Vincentian Care Plus

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8, 9 and 14 May 2018 and was announced.

Vincentian Care Plus is a domiciliary care agency providing care and support to people living in their own homes in the Westminster area of London. At the time of our inspection there were 155 people using the service of which 138 were receiving support with personal care tasks. Whilst we have taken into account any wider social care and support provided to people in their homes and in the community, the Care Quality Commission (CQC) carried out this inspection only in relation to the regulated activity of 'personal care'.

At the time of our inspection the service did not have a registered manager. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A service manager responsible for the day to day running of the service had been in post since 5 March 2018 and was therefore relatively new to the service.

At our previous inspection of Vincentian Care Plus on 11 and 14 August 2017, we identified continued breaches of regulations in regards to person-centred care, safe care and treatment and good governance and the service was rated inadequate overall. You can read the report from our last inspection, by selecting the 'all reports' link for Vincentian Care Plus on our website at www.cqc.org.uk.

Following the last inspection we issued two warning notices in relation to good governance and safe care and treatment. We asked the registered provider to send us an action plan setting out how they intended to improve the quality of the service and meet legal requirements. We received the provider's plan of action on 18 October 2017 stating that improvements would be made by December 2017.

At this inspection we found the registered provider had made some improvements in relation to late and missed visits. However, we identified continued breaches of the regulations in relation to safe care and treatment and good governance. We found a further breach of the regulations in regards to safeguarding, staff training and failure to adequately display CQC ratings. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

People and their relatives continued to express frustration with the way the service was managed.

People and their relatives didn't always feel that staff were equipped with the training, skills and experience required to support people with specific healthcare needs.

Risks in relation to people's safety were not always being addressed through the implementation of a robust risk assessment process.

People told us they felt safe when being supported by regular members of care staff. However, people were less complimentary about the service received from staff they were not familiar with.

People's medicines were not always being managed safely. Medicine records were not always completed correctly. Explanations for recording omissions were not adequately addressed through the provider's auditing processes.

The provider was not always ensuring people being supported with shopping tasks were protected against financial abuse.

Quality assurance procedures were ineffective. We identified multiple shortfalls in the way the provider implemented and operated auditing systems.

Where possible, people were involved in decisions about their care and how their needs would be met. Where appropriate, relatives and healthcare professionals contributed to the care planning process.

Staff had completed training in aspects of mental health legislation. Staff supported people to make their own decisions and sought consent before delivering care and support.

People were supported to eat and drink where this formed part of an agreed package of care.

The provider had safeguarding policies and procedures in place. Staff told us they would speak to a manager if they had concerns about a person's health, safety or welfare.

The service was complying with the Accessible Information Standard (AIS). The AIS applies to people using the service who have information and communication needs relating to a disability, impairment or sensory loss.

Staff supported people to attend healthcare appointments as required and liaised with people's relatives, GPs and other healthcare professionals to ensure people's needs were met appropriately.

Staff were following correct infection control procedures.

Recruitment practices ensured the right staff were recruited to support people to stay safe. There were enough staff deployed to meet people's assessed needs.

People and their relatives felt able to raise concerns and were provided with information about the provider's complaints procedures.

We rated the service inadequate at our previous inspection in August 2017. At this inspection we rated the service 'requires improvement' overall. The service remains in 'special measures'. This is because the service is still rated 'inadequate' in the Well Led domain.

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.

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.

We are considering what further action we are going to take. 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

Suitable arrangements had not been made to ensure that people consistently received safe care and treatment.

People's risk assessments did not always reflect the current risks or provide detail of the actions required to keep them safe.

Peoples' medicines were not always safely managed and records regarding medicines were incomplete.

People were at risk of financial abuse because staff were not always following the provider's policies and procedures.

Background checks had been completed before new care staff commenced employment.

Is the service effective?

Requires Improvement

The service wasn't always effective.

People and their relatives didn't always feel that staff were equipped with the training, skills and experience required to support people with specific healthcare needs.

Staff received regular support through supervision, annual appraisal and attendance at team meetings.

People's mental capacity was taken into consideration where appropriate.

People were supported to access healthcare services when required.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and helpful.

People were supported by staff that respected and promoted

their independence, privacy and dignity.

People were asked about their personal preferences and any goals they wished to achieve.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

The provider's systems did not ensure that care staff had all of the relevant information to ensure that they were fully able to meet people's individual needs.

People were assessed before their care started to ensure their needs could be met appropriately.

People and their relatives felt able to raise concerns and were provided with information about the provider's complaints procedures.

People told us that care staff were responsive to their needs and were adaptable if and when their needs changed.

Is the service well-led?

Inadequate

The service was not well led.

The service did not yet have a registered manager in post.

People and their relatives continued to express frustration with the way the service was managed.

Minimal quality monitoring systems were in place. These were not effective to ensure the service was being managed appropriately and as a consequence, may have put people's health, safety and well-being at risk.

Staff and management meetings were being held on a quarterly basis. Staff felt able to feedback about any concerns or ideas about how to improve service delivery.

Vincentian Care Plus

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.

We inspected this service as it was six months since it was rated 'Inadequate' and placed in 'special measures'.

This comprehensive inspection took place on 8, 9 and 14 May 2018. We gave the provider 48 hours' notice of our intention to visit because we needed to ensure a manager would be available to assist us with the inspection.

Before the inspection took place we looked at information we held about the service including registration information and previous inspection reports. We also looked at statutory notifications received from the provider and other agencies. Statutory notifications include information about important events which the provider is required to send us by law. We also reviewed information about any concerns and/or complaints received from members of the public.

On this occasion we did not ask the provider to send us a provider information return (PIR). This is information we ask providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information with us that they felt was relevant, during and following the inspection process.

One adult social care inspector visited the provider's office location on 8, 9 and 14 May 2018. We spoke with the manager of the service, two care-coordinators, an HR manager, a finance administrator, an IT officer and five members of care staff.

We looked at six records relating to staff recruitment, training and supervision. We reviewed auditing systems and service quality monitoring data. We looked at 13 people's care records and risk assessments.

We looked at corresponding samples of medicines administration records and daily notes where these were available. We also read policies and procedures relating to the service and looked at other relevant information about how the service is managed.

Following the inspection, three experts by experience spoke with 17 people using the service and nine relatives by telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2017, we found a continued breach of the regulations in relation to the safe management of medicines.

At this inspection we found the prompting of people's medicines continued to be inconsistent and poorly recorded. The provider's medicines policy stated that staff were not permitted to directly administer people's medicines. People were supported to take their medicines where this formed part of an agreed package of care and where medicines were dispensed in pre-packaged blister packs by people's pharmacies. Staff were required to complete medicines administration records (MARs) to indicate when they had prompted or not prompted a person's medicines. The manager told us that MARs were collected on a monthly basis for auditing purposes to ensure any errors or omissions were detected and remedied in a timely manner.

In the main, people told us staff provided the right amount of support to take their medicines. However, we heard comments that indicated staff were not always following the provider's medicines policies and procedures correctly. For example; people told us, "They put tablets in my mouth. I know how many I have to take. I take seven tablets every morning, one little white one at lunch and another six at night. There have sometimes been a bit of a mix up" and "I think there has been a problem and medicines have been missed. Some [staff members] aren't used to medication and it's difficult for them." A relative commented, "The agency give me mixed messages regarding a new medication such as an antibiotic - this is especially difficult when there are lots of different carers. I have seen where a course of antibiotics lasted two days longer than it should have so there must have been some missed doses."

The provider was not always following national guidance for the management of medicines in domiciliary care settings. For example, The Royal Pharmaceutical Society recommends that the names of medicines should be attached to or written on each MAR and on each person's care record as good practice. We found only three examples where people's medicines had been listed in their care documentation; either as a screenshot of blister packs or as a typed list. Neither recording system provided staff with any information about the reasons medicines had been prescribed and/or their associated known side effects. One list stated 'current medication' but was undated and another dated back to 10 October 2016. An entry in one person's daily notes dated 1 March 2018 stated, 'given the antibiotic med and morning med'. MARs for the month of March 2018 were missing from this person's care records. Therefore we were unable to check what this person's current medicines were, when the antibiotic was started and what it was for; whether it had been pre-packaged in blister pack form and whether it was being prompted in line with GP instructions.

We looked at a sample of available MARs and found that they were not always being completed correctly. For example; one person's records stated that blister pack medicines were to be prompted three times daily. We noted gaps in the records dated January - March 2018 to suggest that the person in question received their medicines erratically, sometimes once or twice a day and on occasion not at all. At times staff had inserted the letter 'O' indicating 'other' but this provided no clear indication as to why the person had not received their medicines as prescribed. On the reverse side of the MAR there was a space to record the

reasons why medicines were not prompted. We noted, for the above person that these records had been left blank. Week commencing dates were also incorrectly recorded. For example; for the month of March 2018, staff had recorded 4 March 2018 as the commencement date. This had then been corrected to 7 March 2018. The last commencement date of the month was recorded as 26 March 2018 and ended 6 days later, which given that March 2018 contains 31 days was obviously an error. We also noted that staff initials had been scribbled out, and extra prompting times added without direction from people's GPs or dispensing pharmacists. Another person's MAR recorded a prescribed medicine as needing prompting each morning. For the month of December 2017 we noted that this task had been completed appropriately on a total of five days.

Where people's care plans stated that they needed to be prompted to take their medicines, MARs were not always available for us to review. This meant that they were not being audited in a timely manner by those responsible for this undertaking. Where MARs were in place, recording was inconsistent, and contained errors and omissions that were unexplained. People's allergies or known symptoms of peoples' allergic reactions to medicine were not routinely noted on MARs or care records. The manager told us there was currently no system in place that provided an overview of medicines management which meant that where mismanagement of people's medicines occurred, trends could not be easily identified, issues rectified and lessons learnt.

Despite assurances from the manager about future plans for new medicines recording systems, the information in the above five paragraphs means that people's medicines were not being managed in a safe and effective manner. This is a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care coordinators completed a range of risk assessments in relation to people's nutrition and hydration, personal care support needs, home environment, level of mobility and risk of falls. We found that assessments were not always addressing identified risks. For example; one person's initial assessment stated, 'Carers to check [person's name] isn't holding food in [their] mouth or cheeks'. We could find no information in relation to this instruction in the dietary management section of the risk assessment. This may have meant that this person was not being protected from the risk of choking and/or aspiration. For another person, skin integrity was scored as high risk and redness was noted. There was no accompanying body map or guidance as to how staff could minimise the risk of pressure wounds developing particularly as this person already had a history of compromised mobility and poor skin integrity and often refused support with personal care. Two people at risk of falls had been provided with pendant alarms. We could find no supporting information as to whether staff checked to ensure people's pendants were working and whether staff encouraged people to wear them as per the advice. Risks in relation to people's safety were not always being addressed through the implementation of robust risk assessment processes. This above issue constituted a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always following correct procedures in relation to handling people's money safely. The provider's staff handbook states, 'never use credit/debit cards belonging to the service user and never accept or try to find out their PIN numbers.' In one person's daily notes we read, '[Person's name] gave me [their] bank card and the pin to get money for cigarettes.' Care coordinators told us that when staff completed shopping tasks for people they recorded the amount of money received, spent and returned on financial transaction forms and attached these to daily records for auditing purposes. Further entries in people's daily notes read, 'Collected money - £120, went to Tesco, bought milk, bread', 'bought cigarettes and milk' and 'bought coffee.' No information relating to these transactions had been recorded on people's financial transaction forms. The provider was responsible for managing one person's finances following

instruction from the local authority. We were told that senior staff withdrew £200 each week for this person and that this money was collected by a regular member of care staff responsible for shopping tasks. We saw that receipts of purchase were returned to the office. However, we found no robust auditing system in place to accurately record and monitor the exact amounts spent and returned either to the office or the person in question.

The provider was not always ensuring people were being protected against the risks of financial abuse because financial transaction records were not being completed or where completed were not being audited on a regular basis. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found a breach of the regulations in relation to the management of risks to people's health, well-being and safety associated with missed and late visits. We asked the manager what action had been taken to monitor visits and manage lateness. The manager told us that each member of care staff was provided with a mobile hand set which was used to log in and out of people's homes via a simple scanning mechanism attached to people's care plan folders. People we spoke with confirmed that care staff logged in and out each time they visited. Visits were monitored by staff working in the main office. When staff were running late or where visits appeared to have been missed, systems triggered a call to staff who were able to explain their whereabouts and whether or not the service had been provided. Members of staff who failed to log in and out of visits were invited to attend extra supervision sessions and we were told that disciplinary action would be taken if repeated incidents occurred. Staff told us they encountered no difficulties using their mobile phones to log in an out of visits apart from when systems occasionally went down. The IT officer and the HR manager told us and records confirmed that contingency plans were in place for when systems failed. This included informing staff of issues, contacting people using the service with updates and checking that critical visits had not been missed.

We asked people whether staff arrived on time and were told, "[Name of staff member] is always on time and has never missed a call", "[Staff] are always on time, they have to clock in and out and they have never missed a visit" and "[Staff] are mostly on time" and "Yes, they're never late and haven't missed any visits." Relatives told us, "[Staff] are generally on time and we get a call if they are late." However, people also told us, "The time-keeping is not good, they are often running late" and "People need to be on time or it's stressful for me." A relative said, "If I am going to be late back I phone them but they don't do the same for me. It's just common courtesy to let me know who is coming and the times and if they are late." The provider had recorded six missed visits since the last inspection took place in August 2017. These issues had been investigated appropriately.

We asked people using the service if they felt safe and whether they trusted the staff who visited them in their homes. People responded, "I feel safe with most of them. I don't like the men coming as I feel less safe but they haven't sent a man for a while now. I have a key safe and they always call out as they come in so I know who it is - that makes me feel safer", "[Staff] wait at the door for me and they've got badges on their tee-shirts" and "Yes, I feel safe with [staff]." Relatives told us, "I do feel [my family member] is safe - It's the way they talk to [them] - it's reassuring and they go above and beyond doing extra little jobs. [My family member] was dubious about having them initially but now [they] enjoy [staff] visiting which also helps us" and "I do think [my family member] is safe. I trust [their] regular carer- [staff member] really knows what [they're] doing."

The service operated an out of hours (OOH) number between 5.00 pm and 10.30 pm Monday to Saturday and from 6.30 pm to 9.00 pm on a Sunday. People were aware that an OOHs number existed should they require support in the event of an emergency. People told us, "I do know the out of hours number but have

never had to use it", "I have always got through to somebody when I phone the office", "It's easy to get through to the office to speak to somebody there" and "The Out of hours number I have used and I have found it easy enough to get through to them."

Safe recruitment practices were followed to ensure suitable staff were employed by the service. Staff records contained copies of proof of identity and address, reference checks from previous employers and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. There were enough staff who had been safely recruited to meet people's needs. Staff told us they were provided with sufficient time to travel between people they were providing care for.

Staff completed safeguarding training and demonstrated an understanding of what constituted abuse; listing verbal and physical aggression, emotional and psychological abuse and financial exploitation as examples. Staff were familiar with the provider's whistleblowing procedures and told us they would report any concerns they may have to their managers.

Staff followed infection control procedures and told us they had access to disposable gloves and aprons. People and their relatives told us, "[Staff] always look clean, tidy and professional", "[Staff] have a box of gloves and aprons here which they use" and "I do see them washing their hands before preparing [my family member's] breakfast."

The manager told us there had been no accidents or incidents since the last inspection took place in August 2017. The provider had systems in place to record and respond to these events appropriately if and when they occurred.

Requires Improvement

Is the service effective?

Our findings

We asked people and their relatives whether they felt staff had the necessary skills and knowledge to meet their needs. One person told us, "[Staff] are qualified and excellent and have helped me a great deal. It's a pleasure when they come in." Other people told us, "I have [Name of staff member] on two of my three respite visits a week and [they are] excellent. [He/she] was a nurse in [their] own country and brings those skills to [their] work here" and "[The staff] I have are well-trained. It's much better now."

However other people responded, "Not always, I'm afraid. Sometimes I do ask them how long they've been doing this - three months, they say, but not a lot has been learned in 3 months" and "[Staff] are usually helpful and prepared to work with a connection to what's going on but they don't always know what they are doing. I think training is important." A relative responded, "If you are asking me if I think [staff] know a lot about or have training on Alzheimer's, I would say no. Me and the carers have had to learn together on the job." Another relative told us, "Our morning more regular carer is fantastic. [They're] able to deal with [my family member] in a direct way. Other carers don't understand about dementia and will accept [my family member] saying no to food or getting out of bed. [Name of staff member] knows how to encourage [them]. I don't think [staff] get any dementia training. Some of them have done things like putting her to bed with her day clothes on."

The manager told us that staff received an induction training package before they started working with people. This included elements of the Care Certificate which covers the basic standards required for care, e-learning, classroom training and shadowing opportunities. One person told us, "[Staff] do mention training they have. They may say 'I won't be coming tomorrow as I have a training day'. I have had one of the new carers follow my carer to see what she does." Staff we spoke with told us "The induction taught me a lot of things" and "the training is very useful." Staff completed training and refresher courses in moving and positioning, medicines management and safeguarding.

However, a training matrix showed that very few staff had completed training in dementia awareness, basic first aid, food hygiene or fire safety. The provider's training matrix and training calendar showed that no specific training was planned or scheduled in relation to complex health conditions such as a stroke or Parkinson's or drug and alcohol misuse despite staff being deployed to provide care and support to people where these issues had been identified. The provider was failing to provide staff with appropriate specialist training to enable them to carry out the duties they were required to perform when supporting people with complex healthcare needs. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed before care and support was provided. Care co-ordinators met with people and their relatives (where appropriate), before they began providing a service. Care co-ordinators referred to previous professional assessments that had taken place and recorded the outcomes that people wanted achieved in order to better understand what care people required and how they wanted their care delivered. The manager told us that the package of care was reviewed in response to changes of circumstances and on a regular basis to ensure support was still appropriate to the person's needs and wishes. We noted that

some six monthly care reviews weren't always taking place as planned.

The Mental Capacity Act (MCA) 2005 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection.

People gave staff their consent to care and staff confirmed they sought people's consent before providing support. A relative told us, "The carers talk to [them] all the time. They check [they're] happy to do things and will explain everything they are doing or going to do. Whatever move they make they explain to [them] for example; (Name of client), It's your lunch time now - it's hot so be careful and I'm going to wipe your eye now (Name of Client)." Consent to care records were signed by people or their relatives where this was appropriate. Another relative told us, "[Staff] are most helpful, a nice set of people. Yes, they're good on that - permission and consent."

Meals were provided by staff where this formed part of an agreed arrangement. People told us, "They do a meal for me and they know how to cook. I have to show them how to use the cooker but they soon learn", "The carers bring me toast and tea and tidy up the kitchen after themselves" and "[Staff] are very good with the food. They heat it up and they encourage me to eat and drink. Yes, they're very polite." A relative told us, "They do prepare meals and they always ask [my family member] what [they] want and prepare a drink to go with it." People's care records indicated where people required support with food shopping and meal preparation. We saw that people's needs and preferences were being met. For example, one person had stated they liked Malaysian food and we saw from daily notes that a selection of curries, noodles and rice were prepared for them on a regular basis.

People were supported to access healthcare services when needed. The service worked and communicated with other agencies and staff to enable effective care and support. We saw from records that staff made referrals to local health and social services when people's healthcare needs changed.

Staff had regular supervisions with their manager to discuss their role and any concerns. In the staff files we looked at we found supervision sessions were taking place approximately every six months. Staff records showed that any actions from the previous supervision were followed up.

Good

Is the service caring?

Our findings

Staff developed positive and caring relationships with people using the service. People told us, "I've got a wonderful girl, couldn't complain", "[Staff] are very courteous to me", "I couldn't be happier" and "[Staff] are very caring." Relatives commented, "[Staff] are fantastic" and "A lot of [staff] are very good. I couldn't do their job."

Where possible, people were supported by regular members of care staff. Where this was the case, people told us staff knew them well and understood their preferences in relation to care delivery. Comments included, "I have had my regular carer for about a year and [they] are a good friend now", "I've had one [member of staff] all along, who is brilliant. [They've] been with us four years", "There is a group of regular girls who come and they always stay for the full time" and "[My family member] and [their] regular carers have a very good relationship."

People were involved in decisions about their care and treatment and their views were taken into account. A relative told us, "They did ask us whether my relative would prefer male or female carers. We didn't mind and they did send a young man initially. He was very good and would get [my family member] into chats about football." People using the service and their relatives were provided with a service information booklet and a copy of the provider's statement of purpose outlining its aims, objectives and philosophy.

People's care records included information about their healthcare needs, personal preferences and what made them happy, such as having a chat or eating certain foods. One person told us, "[Staff] are fantastic. They know me and I know them. They are helping me with everything. Everybody you speak to on the phone is excellent and the coordinators as well. They are honest as the day is long and even ask me if it's ok if they sit down in my home when they come to see me. They also understand about my stroke and the tremors I get."

Staff took time to talk with the people they were supporting in order to better understand their individual needs and preferences. One person told us, "My partner has dementia and is now in a care home. They used to come to [them] before they came to me and the carers were lovely with [him/her] and put up with [them] getting irritated and telling them to go away. They ask after [him/her] now that [they] are in the care home. They now come to me and they always show an interest in my life. I have a lot of photos in my home and they are very interested and ask about my life." Another person told us, "We have chats about people and things." A relative commented, "[Staff] make an effort to talk to my [family member]. A lot of people are very fond of [my family member]. We have a good rapport too; [member of staff] communicates with me as well." Another relative told us, "They always ask [my family member] how [they are] and for example one always gets down to [them] as [they] speak to [them] and repeats things slowly if my relative looks bewildered or confused."

Staff promoted people's independence and encouraged them to maintain their normal routines and activities. People told us, "They encourage me with my walking and always make sure that I am safe as I cross the road by taking my arm which I find reassuring" and "They always ask 'What can we do for you?' I

like to go out daily and they come with me and help me carry shopping and they do things around the home such as changing my sheets and hoovering." A relative explained, "One of the carers is especially good. [They] use [their] own mobile and go on YouTube and sing songs and get [my family member] singing and clapping [their] hands and feet. [Staff member] will ask me about any song I might sing with [my family member] and looks it up and downloads it to sing with [them] - songs from [their] past that have meaning for [them]."

People were treated with dignity and respect. People told us, "[Staff] help me with the bath. [They] are caring", "They are very good and treat me with respect. They always cover me when helping me wash. If I need anything they will do it for me" and "They help me to wash and they cream me. They always leave things clean and tidy." One person commented, "After a rocky start, I have a regular carer who is excellent and very, very reliable. I have [them] once a day for a shower, dressing and breakfast. I couldn't ask for a better carer, [they're] an angel and I've got nothing bad to say about [them]." A relative said, "[Staff] look after [my family member] well. They shower or strip wash [them], do [their] breakfast and brush [their] hair."

People and their relatives confirmed they had been given copies of their care documentation. Staff understood the importance of keeping this personal information confidential. People told us, "Sometimes they may say 'One lady I go to …..' but they don't say a name" and "They never talk about anybody else - that wouldn't be right would it?"

Requires Improvement

Is the service responsive?

Our findings

People were assessed before their care started to ensure their needs could be met appropriately and effectively. Care plans described the care and support people required at each visit and included information in relation to people's health needs, care preferences, communication, religious and cultural needs and nutritional requirements/preferences.

People told us that care staff were responsive to their needs and were adaptable if and when their needs changed. One person told us, "They are very accommodating. For example I need to go to a hospital appointment next week and so I have phoned them to ask if they can change one of the days next week and when I phoned she said they will try to see what they can do. I find them quite flexible as long as they have notice." Care coordinators told us they arranged joint visits with health and social care professionals when they had concerns about people's changing needs. One person told us, "They've come to see me. I've had to explain my difficulties with the timings of calls because I need to take my medication on time and the call times varied so much. Now that I've got my regular carers, I feel safe and get my meds on time." A relative told us, "[My family member] was not well earlier in the year and the carers voiced this to the office staff and a supervisor asked if we could have a meeting as the carers had said they were struggling with some aspects of looking after [my family member]. That was good as from that we had an occupational therapy (OT) and speech therapy assessment. We have had several meetings with the OT and the carers - making sure the carers are happy with what they are doing so that turned out really well for us all." Another relative said, "[Staff are] nice. The carer mentioned [my family member] had something wrong with [their] throat and that I should tell the GP; it was nice of [them] to tell us that - [they] had noticed problems with swallowing - more so than usual."

However, we found that there were occasions where the provider had not taken appropriate action to ensure that staff were responsive to people's individual needs. For example, there was insufficient guidance for staff in relation to pressure area care for one person, insufficient guidance for staff around a person's nutritional needs in another and people's allergies were not always recorded. This meant that we could not be assured that staff always had access to all of the information they needed to meet people's individual needs fully.

Care staff recorded the care and support they provided at each visit. One person told us, "[Staff] do write what they do and what time they come." A relative confirmed, "[Staff] always write in the folder and they write exactly what they have done. That is helpful for me so I can see what has happened." Staff were kept up to date about any change in people's needs from previous daily records, directly from people and their relatives and from the office staff and management team.

Staff told us that in an emergency they would contact the office and remain with people until assistance arrived. One person told us, "I do have seizures and several times I have fallen to the floor when getting from the bed to the commode. The carers have found me in the morning and phoned for an ambulance. [Staff] stayed with me until the ambulance came." A relative told us, "I'm sure if [staff] were worried about anything they would call the paramedics. I think they would know what to do." Office staff contacted emergency

services and family members (where appropriate) and if necessary, rearranged consequent scheduled visits and informed people of any potential delays to their service.

We asked people if their care needs were reviewed and whether they had the opportunity to express any concerns they may have. People told us, "The Supervisor has been out recently and revised the care plan", "[Member of staff] is lovely and I think calls in about every 6 months", "Sometimes they come out from the office and ask me if I am satisfied" and "[Member of staff] has been in touch recently to see how I am getting on." A relative told us, "One of the supervisors has called a few times and has done a review of [my family member's] care plan but it didn't need any changes." The manager told us care plans were reviewed every six months and that people were telephoned at regular intervals to see if they were happy with the way the service was meeting their needs. Records confirmed that reviews were taking place either face to face, over the telephone or during spot checks on a regular basis. One person commented, "Nobody has yet been out from the office since the original assessment."

People were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service. People told us, "At the moment I feel perfectly able to complain to them if I needed to. I would phone them using the phone button my son has set up for me which goes straight through to them and I would speak to a manager. I would not be afraid to tell them if I had any problems", "I have not had any complaints but would complain if I needed to" and "I'd phone my sister and she would complain for me". People and their relatives were provided with written information in relation to the provider's complaints process. Records of complaints received since the previous inspection in July 2017 showed that people's complaints were investigated and responded to appropriately, including a written explanation of the investigation and an apology.

The provider also sought feedback annually through the completion of quality assurance questionnaires sent to people and their relatives. The results of the last survey dated January 2018 showed that people using the service and their family members were supported by staff who usually arrived on time, who were wearing a uniform and stayed for the correct amount of time allocated. Any other comments included in the survey prompted a plan of action where needed such as reviews of people's care plans.

Although no one using the service was receiving end of life care, the manager provided assurances that people would be supported to receive good end of life care and support to help ensure a comfortable, dignified and pain-free death. Furthermore, they told us that they would work closely with relevant healthcare professionals and ensure staff were appropriately trained.

Inadequate

Is the service well-led?

Our findings

Following our previous inspection of this service in August 2017 we found the provider was in breach of regulations relating to safe care and treatment, person-centred care, the need for consent and good governance. We served two warning notices in relation to the inadequate management of medicines and failure to evaluate and improve the quality and safety of the services provided to people using the service. The provider was given until 18 December 2017 to demonstrate they were meeting the legal requirements and regulations in relation to the above.

At this inspection we found the provider had a service improvement plan in place which took into account the findings of the previous CQC inspection. Revised systems demonstrated that the provider had made efforts to improve various aspects of the service. For example, staff care records had been audited and systems were operating to monitor when supervision and training was due. Checks assessing staff performance, timeliness and competency were taking place on a regular basis. People were receiving more consistent care from regular carers.

However, the provider had failed to make robust and timely improvements to the quality control and auditing processes currently in place. Systems were not always effective and had failed to identify and address shortfalls we found during this and the previous inspection. This continued to place people at risk of inappropriate, unsafe and/or poor quality care and support.

Systems in place to quality assure medicines management processes were inadequate. This was because the names of people's medicines were not always recorded in their care documentation. Staff were not always following the registered provider's policy and procedures in relation to medicines management. In some cases MARs had not been completed accurately or forwarded to the provider's office for auditing purposes. This meant that any trends, errors and/or omissions in the medicines management process were not being detected and managed effectively to ensure risks were adequately mitigated.

The provider was failing to maintain complete and contemporaneous records in respect of each person using the service and audits had failed to identify omissions, errors and inaccuracies across people's care records. Systems and processes in place to monitor people's financial transactions were ineffective because records were not being completed or where completed were not being audited on a regular basis. The management team had no clear oversight of service issues and improvements to service delivery were behind schedule.

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

Providers must ensure that their ratings are displayed conspicuously and legibly at each location delivering a regulated service and on their website (if they have one). On the first day of our inspection the report ratings were not on display at the agency's registered office. This meant that any current or prospective users of the service, their family members, other professionals and the public could not easily access the

most current assessments of the provider's performance when visiting. We asked the manager to rectify this issue and on subsequent visits saw that the inspection report was displayed appropriately on site. The provider had displayed a link to the report summary and ratings on their website. However, they had not displayed their rating on the main homepage of their website, where as many people as possible looking for information about the service will see it as expected. In addition, when we checked the link to access the previous inspection report on the 23 May 2018 this was not working.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The current manager was relatively new to the service having joined the agency at the beginning of March 2018. We noted that the manager's name appeared on documentation such as the provider's statement of purpose and the service user's guide under the title of registered manager. Although the manager had begun the application process with CQC to become the registered manager, registered manager status had yet to be approved.

People we spoke with had mixed views about the management of the service. Some people we spoke with felt there had been improvements to the service within the past six months. Comments included, "It's a splendid organisation; they are very, very good", "I'd give them eight out of ten, I can't think how they could improve", "By and large it's not outstanding but it's satisfactory", "I don't think that there is anything that needs to be improved as it is now", "On the whole it's working well", "There's more sense of management now. It's improved but then the starting point was very low" and "No recent problems."

However, people also expressed dissatisfaction and frustration with the way the service was managed. Comments included, "In the office I get the impression that they have had lots of different coordinators and that there are times when the right hand doesn't know what the left hand is doing", "The organisation never accepts responsibility for anything and just blames the carers" and "I'm not happy with them. The company have let me down a lot. I don't think it's the carers, I think it's the office staff" and "It's not where it should be yet."

Staff spoke positively about the manager and said they felt supported. The manager was experienced in delivering domiciliary care and had previously been registered with CQC as a manager for two separate providers. We asked staff if they had and concerns about the service and the way in which it is managed. Comments included, "I really like my job", "I'm happy with the company, we are treated well", "It's a good company to work for", "We communicate well" and "it has got much better."

Staff and management meetings were being held on a quarterly basis. The last care staff meeting was held in March 2018. We reviewed meeting minutes which showed a range of quality issues were discussed such as; safeguarding, missed visits, provider policies and procedures, mental health legislation and complaints.

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 12 HSCA RA Regulations 2014 Safe care and treatment People using the service are not protected against the risks associated with unsafe management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider is not always ensuring people were being protected against the risks of financial abuse. Regulation 12(1)(2)

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider is failing to ensure that their ratings were displayed conspicuously on their website.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider is failing to provide specialist training to staff where they were supporting people with complex healthcare needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider is failing to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users which arise from the carrying on of the regulated activity. 17(2)(b) The provider is failing to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. 17(2)(c)

The enforcement action we took:

Warning Notice