to be logged however people were still not always protected from the

risk of potential abuse because the provider did not always act appropriately to safeguarding concerns or follow them up to ensure people's safety.

Staff files had been checked and a system was in place for Disclosure and Barring Services (DBS) checks. However robust recruitment procedures were still not in place to minimise the risk of unsuitable people being employed.

Staff still did not have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA). Where family members had signed to consent to the care and support of their family member, the provider was unable to demonstrate that the relative had the legal authority to do so and was therefore not working in line with the MCA.

The action plan that had been submitted told us that staff had received refresher training in a number of areas since the last inspection, however we found that it had not been done. We saw that staff supervisions had started to be carried out however they did not always have an accurate record of what had been discussed.

Relatives commented positively about their regular care workers' caring attitude and said they had built up a positive relationship. There was evidence that people's privacy and dignity was respected. However, training in this area that we had been told had been completed had not been done.

We saw evidence of improved personalisation in people's care plans, however they still lacked detailed information and were not specific to people's needs which put them at risk of receiving unsafe or inappropriate care. We were not assured they reflected people's wishes and how they wanted to be cared for.

Records showed that people were not always involved in making decisions about their care and the support they received, when they were able to do so.

Systems to record and investigate complaints, incidents, accidents and serious events had been introduced however such events were not always recorded, followed up or resolved before being signed off by managers. Information was not used as an opportunity to learn and improve the service.

Quality monitoring systems that had been introduced did not identify or address shortfalls in the operation of the service. Shortfalls identified at our last inspection had not been satisfactorily addressed by the management team.

The action plan that was submitted to us by the provider had not been followed through effectively to improve the service. It was not clear if all staff had access to the plan to work towards achieving the outcomes highlighted.

The provider continued to not meet their legal obligations to notify the CQC about serious incidents and allegations of abuse.

We found continued breaches of regulations in relation to consent, safe care and treatment, safeguarding service users from abuse and improper treatment, receiving and acting on complaints, good governance, staffing, fit and proper persons employed and notifiable incidents. 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 therefore remains in 'special measures'.

The service was kept under review and we have found that not enough improvement was made. Therefore we are now considering what action we will take in line with our enforcement procedures to begin the process of preventing the provider from operating this service.

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 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.

The provider had failed to make significant improvements to address the shortfalls identified at our previous inspection.

Risk assessments were insufficiently detailed to show how people's health care needs were to be safely managed by staff.

Despite an audit on staff recruitment files and systems in place for DBS checks, safe recruitment processes had still not been followed and checks were incomplete.

The provider had set up a system to record and monitor safeguarding incidents, however outcomes and actions from investigations were not always evidenced or followed up.

Despite the provider updating their medicines policy, we could still not be assured that people received their medicines safely. People's medicines were not being recorded correctly or checked.

Is the service effective?

Inadequate

The service was not effective.

The provider had failed to make significant improvements to address the shortfalls identified at our previous inspection.

Staff re-induction and training that we had been told was in place had not been carried out. Staff had not received training to ensure they had the skills and knowledge to care for people effectively.

Staff supervisions had started to be carried out however they did not always have an accurate record of what had been discussed.

Staff did still not have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not always caring.

There was evidence that people's privacy and dignity was respected. However, training in this area that we had been told had been completed, had not been done.

People were not always involved in making decisions about their care and the support they received.

Relatives commented positively about their regular care workers caring attitude and said that they had built up a positive relationship.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

Care plans for people had been updated with more information but still lacked detail and important information to reflect people's wishes and meet their needs.

Complaints had started to be recorded however they were not always followed up or resolved before being signed off. Information was not used as an opportunity to learn and improve the service.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to make significant improvements to address the shortfalls identified at our previous inspection.

The provider continued to not meet their legal obligations to inform the Care Quality Commission of safeguarding incidents and incidents involving the police.

The systems in place to monitor the quality of the service were not effective as they did not pick up the issues we found during the inspection.

The action plan that was submitted to us by the provider had not been followed through to improve the service.

First Choice Home Care & Employment Services Limited - Hackney

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, and to check that improvements to meet legal requirements planned by the provider after our inspection on 24 and 25 May 2016 and 1 and 3 June 2016 had been made. We looked at the overall quality of the service to provide a new rating for the service under the Care Act 2014; prior to this inspection, the rating for the service was Inadequate.

The inspection took place on 10, 11 and 12 January 2017 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of two inspectors, with one present on all three days of the inspection and one on the 11 January. Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report. We considered information of concern which local authorities had shared with us after the previous inspection. In addition to this we reviewed the provider's action plans that had been submitted to CQC since the last inspection.

We were unable to speak with the one remaining service user but spoke with one relative of a person using the service. We also spoke with eight staff members. This included the managing director, the business development manager, the branch manager, one care coordinator, the human resources manager, the trainer and two care workers. We looked at five people's care plans, which included the current person

receiving support, three people who had recently been given notice in December 2016 and one person involved in the previous inspection. We looked at five staff recruitment files, staff training files and records related to the management of the service.

Following the inspection we contacted one health and social care professional who worked with the person using the service for their views and feedback. They told us that they were in the process of changing the care provider and sent confirmation that the person was no longer being supported by the provider on 23 January 2017.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection of the service we found that people's safety was at risk in a number of areas. During this inspection we found that the provider had not taken sufficient action to address the concerns and had not made sufficient improvements to ensure people's safety.

Our previous inspection identified that the provider had failed to manage risks to people's health and wellbeing. Medicines were not managed safely and risk assessments were not detailed, did not provide staff with guidance and were not reviewed if people's needs changed. At this inspection we found that improvements had not been made.

The initial assessment form that was completed when people started using the service had an introductory section to highlight specific health conditions, parts of the body that were affected by pain and measures to alleviate it. It also included a section for a summary overview for the person or advocate. For all the files we reviewed this information had not been completed. We saw that the provider carried out risk assessments on people's mobility, medicines, finances and a general home risk assessment, which covered 17 areas. This included the home environment, gas and electrical safety, food storage and individual risks, such as mental health needs, self-harm and neglect and vulnerability to abuse. We found shortfalls in all risk assessments that we looked at.

We saw from a NHS continuing care review that one person was at risk of developing pressure sores and needed regular repositioning during each visit. The moving and handling risk assessment stated the person struggled when being cared for, but there was no further information about this or guidance for care workers. The assessment had no reference to the person's behaviour or how to respond to it. It highlighted that the person was bed bound and gave a risk rating of two, without any explanation of what this meant. There was no reference to how they needed to be transferred, repositioned or cared for in bed, or guidance for care workers to ensure this was managed safely. We also received further information from a care coordinator that the person needed to be supported with nutrition and needed to be in a specific position, but there was no reference of this in the assessment. Despite these risks being identified, there was no further information or guidance for care workers to deal with or manage them safely. We spoke to the manager about this who acknowledged that the risk assessment needed more detailed information.

Each hazard for this person's home risk assessment had been rated as two, with the risk score guide highlighting it was possible a minor injury or incapacity could occur, but there was no further information explaining what this could be. The final score determined when the assessment would be reviewed. There was no further information and the assessment recorded them as medium risk, but again with no further information.

Another person was assessed as being at risk of falls. The home risk assessment said the person was at a medium risk but there was no information of what this risk was. It stated it should be reviewed in three months but this had not been done. The moving and handling risk assessment said they were at low risk of falls, despite the local authority assessment and the provider's own care plan recording they were at high

risk. No hazards were highlighted and there was no information or guidance for care workers on how these tasks were to be carried out to ensure the person received safe care.

Another person's financial risk assessment stated that no support was required in this area however we saw four records in their daily logs where they were supported with shopping. Only one financial transaction record had been completed but it had not been signed off by management. Three of the records did not record how much money had been spent and what change was returned to the person. We asked the branch manager and care coordinator about this who told us that it was a one off occasion and they were not being supported. However we saw further daily logs from May 2016 to October 2016 confirming that they were being supported and this had not been recorded in the risk assessment. A spot check record had been completed saying that financial records were being filled out correctly, but this is not what we found. The business development manager confirmed that support was being provided but it was not recorded in the care plan. This meant that people were at risk of financial loss or abuse.

The above information demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no assurances that people received their medicines safely. The provider had updated their medicines policy since the last inspection and it was now a requirement to keep a medicine administration record (MAR) for all levels of support, however we found that this was not being done. The medicines risk assessment for one person had not been completed correctly as their health condition and previous refusal of medicines had not been recorded. MAR records for this person were incomplete as medicines details had not been recorded and there was no start date. The record started on the 22 September 2016 but MAR records only started on the 24 September. The record was not consistent because between 24 September and 31 October, there were signatures for morning, lunchtime and evening medicines, which changed to morning, teatime and evening from the 1 November, with no explanation in the care plan as to why. There were also gaps within the MAR record for this period, even though it had been checked and signed by the manager. The issues that we found had not been highlighted by these checks.

Another person's risk assessment said the person was prompted with their medicines but we found that the care plan said they needed to be assisted. We saw a record in this person's daily logs from a care worker that highlighted medicines needed to be put into a cup and given to the person, which confirmed they were being assisted. However no MAR records had been completed between 20 October and 29 November and logs had not been checked. A spot check record that said medicines management was in line with their policy had been ticked as 'yes', even though this was not in place. There were also no MAR records in place for one person from July 2016 to 24 October 2016, and then from 24 October to 4 December, no records were completed despite them being supported with their medicines.

We saw records in three people's daily logs that they were being supported with creams. The provider's updated policy stated that applying a cream would be classed as assisting but we found no records in people's care plans that this had been recorded. One person was being supported with three different creams but the name of the creams, the reason for their use and what areas they were for were not recorded in their care plan.

The action plan sent in by the provider said that annual medicines competency assessments had been scheduled for care workers. We spoke to the branch manager about this to see what was in place and if any care workers had been assessed since the last inspection. They told us that this had not been done and there was no evidence of scheduled assessments for the three remaining care workers employed by the provider.

The above information demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we found that the provider was not carrying out sufficient checks to ensure that new staff were suitable to work with people using the service. At this inspection we found that some improvements had been made but not all issues had been addressed. A system for Disclosure and Barring Service (DBS) checks was now in place and all were up to date. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. We checked how DBS alerts were set up and saw that the managing director was set up to receive alerts, who then informed the human resources (HR) manager when the DBS checks were due to be reviewed in line with their policy. We saw an example of where this was highlighted as an alert on the system.

The provider sent us in an action plan and told us that all staff files had been audited and checked. A recruitment checklist was in place for all files however some areas were incomplete. For the five staff files we looked at, two files only had one reference in place. When we showed this to the HR manager they showed us a letter in one of the files, which they said was the reference. However, the letter was from a recruitment agency which stated they were unable to provide a reference or comment on the person's character or suitability. For the other staff member, the reference was from a part time job not related to health and social care, despite the application form stating they had recently worked in a health and social care setting as a support worker. There was no evidence that the provider had attempted to get a second reference at the time of employment. A record showed that the staff file had been audited but it had not been signed or dated and the HR manager could not confirm when it had been done, by who or why the issues with the reference had not been picked up.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we found that the provider did not always protect people who used the service from abuse and improper treatment and did not have effective systems and processes in place to prevent abuse. Safeguarding concerns were not appropriately shared, investigated, recorded or recognised. At this inspection we found that some improvements had been made but not all issues had been addressed. Care workers had received training in safeguarding however there were no records available to confirm that the care coordinator had received any training. The action plan sent in by the provider said that management staff will receive safeguarding training appropriate to their level and responsibility and we saw the branch manager and trainer had been registered on a safeguarding course with a local authority. However no refresher training had been scheduled for the business development manager, as they were only able to provide us with training records from February 2016.

We saw that safeguarding issues had started to be logged and investigated, with disciplinary action being taken when necessary. After the last inspection, we received a number of backdated notifications of safeguarding incidents that had been recorded and investigated, however not all of them had been followed up or had evidence of the final outcome before being signed off as complete by a manager. For one safeguarding incident recorded, a letter was sent to the person stating the investigation had concluded and that appropriate action had been taken. However, the outcome was not recorded and the business development manager was unsure what the outcome was. For another safeguarding investigation, we were told that the care workers involved were booked onto specific training courses as actions from the investigation. We found that they had not attended all the training, which was confirmed by the trainer. The investigation log had also not been completed or signed off. The provider told us after the inspection that the investigation logs had not been signed off as the case conference minutes had still not been received.

We saw information in the provider's out of hours report records that a relative had called to say that the care workers had not attended their calls for many weekends. There was no record that this had been followed up and it had also not been notified to us, which is a requirement of the provider's registration. The business development manager acknowledged this and added that it was dealt with by a previous care coordinator who was no longer working for the provider. Another record showed a care worker was accused of leaving a person with no electricity and refused to return to check they were safe. There was no evidence of any action from this or disciplinary follow up with the member of staff. The outcome had not been completed and it had not been signed off.

The above information demonstrates a continuing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Our previous inspection identified that the provider had failed to provide staff with the support and training they needed to carry out their roles effectively. Staff also did not have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA). At this inspection we found that improvements had not been made.

At the time of the inspection, there were three care workers who were supporting a person who needed to be transferred using a hoist. The action plan that was sent in by the provider stated that all staff had completed practical moving and handling and training with the use of a hoist. We found that the three care workers had not received this training and had only received the theory based training. We spoke to the trainer about this who confirmed that it had not been done. We showed them the action plan which stated this, however they told us that they had only received a copy of the action plan on the second morning of the inspection, so was unaware this training needed to be carried out.

We found that information in the provider's action plan stating that training that had been carried out had in fact not been done. Training we were told about included refresher training for carrying out risk assessments, refresher training on person centred care planning and re-induction of office staff in relation to dealing with complaints. The branch manager and trainer confirmed that this training had not taken place. We were also told that all care workers attended an induction refresher course by the end of September 2016. We could see that only one of the care workers had been through this re-induction programme, however the records for this care worker were unclear. The induction was signed by the manager and care worker on 14 November 2016 but the end of induction was dated 14 November 2014. The induction was due to be reviewed after three months but was dated 14 November 2014. The policy and procedure checklist attached to the back of the form was not completed to confirm if the care worker had read through them or received a copy of them. It was also then signed by the manager but not the care worker, so we could not be assured if it had been carried out. The trainer said it must have been an error but could not find any further evidence it had been completed.

Another staff file had no evidence of a completed probation period or supervision, and not all training certificates were in place. We received information from this member of staff during the inspection that there had been occasions when they had to carry out care visits to cover for care workers who were unavailable. There was no evidence of any training in place to show the member of staff was capable of supporting people with personal care. The staff file had been audited but it had not been signed or dated and the issues we found had not been picked up.

We saw that supervisions for staff had started to take place since the last inspection, however found that they were not always fully completed. Supervision records showed that 18 topics could be discussed, including training, safeguarding, record keeping and medicines compliance, with sections for what the staff and supervisors wanted to discuss. For two care workers' most recent supervisions, we saw that two topics were discussed, despite the form stating that a minimum of four topics should be discussed. The sections for what the care worker wanted to discuss were both blank, with no training or learning needs recorded. Attached to the form was a monthly medicines audit tool that identified that the care workers needed more

training in completing medicine administration record (MAR) sheets. The manager had documented that they went through the MARs and what needed to be done, and that for one care worker, the coordinator would monitor them over the next few weeks by carrying out spot checks. There were no spot checks completed after this date. We also found two supervisions that were identical, for two different care workers. We spoke to the manager about this who told us the information was the same as the same topics had been discussed, but acknowledged that the sections for care workers should not have been left blank.

We also saw one record of supervision for a member of staff that had been involved in a safeguarding incident. We were told that it was a disciplinary supervision however the form was blank, there was no information about what was discussed or what the learning points were. It only included the signatures of the previous branch manager and the member of staff involved.

The above information demonstrates a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We still found that staff did not have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA).

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.

The provider had amended their forms since the last inspection which highlighted if people were unable to sign but could show signs of consent, either verbally or with gestures, but they were not being completed. It also allowed a relative to sign to say they had the legal authority to consent on the person's behalf, but no further information to say what evidence they had of this.

For one person receiving care, we saw that a relative had signed all consent forms. When we asked the business development manager and branch manager what evidence they had to document that the relative had the legal authority to do this, they said they should have a lasting power of attorney (LPA) but confirmed that they did not have one in place. They were unaware that the local authority assessment had highlighted that the relative was able to assist with making decisions in the person's best interests.

For three people who had been given notice by the provider for their care package to end at the end of December 2016, we found issues in each file. For two people, we saw that relatives had signed documents when there were no confirmed capacity issues. We were told that one of them was physically unable to sign, however it had not been recorded in the care plan and the option in the updated form had not been used. There was no legal documentation confirming that they had the authority to sign on behalf of their relative. We saw a home visit document signed by a relative, but the corresponding spot check form was signed by the manager, with the name of the person written in where they were supposed to sign. The manager confirmed this was not the signature of the person, even though they were able to sign the consent form themselves. For a person who had signed their own contract, we saw that their medicines consent form had not been signed, although it had been signed by the manager with no reason why the person had not been able to sign it.

The action plan that was sent in by the provider told us that staff responsible for carrying out assessments had received in the MCA. We saw the training certificate for one member of staff who had completed an

online training course, however the certificate showed that they had achieved a score of 52% which was not sufficient to demonstrate their understanding of their responsibilities. We spoke to the trainer about this to see if there was any evidence of this being followed up or if further training was booked, but they said it had not been.

The above information demonstrates a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For one person who was supported with their meals, we saw information in their care plan of the type of diet they had and some of their preferred foods. From a sample of daily logs that we looked at we saw that care workers were recording the names of the food the person was given.

However, we found information in their NHS continuing care assessment about guidance for care workers on how to support the person during mealtimes, which was not included in the person's care plan so we could not be assured that the person was receiving the correct support. We spoke to one of the care workers who supported this person and they were able to tell us how they supported this person during mealtimes, however there were specific instructions that were important to ensure the person's safety that had not been recorded in the care plan or risk assessment.

Care plans included people's GP contact details and other health and social care professionals who were involved in their care. However there was no information for when staff might need to make contact with them if people's needs changed. Care workers we spoke with told us that if they reported problems to the office they did respond. The action plan that was sent in by the provider said that each person would have a healthcare professional contact form in their daily notes and electronic records, to record communication with other services such as GPs and district nurses. We did not see any evidence of this in place in all the files we looked at.

We did see an incident in the out of hours report after the last inspection that recorded a care worker had called to say a person's health had deteriorated and they needed an urgent reassessment. We looked to see if there had been any follow up as the branch manager provided us with their file. There was no record that this person was visited as their needs assessment was dated November 2015, or any evidence that this had been followed up with the relevant health and social care professionals. We spoke to the business development manager about this who told us that after the last inspection the service experienced a very chaotic period as many members of staff left. He showed us correspondence with the then branch manager that the service was at risk of breaking down, and said he had requested that the local authority take care packages back from them to help them manage. We requested to see the correspondence sent to or received from the local authority but it was not made available to us at the time of the inspection.

Requires Improvement

Is the service caring?

Our findings

The two care workers we spoke with were able to tell us about the needs of the person they were supporting, with one of them supporting the person for three years. They were able to explain what this person's needs were and how they liked to be supported. One relative we spoke with confirmed this and told us that they were happy with the three regular care workers who supported their family member. They added, "I'm happy with the care workers, they are nice and can communicate with my [family member], and understand his/her needs."

We were told that the care workers had built up a good relationship with the person in the time they worked with them, and information in quality assurance records confirmed this. One relative gave us examples of how care workers showed a kind and caring attitude. They told us that the care workers would put the heating on if they thought it was cold, and one previous care worker had learnt some phrases to be able to communicate with their family member in their own language.

We saw information in quality assurance records that highlighted people's relatives were involved in planning and making decisions about their family member's care and support. One relative told us that they were able to liaise with the office and were updated if there were any changes. They told us that the provider had visited them in October 2016, but had not done this previously. However there was not always evidence that people who were able to contribute towards their care planning had been asked about their views.

The action plan that was sent in by the provider said that coordinators had received refresher training on person centred care planning, had signed up to the Dignity Charter and would be the dignity champion for the branch. We spoke with the care coordinator and the trainer who confirmed that this had not taken place.

Care workers we spoke with were able to demonstrate the importance of respecting people's privacy and dignity. A comment in a telephone questionnaire said 'They are caring and treat my [family member] with respect and maintain their dignity.' The trainer showed us the content of the re-induction training which covered privacy and dignity and had been added to the programme. However we saw that the three care workers involved had not been re-inducted to cover this topic.

Requires Improvement

Is the service responsive?

Our findings

Our previous inspection identified that the provider had failed to provide people with personalised care that met their needs and did not have systems in place to monitor and effectively manage complaints. At this inspection we found that slight improvements had been made, however we still identified some issues.

During our last inspection we found that the provider did not have an effective system in place to deal with people's complaints as they were not being recorded or followed up. At this inspection we found that slight improvements had been made, however we still identified a number of issues.

The action plan that was sent in by the provider said that office staff had been re-inducted in relation to dealing with complaints. We found that this had not been done. We spoke to the branch manager about this who confirmed that it had been intended but had not been done. We saw from some of the complaints recorded that there were allegations of neglect which had not been prioritised or treated as safeguarding incidents.

We saw that two complaints logs were in place during the inspection. One with complaints after the previous inspection in June 2016 up until 22 September 2016, when the majority of people were transferred to another care provider. The second was everything from October 2016 onwards. We reviewed complaints from both folders and found that despite them being logged, we found that not all of them had been followed up or signed off when they had been resolved.

For one complaint from a relative relating to poor care for their family member, we had been told that the care worker involved was no longer working for the provider and after carrying out checks on the person and family, they were happy with the outcome. We saw a letter sent to the family saying the allegation had been concluded but there was no outcome or records that a spot check had been carried out and the person was happy with the outcome.

Another complaint recorded unprofessional behaviour from the out of hours staff. A letter was sent to the complainant to say that an investigation had been concluded and reassured them that appropriate action had been taken, however there was no further documentation within the file to confirm this.

For a complaint relating to allegations of poor care and neglect, we could see that the incident had been investigated and the investigation report highlighted that in-depth interviews with care workers had taken place, however there were no records available. We spoke to the business development manager about this who said that the care workers had left by the time of the investigation, so we could not be assured what the outcome was or whether it had been resolved.

We saw a complaint from a health and social care professional that required follow up action from the provider. We saw that a statement had been taken from the care worker involved but there was no further follow up and the outcome had not been recorded, even though the complaint log had recorded it as closed.

The above information demonstrates a continuing breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection, we found people's needs had not been identified in sufficient detail and some people did not have any care plans in place. We saw evidence that people's files now included a section called 'A little about me', which gave the provider the opportunity to find out some more information about the people they supported. It included people's nickname, if they had one, birthplace, job history, likes and dislikes, food preferences, favourite television shows and what people were important to them. We saw information for one person which highlighted culturally specific food and had good information about accessing the community and voluntary/education opportunities. Another person's records highlighted their religious needs and what was important to that person.

Each person had an assessment from the local authority or NHS, along with an assessment of needs from the provider. However we found that information was still limited and did not include all the relevant health and medical information about the person.

One person with communication difficulties had information within their NHS care plan which recorded how the person was able to communicate when they were in pain, which had not been recorded in their assessment of needs. In the communication section of the assessment, it said they were unable to communicate but could make hand and face gestures, but did not give any information about what the gestures meant. This person's assessment was also inconsistent as it was recorded that they were unable to communicate at all in a moving and handling assessment.

Another person's NHS assessment highlighted that there were significant concerns about their mental health and could be at an increased risk of harm. Warning signs that were recorded in the NHS assessment had not been carried over to their assessment by the provider. In their assessment it had recorded 'sometimes my mood changes' but it did not include all the information that explained the diagnosis. Further information about this was not included and the corresponding home risk assessment had scored the individual section, including mental health needs and self-harm as '0', with no further information. There was no reference in the person's care plan about these issues. We also found that the summary overview from the person and their relative in the assessment of needs had not been completed in all the files we viewed.

We saw in one person's file that as they were unable to contribute to the planning of their care, their relative had been involved to identify their preferences. We saw exact words from a relative taken during an assessment included within the support plan for what support was needed for their family member.

However we found that there was not always evidence to show that people without capacity issues were involved in their care. We saw records for one person where the only views that had been documented during a home visit were by a relative, even though there was no information to show the person was unable to do this. We spoke to the branch manager about this who told us that the person was asleep at the time of the visit, however there was no evidence of a follow up visit or telephone call to get the views of the person.

We saw the same information for another person when only views of a relative were recorded during a telephone questionnaire. We followed this up with the branch manager who told us that the person did not have a telephone. However a record of a home visit had the views and signature of a relative only, so we could not be assured that the person had been given the opportunity to share their views about the service. A telephone monitoring record on the 23 October 2016 and a home visit record on 24 October 2016 for another person again only had the views from a relative and it was confirmed that the person had no

communication issues. The branch manager acknowledged this was something that needed to be looked at.

Inadequate

Is the service well-led?

Our findings

Our previous inspection identified that the provider did not have effective systems in place to monitor the quality of the service and failed to notify us about specific incidents for which they have a legal obligation to do so. At this inspection we found that sufficient improvements had not been made.

At the time of our inspection there was a newly appointed branch manager who had been in place since 1 October 2016 and had applied to the Care Quality Commission (CQC) to become a registered manager.

The registered provider is required by law to notify the Care Quality Commission (CQC) of important events which occur within the service. We saw that a safeguarding log was now in place and incidents that had been found at the previous inspection, along with incidents that occurred after the inspection, were now being recorded. However we still found incidents which should have been reported to us which had not been. They included safeguarding incidents of allegations of neglect, financial abuse and incidents involving the police. We spoke to the business development manager about this who acknowledged that they had not been notified and admitted that this was an oversight.

The above information demonstrates a continuing breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We also found that where incidents had been recorded, there was not always follow up and actions identified had not been carried out. For one safeguarding incident that we had not been notified about, we saw that the care worker involved had been called to the office to give a statement. We saw an email that requested the care worker attend urgent moving and handling training, but records showed that this had not been done. The provider told us that the care worker involved was no longer working for them but it had not been recorded in the file. We also found that the provider was unable to attend one of the strategy meetings they were invited to by the local authority so not all outcomes of the incidents had been recorded.

We saw that an accident and incident log had been created since the last inspection. There was only one record in there, from 14 September 2016 that had not been completed fully. There were no incident report records for the incidents that we found in the on call reports.

We saw that an audit governance structure had been implemented since the last inspection, covering areas such as care plans, risk assessments, daily logs, missed calls, spot checks, training and safeguarding incidents. However despite this being in place, there were still acknowledged gaps found and checks did not pick up the issues we found during the inspection.

The action plan that was sent in by the provider said that monthly telephone checks, home visits and spot checks would be recorded in people's files but we could see that this was not taking place as regularly as we had been told. For one person, the most recent monitoring records were dated October 2016. The branch manager confirmed this and said the next visit was scheduled for some time in January. We found the same for three other files we reviewed for people who were receiving care up until the end of December 2016.

We found that people's MAR records were not being completed and some were not available, even though we were told they would be checked on a monthly basis. Daily logs for one person after 12 September 2016 were not available and we were told they had been archived by mistake. Daily logs for one person from July 2016 to October 2016 had not been checked and also from 20 October 2016 to 29 November 2016 for another person. In some of the checks, we saw that the quality of recording in the daily logs had been marked 'very good', however we found examples of ineligible recording that had not been picked up when they had been checked. We spoke to the business development manager about this who said that these records should be audited and systems had been put in place however acknowledged from our findings that they had not been done.

We looked at how late and missed visits were recorded. We saw that these incidents were logged in improvement plan updates from 1 August 2016. We saw that there were six late or missed visits recorded between 1 August 2016 and 14 August 2016 but the dates were not recorded. The business development manager said the information would be in the on call reports however there were no on call records before 12 August 2016. We saw the same issues recorded for September 2016, with times of incidents not being recorded, so it was difficult to ascertain who had a late or missed visit. Information in the out of hours records did not always record what action was taken to resolve matters. From 19 to 27 September 2016 there were no on call records or improvement plans update to see if any incidents had been recorded. From the 28 September, a daily on call log was put in place, however we still found that information was not always included for what action had been taken and what the outcome was. One record showed a relative called as they wanted to change the care worker. The response was that another person would attend the next day, however the action and outcome box had not been completed but it had been signed off as resolved.

Another on call record had information showing that a person had called asking where their care worker was, with the response being 'I explained I will be there in five minutes'. We spoke with the care coordinator who confirmed that they covered this care visit whilst still being on call. They explained that the phone did not ring during the visit, but that they would not have answered it if it had rung. This showed a lack of understanding about the responsibilities for covering the on call service. The business development manager told us that they now had a dedicated member of staff to carry out the on call service.

We found inaccuracies within information that had been sent to us by the provider. The provider stated that on 23 September 2016 there were five people using the service, which amounted to 140 visits by four care workers. When we checked this information with the business development manager on their electronic monitoring system, we found that it was inaccurate. The record showed that they were supporting six people which amounted to 121 visits.

We looked through the monthly meeting minutes since the last inspection. The action plan that was sent in by the provider said that all meeting agendas would be recorded. There were no records for August and September 2016.

Minutes of one meeting recorded that the new branch manager carried out an audit of the branch before starting work at the service and submitted their findings to the business development manager, who stated that a lot of support was required to work on the findings of the report. We asked the branch manager for a copy of the report but they confirmed that this had not taken place and was unable to account for why this information was in the minutes.

Information the provider sent to CQC told us that mock inspections had been carried out by a consultant but when we asked to see copies of the findings of these mock inspections we were told by the business

development manager that they had not been carried out. They added that they had been scheduled for December 2016 but did not take place. We also saw information from the October 2016 managers meeting that the consultant would provide training for staff in November but the business development manager confirmed this had not taken place.

We saw in one person's needs assessment form that the provider was unable to provide services where people or relatives declined the use of the electronic monitoring system, where care workers could log in and out at each visit to enable safer monitoring. For this person we saw that the relative declined the use of the system. We spoke to the business development manager about this who said that if this was the case, they should follow this up with the commissioners who fund the care. However they acknowledged that this had not been done as no record of this was available.

At the time of the inspection the provider was supporting one person. They had recently sent out letters dated 28 November 2016 to the other people using the service stating that due to unforeseen circumstances, the First Choice Hackney branch will be relocating to another branch, which was their head office and would no longer be able to provide a service. Two weeks' notice was given but the business development manager told us that in some cases the notice period was extended up to the end of December 2016 to allow more time to find an alternative provider. We saw an email from the branch manager to a relative saying that they could no longer provide services as the Hackney branch had already relocated, and gave a list of possible care providers they could contact. We spoke to the branch manager and business development manager about this as this information was not true. They said that the office had not been relocated and were still planning on carrying out services from this branch.

The above information demonstrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.