Mr Ajvinder Sandhu

De Vere Care - Ealing

Inspection report

22-24 Central Chambers
The Broadway
Ealing
London
W5 2NR

Tel: 02036751330
Website: www.deverecare.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 16 July 2018 and was announced. We gave the service two working days' notice as the location provided a service to people in their own homes and we needed to confirm someone would be available when we inspected.

The last inspection took place in January 2018. The service was rated requires improvement overall, and in the key questions of 'Is the service Safe, Effective, Responsive and Well Led?'. The key question of "Is the service Caring" was rated good. We found five breaches of regulations relating to consent to care and treatment, safe care and treatment, receiving and acting on complaints, good governance and staffing. We served warning notices on the provider in relation to complaints, good governance and staffing. We asked the provider to make the necessary improvements by 10 March 2018. At this inspection we found the provider had not made sufficient improvements and had not been able to fully meet the regulations. In addition, we found two further breaches of regulations.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, some living with the experience of dementia, people with learning disabilities and people with mental health needs. People's care was funded by the local authority or privately. At the time of our inspection twenty people were using the service. Not everyone using De Vere Care received the regulated activity of personal care; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a registered manager, but they were on long term leave and the provider had not made arrangements for an interim registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found that risk assessments and risk management plans were not always robust enough to minimise risks to people and others. This meant the provider was not assessing, monitoring and mitigating risks to people to help minimise their exposure to the risk of harm. Incidents and accidents were not always recorded, for example, when care workers missed calls. This meant the provider was not always acting to minimise risks to peoples' safety and well being

Medicines management was inconsistent including care workers not recording when they supported people to take their medicines and the failure to use medicines administration records (MAR) to record the administration of prescribed topical creams. In addition, the medicines policy had not been appropriately updated to provide effective guidance and the audits did not always identify discrepancies to help ensure people always received their medicines in a safe way. Furthermore, not all care workers had up to date medicines training or medicines competency testing to make sure they could support people with their

medicines safely.

Safe recruitment procedures were not always followed to ensure care workers were suitable to work with people. Training, supervisions and appraisals were not up to date which meant care workers did not always receive the support they required to develop their professional skills and knowledge.

Where people lacked the mental capacity to consent to specific decisions, the provider did not always follow the principles of the Mental Capacity Act 2005 (MCA). Nor did care workers have a good understanding of the MCA.

Care workers were not always adequately deployed to ensure that calls took place and that care workers stayed the length of time as planned and agreed with people using the service.

The monitoring officer and the care co-ordinator were available to care workers and listened to their concerns and tried to address these. However, we saw complaints were not always being recorded, investigated and followed up in a timely manner and care workers were not made accountable for their actions that resulted in a complaint.

Care plans were not always robust or detailed enough in their guidance and in some cases, were not person centred.

The provider had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people. However, these were not always effective because of the lack of improvements and to an extent to the deterioration in the quality of the service since our last inspection.

The provider had an infection control policy in place but not all staff had undertaken training in this area to help protect people against the risks of the spread of infection.

We saw there were procedures for reporting and investigating allegations of abuse and whistle blowing. Staff we spoke with knew how to respond to safeguarding concerns.

People's nutritional needs and dietary requirements were assessed and care workers knew how to support people to maintain good health.

People's needs had been assessed prior to starting with the service and care plans included people's likes and dislikes. However, people and their families were not consulted about end of life care.

We found seven breaches of regulations in relation to person-centred care, fit and proper persons employed, consent to care and treatment, safe care and treatment, receiving and acting on complaints, good governance and staffing. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is inadequate and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People had risk assessments to minimise the risk of harm, but not all risk assessments were robust or relevant which meant the risk assessments were not effective.

Incidents and accidents were not always recorded, for example when missed calls occurred. This meant the provider was not always acting to minimise risks to peoples' safety and well-being and to ensure learning took place to prevent reoccurrence.

The provider did not always follow safe medicines management procedures.

The provider did not have appropriate arrangements to manage and record financial transactions on behalf of people or to carry out audits to help keep people safe from financial abuse.

Safe recruitment procedures were not always followed to ensure care workers were suitable to work with people using the service.

Care workers were not always adequately deployed to ensure that calls took place and that care workers stayed the length of time as planned and agreed with people using the service.

The provider had an infection control policy in place but not all staff had undertaken training about this.

Care workers knew how to respond to safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Care workers did not receive up to date supervisions, appraisals, spot checks, training or medicines competency testing to be adequately supported in their roles as care workers.

Consent to care was not always sought in line with the principles of the Mental Capacity Act 2005.

The provider assessed people's care needs and recorded how they liked their care to be delivered.

People's nutritional needs and dietary requirements were also assessed and care workers knew how to support people to maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring.

Although we had feedback to indicate individual care workers treated people with kindness, we saw that the provider did not always operate the service in a person-centred manner.

Care workers we spoke with supported people to make day to day decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider did not ensure complaints were appropriately recorded, followed up and responded to, to prevent reoccurrence.

Some people and their families were involved in planning their care but were not consulted about end of life care.

Care plans were not always robust or detailed enough in their guidance and in some cases, were not person centred.

Is the service well-led?

Inadequate

The service was not well led.

The provider had a number of audits in place to monitor the quality of the care provided. However, these were not effective in identifying the areas where improvements were required and the risks associated with the provision of a care service so appropriate corrective action could be taken.

Records were not always complete and contemporaneous.

People and care workers told us they could approach the monitoring officer or the care co-ordinator with any concerns and they listened.

The registered manager was on long term leave and the provider

had not made arrangements to have an interim registered manager so as to meet their condition of registration.

De Vere Care - Ealing

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 16 July 2018 and was announced. We gave the service two working days' notice as the location provided a service to people in their own homes and we needed to confirm someone would be available when we inspected.

The inspection was conducted by two inspectors.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We contacted the local authority's safeguarding and commissioning teams to gather information about their views of the service.

During the inspection we spoke with the operations officer, the monitoring officer, the care co-ordinator and one care worker. We viewed the care records of six people using the service, the employment files for six care workers which included recruitment records, supervision and appraisals and we looked at training records for all staff. We also viewed the provider's checks and audits to monitor the quality of the service provided to people. After the inspection visit we spoke with eight people using the service, two relatives and three care workers.

Inadequate

Is the service safe?

Our findings

At the inspection on 5 April 2017, we identified a breach of regulation relating to safe care and treatment regarding medicines administration. On 9 January 2018 we returned to the service to see if the provider had met the regulation. They had not and we identified additional concerns regarding incidents and accidents not being recorded properly. As a result, of the repeated breach, we served a warning notice on the provider. During the 16 July 2018 inspection we found the provider remained in breach of the regulation.

At this inspection, we found risk assessments were not always robust as in some cases they were written in the same format as the care plan by describing the care provided and did not identify the specific risks related to the care provided and how this could be reduced. Some people's risk scored as high without any evidence as to how they had arrived at the score and other people did not always have relevant risk assessments.

One person's referral from the local authority said, 'Highly sensitive to latex so care worker must use alternative gloves.' We did not see a risk assessment for the use of latex or how the provider ensured care workers did not use latex gloves with this person. Another person's file indicated they were doubly incontinent and on one day a week they were supported in the community for several hours at a time. The risk assessment for 'community engagement' did not indicate how the person's incontinence was managed when they were out. Nor did the risk assessment provide details of how they were supported in the community or for the safe use of public transport as a wheelchair user. Another risk assessment for personal care indicated the care worker should use prescribed cream but there was no record of the cream on the medicines administration records (MAR) or a body map to indicate where to apply the cream. As risk assessments had not been completed in relation to specific issues identified for each person, the care workers did not have guidance on how to reduce these risks.

Some peoples' risk assessments, were not risk assessments but care plans. For example, one person's risk assessment indicated personal care was a medium risk but did not explain how they had reached this judgement or what the actual risk was. The action taken to minimise the risk was a description of the care required and not the action to reduce the unidentified risk, as personal care in itself is not a risk.

Other people had risk assessments that were not realistic or relevant. For example, one person had medicines recorded as a high risk 'hazard' but as they did not administer their own medicines they were not at a high risk of not taking them. Non-relevant risk assessments were highlighted in the last inspection report but we did not see evidence that this had been acted upon. In addition, risk assessments did not always reflect information in other areas of the files. One person's needs assessment said they used a walking frame but their risk assessment completed on the same date as the needs assessment recorded that no equipment was used for walking.

At the January 2018 inspection we found there were no incidents or accidents recorded in the incidents and accidents book and that no analysis had been carried out to identify trends and patterns. As a result, no preventative measures had been put in place. Consequently, the registered manager did not have an overall

view of incidents and accidents and had not identified if there were any trends or patterns so they could take action to prevent reoccurrence.

At this inspection we saw, as at the previous inspection, no incidents or accidents had been recorded since October 2015. We saw in the complaints book there had been a number of missed calls to people and the provider confirmed they would identify these as incidents. However, these had not been treated as incidents or investigated, which meant the provider was not always acting to minimise risks to peoples' safety and well-being.

During this inspection, as per the last two inspections, the provider had not updated their medicines policy to include as required (PRN) medicines guidelines. At the last inspection we saw not all care workers had up to date medicines training or medicines competency testing. We found the same at this inspection. The managers advised us that no one using the service was currently being administered medicines but they were supporting some people with their medicines which they called prompting. They had not recognised that irrespective of whether people were being administered or prompted with their medicines that this needed to be recorded because people were being supported with their medicines. They were therefore not following the NICE Guidance, 'Managing medicines for adults receiving social care in the community', section 1.5.1 which states, "When social care providers have responsibilities for medicines support they should have robust processes for recording a person's current medicines. These should ensure that records are:

- accurate and kept up to date
- accessible, in line with the person's expectations for confidentiality."

Furthermore, the provider failed to use records, including medicines administration records (MAR), to document the support people received with prescribed topical creams or body maps to indicate where the cream should be applied to. This meant people were at risk because the provider was not following national guidance and was not managing medicines in a safe way.

The above paragraphs were a repeated breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection on 5 April 2017, we identified a breach of regulation relating to safe recruitment. At the inspection of 9 January 2018, we saw safe recruitment practices were being followed. However, at the inspection of 16 July 2018, we saw that the provider again had failed to follow safe recruitment practices.

There was a procedure in place to ensure care workers were suitable to work with people using the service, however this was not always followed and people were therefore placed at risk of receiving unsafe care. The files contained checks and records including application forms, two references, identification documents with proof of permission to work in the UK if required and criminal record checks. We viewed six care workers' files. One care worker who had no previous experience in care and had not worked in the UK previously had only two unverified character references. The first spot check to ensure they were doing their job competently, was undertaken by the provider four months after the person was employed. The spot check template was not fully completed and the provider had not completed answers past question two. Another care worker had an employment reference from the agency they last worked for but the reference had no stamp or official email address, to confirm its validity. The person had also previously worked in a school but there was no reference from the school. This meant the provider did not always carry out robust checks to ensure employed care workers were suitable to provide safe and appropriate care to people.

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

2014.

Care workers were assigned to people based on need but the provider did not ensure staff were appropriately deployed so that people received their calls at the time these were planned for and that care workers stayed the full length of the calls. We asked people and their relatives if their care workers arrived on time and stayed for the right length of time. Comments included, "[Care worker] comes in on time and stays for her time. We fit in together", "They stay for the right amount of time. Sometimes they are late. If they are very late, the office will ring", "[The first time the carer came] she was an hour late because of poor directions. No one rang to say she was going to be late", "Carer shows up dead on time" and "I would like the carers to tell me when they are going on holiday. I have to chase the office. They don't always replace who is going on holiday."

Not all care workers used the electronic call monitoring system (ECMS) that is used to monitor when care workers attend the calls and if they stay the length of the calls. If a care worker did not use ECMS they rang the office when they finished the call to confirm the start and end time for the call. Consequently, it was not possible to check if they had completed the call correctly. We saw some timesheets did not match the call times on the support plan. For example, one person's care plan indicated they had a one and half hour call daily for support with personal care. The care plan stated, 'I would like my care worker to arrive at 8am every morning.' The time sheets we saw for June 4 to 18, 2018 showed the care worker arrived at 8am once in two weeks and in all but two instances it was after 9am. In addition, we saw in the complaints file, the predominate theme of complaints was care workers not arriving on time for the call. Despite this, the provider had not been able to make any improvements in this area. This meant people were not receiving personalised care that met their needs and wishes.

This was a breach of Regulation18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had updated safeguarding and whistleblowing procedures in place to help safeguard people from abuse. People we spoke with who used the service told us they felt safe. Care workers we spoke with were able to identify the types of abuse and knew how to respond to concerns. One care worker said, "I would contact the office or social worker."

The operations officer told us they knew how to raise safeguarding alerts appropriately with the local authority and notify the CQC. However, there were no safeguarding incidents recorded by the provider since 2014 and the local authority confirmed no safeguarding issues had been raised in the last eighteen months.

During this inspection we saw financial transactions were being completed by care workers to purchase food for one person using the service, however there were no records to demonstrate these transactions had been completed accurately and in an appropriate manner. We discussed this with the operations manager who agreed to begin recording the transactions.

There were measures in place for the control and prevention of infection. Care workers had access to personal protective equipment and the provider ran infection control training. Care workers told us, "Wash your hands properly and wear your gloves" and "I use gloves, aprons and shoe wraps."

Requires Improvement

Is the service effective?

Our findings

At the inspection on 5 April 2017, we identified a breach of regulation relating to staffing due to a lack of staff supervisions, appraisals, observational spot checks and competency monitoring which meant that we could not be sure care workers were being supported to develop in their roles as care workers. On 9 January 2018 we returned to the service to see if they had met the regulation and found they had not. As a result, of the repeated breach, we served a warning notice on the provider. During the 16 July 2018 inspection we found the provider remained in breach of the regulation.

People we spoke with told us they thought care workers had the right skills and knowledge to care for them. Comments included, "[Care worker] is skilled. They have been doing this for a long time" and "The carers know what they need to do." However, we saw gaps in training and not all care workers had a supervision completed in 2018 or an appraisal.

The provider's supervision policy stated, 'There is a minimum of four supervision sessions in a year. The date and time is usually informed to employees by their managers. Two of these supervisions are normally held in the office premises and the other two are held on-the-job, conducted by the Monitoring officer/Branch Manager.' We did not see evidence of four supervisions a year and the spot checks were not consistent. This meant the provider was not adequately supporting staff in line with their own policy.

The training matrix we saw indicated 15 out of 23 care workers had not completed adult safeguarding training in the last two years, 10 out of 25 had not completed infection control training, 19 out of 25 had not completed moving and handling in the last year and 12 out of 25 had not completed Mental Capacity Act (2005) training in the last year. The lack of appraisals, observational spot checks, competency monitoring and up to date training meant that staff were not being adequately supported in their roles or to develop and maintain the required skills to support the people they provided care for.

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

At the inspection on 5 April 2017, we recommended that consent was sought for care and treatment and where a person lacked mental capacity, for the provider to act in accordance with the requirements of the Mental Capacity Act 2005 (MCA). During the inspection of 9 January 2018, we saw the provider had not made adequate changes to fully demonstrate they were compliant with the requirements of the MCA. At the July 2018 inspection we found improvements had still not been made.

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

The provider's MCA policy was dated November 2017 and did not include information on consent to care or Court of Protection authorisations where people might have been deprived of their liberty whilst living in their homes. It also quoted out of date guidance from 2007. We saw where people had the capacity to consent, they had signed forms including their consent to care, medicines self administration forms and timesheets. However, for people who lacked the capacity to consent to specific decisions, the provider did not always follow the principles of the MCA.

For one person a consent to care form had been completed and we saw a relative had signed the form on behalf of the person. However, we did not see a mental capacity assessment to confirm the person did not have the capacity to make specific decisions, nor did we see evidence of a Lasting Power of Attorney in place for the relative to consent on behalf of the person. Lasting Power of Attorney in health and care matters legally enables a relative or representative to make decisions in the person's best interest as well as sign documents such as the support plan on the person's behalf.

Another person had a completed mental capacity assessment form but the decision was related to general 'wellbeing' and was not decision specific. It also stated the person did not have an impairment but their 'parents make decisions.' The consent form indicated a relative had power of attorney but it did not record for what and there was not a copy in the file. Furthermore, the needs assessment indicated the 'client has the capacity to make their own decisions with their parents' assistance.' The above meant these people were not appropriately supported to have their views taken in to account when decisions about their care were being made and there was no evidence that the best interests process was being followed where the person did not have the mental capacity to make decisions.

Only half the care workers had up to date MCA training and when we asked care workers about their understanding of the MCA principles they did not have a good understanding of the MCA. Comments included, "They can't make decisions by themselves so for them the next of kin or social worker makes decisions for them" and "I don't think I have done that [MCA]. [It's to] help people who are in need."

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

When new referrals were received from the local authority or privately, the care co-ordinator met with people in their homes to complete a needs assessment that was used to form the basis of the care plan. Some people's files included assessments and support plans completed by the local authority and we saw, for the most part, the provider's care plans reflected the local authority's assessments. Care plans identified people's religion and language and asked about people's sexuality. The 'How I like my care to be delivered' form was a summary care plan and provided details of peoples' preferences and routines.

People's care plans recorded information about their nutritional needs, dietary preferences, health needs such as diabetes, help with meal preparation and if they required assistance with eating. Care plans also had information around peoples' day to day health needs, for example if they wore glasses or required support to mobilise. As most people lived with relatives, the relatives tended to organise appointments and referral to healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

People using the service spoke positively about the care they received. Comments included, "It suits me very well. The carer is very, very good indeed", "The first few I had weren't very good. [My relative] sorted it out for me", "She's very good. She's clean and not talking on the phone. She's professional. She doesn't forget things" and "She's been coming to me for a long time, so she knows what I want."

The provider had not always ensured people were supported to make decisions in their daily lives because they had not made sure information was provided to all people in a way they could understand. We saw one person's care plan indicated they used Makaton. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. The care co-ordinator said the care worker could sign but we did not see any evidence of this or of any other form of communication for this person, such as a picture chart, so they could indicate what they would like.

In addition, we did not see that the provider had considered that information should be presented to people in an accessible way. For example, there were no easy read care plans that may have been appropriate for some people using the service and made these care plans more person centred. Also, the provider did not demonstrate that people's rights and independence were always considered as they were not always involved in the care planning process and making decisions about their care. This was because in some cases, relatives had signed care plans on people's behalf without the legal authority to do so.

The needs assessment identified people's cultural needs and asked if people could make choices about their individual routines or if they needed assistance. People we spoke with did not always know about their care plans but told us the care workers knew their likes and dislikes and they had choices. Comments included, "They're nice. They know everything [the person] likes because we tell them", "The carer I have is wonderful. They're social" and "[Care worker] is nice. I'm very happy. She is good at cooperating. She picks it up as she goes along." Care workers said, "When we go to someone new they tell us about them and what kind of help they need and we read the file" and "People tell us if they don't like something or if they do like it. We want the client to be happy."

We asked care workers what was important when they were providing personal care to people. They said, "Ensure they are comfortable, so we can do personal care. We don't force, them" and "Through communication to find their needs and come to their level. If they trust you, they feel comfortable and I can ask them [what they would like regarding personal care]. People using the service said, "The girls are nice. They're very respectful. They know what to do", "They're very, very respectful. They ask me, 'Can I do this for you'" and "They always speak to me very politely and ask if I need help."

People using the service received a service user guide that provided details of who to contact in the service if they needed to and indicated that people could request for it to be translated into different languages according to their preferences.

Requires Improvement

Is the service responsive?

Our findings

At the inspection on 5 April 2017, we identified a breach of regulation relating to receiving and acting on complaints because we did not see evidence of how complaints were followed up. On 9 January 2018 we returned to the service to see if the provider had met the regulation and found they had not. During the 16 July 2018 inspection we found the provider remained in breach of the regulation.

People we spoke with were generally happy with the service they received and most knew how to make a complaint if they wanted to. Their comments included, "I can't get anyone [on the phone] in the office. I make a complaint to social services because [De Vere] don't answer the phone", "I would never complain but I have their book and their number is in it" and "I can make a complaint if I had one."

The provider had an updated complaints procedure. We saw that there were six complaints recorded from January to February 2018 but none from March to July 2018. One relative complained the care worker was arriving up to an hour late in the morning, not staying for the full time and the office was not returning calls. The issue was raised by the local authority who requested documents in response to the complaint. We saw that the action from the complaint was for the care worker to be removed from the care package but we did not see learning from this such as evidence of any action to address the care worker's performance.

A second person made a complaint in January 2018 relating to missed calls. The complaint form indicated the actions taken to resolve the issue were spot checks and monitoring visits. However, the only monitoring visit was on 11 April 2018 and it did not address the issues identified in the complaint. A third person also made a complaint of a missed call. The system did not pick up on the missed call and the care worker did not report to the office they had missed the call. The complaint form indicated there was no follow up because the care package was cancelled and there was no indication if the performance procedure was followed through with the care worker.

The lack of evidence of investigations for learning to take place and for actions to be identified and implemented to prevent reoccurrence indicated the provider was not following their complaints procedures and as a result putting people's safety and well-being at risk.

This was a repeated breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they received personalised care. Their comments included, "Anything I want, they do it" and "I tell them what I need help with and they help." However, we also saw the care plans were not always comprehensive, detailed or person centred in their guidance for care workers. For example, one person's care plan for 'community engagement' did not contain meaningful action to take to support the person with the community engagement and only advised the care worker to assist the person to dress appropriately and support them to the shops or park and listed a single option for having lunch. The person did not use words to communicate, was doubly incontinent and was a wheelchair user. The care plan did not say the person could use sign language or for example a communication board so their opinion could

be sought on where they wanted to go. There was no care plan to support the person with toileting if they were in public and there was no guidance for using public transport with a person using a wheelchair. Furthermore, the person's relatives were signing on the person's behalf and we did not see evidence of how the person was involved in the planning of their care, although the needs assessment indicated they were able to make choices with assistance.

Care workers completed daily records for people which were task focused and not person centred which meant there was no evidence of people's wishes being taken into account when care was being provided.

We also noted that care plans did not record any information around people's wishes, views and thoughts about end of life care and this had not been considered as part of the care planning process. Neither had staff been trained to have an awareness of or to support people with end of life care needs.

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

Inadequate

Is the service well-led?

Our findings

At the inspection on 5 April 2017, we identified a breach of regulation relating to good governance due to poor quality assurance systems and ineffective checks and audits that did not identify issues raised at the inspection. On 9 January 2018 we returned to the service to see if the provider had met the regulation and found they had not. As a result, of the repeated breach, we served a warning notice on the provider. During the 16 July 2018 inspection we found the provider remained in breach of the regulation.

During this inspection we identified multiple breaches of regulations. These included breaches we had already identified at the previous two inspections where the provider had made little or no improvement. This was because the provider did not have an effective management structure and leadership to support improvements at the service. There was also a lack of effective monitoring, assessments and actions being identified to improve the quality of the service and to meet the needs of the people using it.

We found that the provider still did not have effective arrangements to assess, monitor and mitigate risks associated with the provision of care, despite the fact that we had identified this at our previous two inspections. They did not demonstrate that they were providing care and treatment to people which was safe and appropriate. These risks included poor risk assessments and a failure to manage medicines in a safe way.

We also saw that the risk management systems and governance arrangements were not effective as they did not always identify when a risk assessment was required or if the risk management plan was robust enough to mitigate the identified risk. This meant the provider could not ensure a consistent quality of care to protect people from the risk of unsafe care and treatment. For example, risk assessments judged to put people at high risk when this clearly was not the case could have been restrictive because they might not have fully promoted people's independence based on the level of risk they faced.

The provider had a number of checks and audits in place which included, an internal audit that was not effective because its focus was to indicate if the document had been seen. They did not check the effectiveness or quality of the document and had not identified the numerous concerns that we found during the inspection.

The medicines audits were also not that effective because these had not picked up that some medicines such as topical creams were not being recorded correctly on the MAR charts. In addition, we saw paperwork such as financial transactions and some daily records that were not brought into the office in a timely manner to be audited. Furthermore, there was no clear systems for monitoring calls so people received calls as planned, even though people and their relatives had complained about late calls.

There was inadequate supervision and monitoring of the delivery of care and gaps in care workers' training which meant care workers did not receive the support required to develop and improve their practice. There was also a lack of regular team meetings with the care workers to promote good practice and provide an opportunity for care workers to give feedback to the provider. We also saw that the performance and

disciplinary processes were not involved where complaints had identified areas to improve to prevent the incident happening again and to improve care practices. These matters had not been picked up by the management team so these could be put right and service delivery improved.

Records were not always complete and contemporaneous, as demonstrated by MAR charts and incident and accident forms not being completed as appropriate.

The above paragraphs show that the provider did not have adequate systems and processes to ensure people were receiving a safe and appropriate standard of care and that they were protected from risks that can arise whilst they received a service.

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

When we spoke with care workers, some of them told us their salaries were paid late on a number of occasions and had caused them undue stress. We discussed this with the operations officer who told us concerns regarding the financial cash flow within the organisation had been resolved about two months ago.

The registered manager for the service was on long term leave from 20 April 2018, but the provider had not made appropriate plans in a timely manner in relation to the ongoing management of the service to comply with the condition of registration to have a registered manager. The monitoring officer and the care coordinator had been providing cover for the registered manager without the benefit of training or management support to prepare them. During the inspection we discussed this with the operations officer who advised they would be the main point of contact and oversee the service's operations while the registered manager was on leave. CQC are further reviewing the fact that the service does not have a registered manager to comply with their condition of registration while the registered manager is on long term leave.

The lack of leadership and proper management support was further demonstrated by comments we received from people using the service, including, "Not experienced management I don't think" and "When I spoke to the office [regarding a late carer], they didn't really know what was happening." Care workers we spoke with told us the monitoring officer and the care coordinator were who they would approach with any concerns and that they were "really helpful." The operations officer told us, the management team were aware of the issues and were addressing them. They were also developing their skills and keeping up to date with guidance and legislation through attending local authority provider forums and receiving emails from CQC and the United Kingdom Homecare Association (UKHCA) to keep them informed of any changes.

We spoke with the local authority to obtain their views of the service. They informed us they had visited the service in March 2018. The local authority told us an action plan had been developed but further discussion indicated that it had not been implemented by the time of the CQC inspection. Areas that had been identified for improvement by the local authority included consent to care forms, risk assessments, the management of medicines, recruitment, staff support, record keeping and the need to strengthen internal audits.

The provider used a monitoring form to ask people using the service if they were satisfied with the service they received. Questions included if they knew what their care package was, how to complain, the care workers' capabilities, and overall how satisfied are they are with the service. Most monitoring forms we saw recorded that overall people were satisfied with the service.

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 care and treatment of service users did not always meet their needs or reflect their preferences. Regulation 9 (1)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not operate recruitment procedures effectively to ensure that people employed for the purpose of carrying on a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (2) (b)