Avant Healthcare Services Limited

Avant Healthcare Services ltd

Inspection report

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08 August 2017

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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?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an announced inspection of Avant Healthcare on 1, 2, 3, 4 and 8 August 2017. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people and we wanted to be sure someone would be available to assist with the inspection.

Avant Healthcare Services Limited provides a range of services to people in their own home including personal care in the London Borough of Hounslow. At the time of our inspection approximately 250 people were receiving personal care in their home. The care had either been funded by their local authority or people were paying for their own care.

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

The provider had a process in place for the recording of incidents and accidents but information relating to any actions taken had not been noted in the relevant paperwork. Care plans and risk assessments had not been reviewed and updated if required following the incidents.

Risk assessments were not developed to ensure specific risks related to each person were identified and guidance was not provided as to how to reduce identified risks.

Care workers used a telephone based system to record their arrival and departure times to monitor the visits but some care workers did not have travel times included in their rota for some visits and therefore did not always arrive or leave on time.

Care plans described the tasks required during each visit but did not identify how the person wished their care to be provided. Records relating to care and people using the service did not provide an accurate and complete picture of their support needs.

The provider had a range of audits in place but some of them did not provide appropriate information to enable them to identify any issues with the service and to take action to make improvements.

The provider had a process in place for the administration of medicines but at the time of the inspection this was not in line with guidance from the National Institute for Health and Care Excellence.

The provider had an effective recruitment process in place. Care workers had received training identified by the provider as mandatory to ensure they were providing appropriate and effective care for the person using the service, as well as regular supervision with their line manager and annual appraisal.

The provider had procedures in place in relation to the Mental Capacity Act 2005. The process in place to assess a person's capacity to make decisions relating to their care was being reviewed by the provider.

Care plans identified if the person required support from the care worker to prepare and/or eat their meal.

The provider would contact the relevant healthcare professional and the person's relatives if they identified a change in their health.

People felt the care workers were kind and caring as well as respecting their privacy and dignity when they provided support.

The care plan identified the person's religious and cultural needs as well as their preference in the gender for their care worker.

The provider had a complaints process in place and people receiving support from the service or relatives of people using the service knew how to raise a concern if they needed to.

The governance arrangements in place were not effective as they did not provide information identifying areas requiring improvement. There were positive comments from people using the service and staff when asked if they thought the service was well-led. There were equally many negative comments, which meant they did not think the service was always well-led. This meant a consistent quality of service was not being provided for all the people using the service.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to person-centred care (Regulation 9), safe care and treatment of people using the service (Regulation 12), good governance of the service (Regulation 17) and staffing (Regulation 18). You can see what action we told the provider to take at the back of the full version of this report.

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

Some aspects of the service were not safe.

The provider had a process in place for the recording of incidents and accidents but information relating to any actions taken had not been noted in the relevant paperwork. Care plans and risk assessments had not been reviewed and updated if required following the incidents.

Risk assessments were not always developed to ensure where specific risks related to each person were identified, guidance was provided as to how to reduce any possible associated risks.

The provider did not always deploy care workers appropriately to ensure people received visits at the time agreed with them and for the care workers to stay the full length of the visits.

The provider had a process in place in relation to the administration of medicines which was not in line with guidance from the National Institute for Health and Care Excellence.

The provider had systems in place to protect people using the service. All care workers had completed safeguarding adults training.

The provider had a recruitment process in place and the number of care workers required to provide appropriate care for a person was based on the assessment of the person's needs.

Is the service effective?

Requires Improvement

The service was effective.

Care workers had received the necessary training, supervision and appraisals they required to deliver care safely and to an appropriate standard.

The provider had procedures in place in relation to the Mental Capacity Act 2005. The process in place to assess a person's capacity did not reflect the principles of the Act.

If the person's health changed the provider would ensure the

relevant healthcare professional was contacted.

Care plans identified if the person required support from the care worker to prepare/eat meals and care workers recorded how they supported the person in the record of each visit.

Is the service caring?

Good

The service was caring.

Care plans identified the person's cultural and religious needs as well as their preferences for gender of the care worker.

People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Care plans described the tasks required during each visit but these were not individualised enough to identify how the person wished their care to be provided.

An assessment of a person's support needs was carried out before home care started to ensure the person's care needs could be met.

The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Records relating to the care of people using the service did not always provide an accurate and complete picture of their support needs as information was not consistently recorded.

The provider had a range of audits in place but some of these did not provide appropriate information to identify areas of the service requiring improvement so these could be addressed.

There were positive and negative comments from people using the service when asked if they thought the service was well-led. This meant a consistent quality of service was not being provided for all the people using the service.

Avant Healthcare Services ltd

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 inspection took place on the 1, 2, 3, 4 and 8 August 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

One inspector undertook the inspection and an expert-by-experience carried out telephone interviews of people who used the service and relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service. The expert-by-experience at this inspection had personal experience of caring for older people.

Prior to the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports. Registered providers need to send notifications to the CQC about certain changes, events and incidents that affect the service or the people who use it.

Before 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.

During the inspection we spoke with the registered manager, managing director, a non-executive director and the human resources and training manager. We reviewed the care records for 11 people using the service, the employment folders for five care workers, training records for all staff and records relating to the management of the service. We also contacted by telephone 12 people who used the service and one

relative. We sent emails for feedback to 60 care workers and received comments from nine.

Requires Improvement

Is the service safe?

Our findings

The provider had a process in place for the reporting and investigation of incidents and accidents but this was not always followed. During the inspection we looked at the information for two incidents and accidents that had been recorded on the system. We saw details of the incidents were recorded but the risk assessments and care plans for each person had not been reviewed to reflect any identified changes in support needs. The registered manager explained the field based manager had contacted relevant healthcare professionals and the local authority in relation to reviewing care packages and assessments but this information had not been recorded in each person's care records or on the incident and accident form. Copies of correspondence had been stored on the computer and the information had not been transferred to the person's records. This meant there was no record of the action taken in response to the incident and accident in the care plan or risk assessment to ensure care workers understood what to do so the risk of reoccurrence was reduced.

The provider had a range of risk assessments in place but some people did not have assessments that responded to specific risks identified through their referral and needs assessment. Risk assessments were completed for moving and handling, medicines, the person's home and any specific tasks to be carried out for example housework and shopping. During the inspection we looked at the records for 11 people and we saw six people had risks identified which had not been addressed through a risk assessment plan. These risks included epilepsy, use of blood thinning medicines, diabetes and renal issues.

As risk assessments plans had not been completed in relation to some of the specific risks identified for each person, guidance had not been provided for care workers as to how to reduce any possible associated risks when providing care.

During the inspection we looked at the medicines administration record (MAR) charts completed for eight people who received medicines from original packaging, eye drops or had a cream applied. We saw the dosage in relation to one medicine had been amended and initialled but there was no record of who had made the change. The registered manager confirmed the GP had amended the dosage but not recorded the date of the change or their name in full so it was clearly identifiable as to when the change occurred.

The MAR charts for another person indicated in March 2017 the supply of one medicine had run out for four days in one month. The MAR chart had been originally left blank by the care workers and then completed by the field based manager who had carried out the audit at a later date with the letter F to indicate the medicine was finished. The medicine was in fact out of stock and the pharmacy provided the next prescription a few days later.

The MAR charts had been reviewed as part of the audit and where care workers had not recorded the administration of a medicine it had been completed as part of the audit.

We discussed this with the registered manager who confirmed they would review how information was recorded on MAR charts when the supply of a medicine had run out.

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

We asked people if the care workers arrived at their homes on time and, if the care workers were going to arrive late, if they contacted the person to let them know. The majority told us that their regular care workers were punctual, but when other care workers attended to them, they did not arrive on time. They also said they were not always informed when there were changes in their care worker. People made a range of comments which included "The regular carer does but the ones that cover or do weekends don't. It's very bad on the weekend", "No one contacts, some are on time others aren't", "Most of the time my carer will let me know", "No they don't, they don't phone when running late and I'm a diabetic. It's important they arrive on time to give me food", "Some of the carers are on holiday so the carers that are left are struggling but do a fantastic job and still come on time", "Sometimes they arrive a bit late but they always come but don't let me know", "During the week they do but not at the weekend. Last Sunday they were over two hours late. They don't phone" and "Today the carer was 30 minutes late. They do this sometimes but they don't call me."

We also asked people if the care workers who visited them stayed for the agreed length of time. People felt their care workers often stayed longer and helped them with extra tasks if asked. People told us "Yes some do but some are panicking because they are worried about travelling to the next client. Especially on weekend this is a problem", "Well if they finish early I let them go. No point in them hanging around", "Well they don't have enough time to do what they need to. They probably do more for me than they should", "They aren't given enough time to do what needs to be done but they do it" and "They always stay longer than they should."

During the inspection we reviewed the records for the electronic call monitoring system (ECMS). This system was used by care workers to record their arrival and departure time for each visit. We looked at the time sheets for all the visits completed on the 22 July 2017 and 25 July 2017. We then reviewed the timesheets for 14 care workers we had identified having a level of visits which were made earlier or later than scheduled. We saw of the 10 care workers who completed visits on 22 July 2017, six care workers had at least one occasion where a visit was scheduled without any travel time from another visit. From the 13 care workers who completed visits on 25 July 2017 we saw four care workers had at least one occasion where travel time had not been identified between two visits. This meant the time they either left one visit or the time they arrived at the next visit would be affected and could impact on the care provided. The above shows that the provider had not always appropriately deployed staff to ensure people received visits at the time agreed with them and that the length of the visits was also as agreed with them.

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

The provider had a policy and procedure in place in relation to the administration of medicines. The registered manager explained they were following the medicines policy of the Local Authority which commissioned the majority of the care packages provided by the service. This policy required care workers to only complete a MAR chart for medicines provided in their original packaging and any liquid medicines such as eye drops. If medicines were provided in a blister pack by the pharmacy the care worker only had to record the medicines had been administered in the record of care they completed at each visit. They did not need to record which medicines had been administered. This process was not based upon guidance on administration of medicines for adults in the community provided by the National Institute for Health and Care Excellence (NICE) which states there should be a record of medicines support given to a person for each individual medicine on every occasion. The registered manager told us that from the 1 August 2017

they were introducing MAR charts for the administration of all medicines in line with the NICE guidance.

All the people we spoke with confirmed they felt safe when they received care in their home from their care workers. We saw the provider had effective policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. During the inspection we looked at the records for three safeguarding concerns that had been raised. We saw the records included details of the concern, any correspondence, the outcome and any actions taken. Records indicated that all care workers had completed training in relation to safeguarding vulnerable adults.

The provider had a contingency plan in place to ensure the service would continue to provide care if there was an emergency or a situation which meant they could not work from their office facilities.

We saw the number of care workers required to attend each visit was identified from the referral information provided by the local authority. This was also discussed with the person using the service and relatives during the initial assessment to ensure the information was accurate. The number of care workers was also checked as part of the review of the care plans in case the person's support needs had changed.
The provider had appropriate recruitment processes in place which meant checks were carried out on new care workers to ensure they were suitable and had the necessary skills to provide the care required by the people using the service. During the inspection we looked at the recruitment records for five care workers and we saw all the required paperwork was in place. This included requesting up to three references with a minimum of two references from previous employers. Character references would be requested if the applicant had a limited work history. The human resources manager told us the role was discussed with any applicants on the telephone to see if they had any previous experience. A Disclosure and Barring Service (DBS) check in relation to checking for criminal records was carried out before the new care worker started working in the service. If a positive criminal record was identified from the application form the provider asked the applicant to complete a statement describing any disclosed offences while the DBS check was being requested. A risk assessment would then be carried out to ensure people using the service would not be at any risk from the applicant if they provided care.

The provider had processes in place in relation to infection control. The care workers were provided with personal protective equipment including aprons and gloves to use when providing support. The care workers had also completed training in relation to infection control as part of their induction.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We saw the needs assessment and care plan had a section which had a question relating to the capacity of the person. This was not a full assessment of the person's capacity relating to a specific area of their life. We asked the registered manager how they assessed if a person had capacity and they told us if the person could not understand or follow the discussion regarding the care to be provided they assessed them as not having capacity.

If a person was identified in the needs assessment as having capacity they were asked if they wanted their next of kin to be involved in agreeing their care plan and the name was recorded on the form.

If the person had been assessed as not having capacity there was a question identifying if a Lasting Power of Attorney (LPA) was in place. A 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.

During the inspection we saw the care plan for one person stated they did not have capacity to make decisions but a full capacity assessment records had not been completed and did not take into account that capacity is decision specific. The care plan and other documents did not indicate how care workers should support the person in making decisions. The records showed there was a LPA in place and identified who had authority to make decisions on the person's behalf.

We discussed the MCA with the registered manager during the inspection and how a person's capacity to make decisions in relation to specific issues and they confirmed they would be developing a new assessment process.

During the inspection we looked at the care plans for 11 people and we saw some of them did not include information on the person's nutritional needs. This was raised with the registered manager who confirmed this would be reviewed. The information relating to the care activities for each visit identified if the care workers were required to prepare meals for the person or if this was carried out by a relative and if the care worker needed to assist them to eat. Care workers would record if they supported the person with food in the records completed at the end of each visit.

We asked people if they thought care workers that visited them had the appropriate training and skills to provide their care. People told us "They know about some things but could be better trained on commode cleaning", "Some are better trained than others. They could learn more about care giving", "My regular carer is trained well, not so sure about the others" and "They get training on the job. They're ok but they don't get paid for training which is wrong." A relative commented "I'm not sure if they are. Sometimes care workers get tablets mixed up even though they are in the dossette box. They give the PM tablets instead of AM and vice versa. Fortunately, the tablets are the same."

The human resources manager told us new care workers completed a five day induction course which was run in the office by an external provider. The new care workers completed the Care Certificate during the first four days. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to staff new to health and social care. On the fifth day they completed practical training which included moving and handling and medicines administration with assessments of their competency. They also discussed the policies and procedures put in place by the provider.

Following the induction the human resources manager explained new care workers completed up to 20 hours shadowing an experienced care worker and then being observed to assess their competency. A form recording the shadowing sessions was completed and the new care worker was assessed by the experienced care worker and a field based manager.

Care workers completed annual refresher training based upon the induction including moving and handling, safeguarding adults and infection control. Other training related to the specific support needs of people using the service was also provided including helping a person to eat and dementia care.

Following the three month probation period care workers completed four monitoring checks per year which consisted of face to face meetings, spot checks observing the care worker on a visit and an annual appraisal. In addition there were two checks carried out by the human resources staff to ensure all the care workers' employment paperwork was up to date and to discuss with the care worker if they had any concerns or training needs. New care workers were also offered the opportunity to complete a level two or level three Qualification and Credit Framework (QCF) course in health and social care once they had completed the probation period.

During the inspection we saw records for five care workers which confirmed they had completed their induction training, Care Certificate and shadowing assessment in line with the provider's procedure. Records also indicated the care workers had regular spot checks and supervision meetings with their field based manager. Where the care worker had been in post long enough they had also completed an annual appraisal.

The care plans provided the contact information for the person's GP, district nurse and other healthcare professionals involved in their care. The care plan also identified the pharmacy that dealt with the person's prescriptions. If care workers identified the person's health needs had changed it would be recorded in the record of care completed at each visit and they would contact the office as soon as possible. The office staff would then ensure the person's family were aware if the change in health needs and the relevant healthcare professional would be contacted.

Good

Is the service caring?

Our findings

We asked people if they were happy with the care and support they received from the service. We received a range of comments from people both positive and negative. This included "The regular ones are OK but there is a problem with the ones that come on the weekend. They come late and it's hard when they are short staffed as they rush", "There are a couple of them who are fantastic but there are a couple who are shoddy", "The carers are great", "It's alright when they are on time. They're always off sick or on holiday but the ones that come are good", "I can't fault the regular girl", "They're good girls", "I couldn't wish for any one better" and "I have two or three carers. They are very good."

People told us they felt care workers were kind and caring when they received support. Their comments included "They are fantastically caring" and "They are very good. They do more for me that they should."

People commented to us that they felt the care workers treated them with dignity and respect when they provided care. People's comments included "Most of them treat you with respect. My regular carer does, she's very good", "Mostly, you get the odd one that can be curt", "I've had no trouble with them. They treat me well, it's just I need the laundry done too" and "My carer does. She is great and looks after me well."

We also asked care workers how they maintained the privacy and dignity of the person while they are providing support. They gave a similar range of comments based upon ensuring the person was covered during personal care and maintaining confidentiality. They told us, "Ensure a confidentiality policy is in place and followed by all", "Ensure that consent is gathered. To always encourage independence and to cover and protect the private areas of a service user", "Closing the bathroom door or bedroom when providing personal care", "To not speak about service users with anyone else", "Maintaining the customer dignity and privacy is always important when I am assisting with personal care" and "I ensure people's privacy and dignity is maintained by treating their personal information confidentially and that I communicate with the person so they can make their own decision and express their views."

People were asked if they felt the care workers supported them in maintaining their independence. People told us, "They do encourage me to do what I can" and "I can do what I can and tell them what I need." A care worker told us how they supported people to maintain their independence, "Allowing the customer to make decision regarding what I can do to help and what they can do themselves is very important, for example personal hygiene, living environment etc.

In regards to whether people had the same care worker or, six people we spoke with told us they regularly had the same care worker and seven people confirmed they had different care workers visiting their home. Their comments included "Different workers come on the weekend", "They do change from time to time", "I always get the same person", "I always get different carers at the weekend" and "I have the same carers."

We saw the care plans identified the person's cultural and religious needs as well as the name they preferred the care workers to call them by. Care workers were provided with information about the personal history for some of the people they were supporting where the information was available. This meant care workers

had information so they were aware of people's cultural or religious needs that could affect the way care should be provided. We saw from the rotas that the person's preference for the gender of the care worker was respected.

Requires Improvement

Is the service responsive?

Our findings

People using the service had a care plan in place that had been regularly reviewed but some of them did not always identify how the person's wishes and preferences had been accounted for in their care and support.

The sections of the care plans related to each visit provided information which was focused on the tasks which needed to be completed during that visit. The information did not identify how the person wanted their care provided. For example, the care plan would say the care worker should help with personal care but did not include any specific information on how the person wanted this care provided. Other examples of term used included 'assist to use toilet', 'to provide personal care wash or bathe and apply cream on body'. The registered manager told us they were providing training on producing care plans which identified people's wishes in relation to how their care should be provided.

We saw care workers completed a record for each visit to the person they provided care for. Some of the communication records we looked at during the inspection were focused on the care tasks completed during each visit and not the person. This meant the records did not provide accurate information to ensure people received person centred care.

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

We asked people if they were involved in the decisions regarding their care and support needs. They told us, "They ask me what I need but my regular carer knows me well now and what I like" and "We tell the carers what to do and they do it."

During the inspection we saw detailed assessments of the person's care needs were completed before visits started in their home. This assessment identified what care the person required, their health issues and other support needs. The information from the local authority referral as also reviewed as part of the process. A checklist was used by the field based managers to ensure they provided appropriate information including how the care would be provided and the complaints process. The information from the assessment was added to the electronic records system and was used to develop the care plan and risk assessments.

The registered manager told us before the start of a new care package the person would be contacted to confirm the name of the care workers who would be carrying out the visits and the time they would arrive. The person would also be contacted by telephone after the first visit to ensure their care needs had been met or if any changes were required to the care plan.

We asked people using the service if the care workers completed the support tasks agreed with the service during their visit. The people we spoke with confirmed the care workers completed the tasks identified to be completed during each visit. They told us, "Yes, now they do but in the past they didn't. Some of them used to say I'm very demanding but now it's ok", "Yes, but if they finish early I'll say they can go" and "I think they

do more for me than they are meant to."

People we spoke with told us they knew how to make a complaint. We received both positive and negative comments about the way the provider responded to complaints. These included "I call the manager. One is allocated to me", "I know who to complain to and I do regularly but there is no change. The carers come late and if it's different ones coming, no one tells you", "They've been very good when I complained and they changed the carer", "Yes, I've made complaints but they don't do anything about it. It's mostly complaints about the time they arrive" and "I made a complaint about the cleaning. It was resolved and things are much better now." This meant the provider did not always respond to a complaint in a way the person raising the concern finds satisfactory.

The provider had a policy and procedure in place in relation to complaints. People were given information on how to raise a concern or make a complaint when they started to receive care from the service. At the time of the inspection there were five complaints that had been received recently and were being investigated. The records included details of the complaints, copies of correspondence, any investigation and the outcomes with any actions taken.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we found records relating to the care offered to people did not provide an accurate, complete and contemporaneous record for each person using the service.

The dietary section of the care plan for one person stated there were no dietary needs but the person was diabetic. The dietary requirements record for another person identified the person was living with diabetes but did not state if it was controlled by medicine or food. This meant the information provided for the care workers was not consistent across the care plans.

The telephone review for another person identified they sometimes refused the care provided but their care plan did not reflect this and care workers were not provided with guidance as to how to support this person.

The customer review forms included a section listing what specific care should be provided for the person but we saw the list of care tasks did not reflect the care that should be provided. The same list of care tasks had been used on a number of review forms and did not relate to the person identified in the review.

We saw a telephone review and customer review for one person had been carried out on the same day. The reviews were either carried out face to face or over the telephone to identify any changes to the care needs and obtain feedback on the quality of care provided. The telephone review identified the person had made comments in relation to weekend care workers arriving early for their visit but this concern was not mentioned as part of the customer review.

The lone working section in one person's care plan stated that all visits should be made with two care workers. The moving and handling risk assessment also stated that two care workers were required for all transfers to the commode. We saw the care plan stated that two care workers should only attend the evening visit. Therefore this meant the person could only be assisted to use the commode in the evening. The assessment for this person identified they had been prescribed blood thinning medicine but this was not recorded in the section of the care plan related to medical conditions.

As part of the computerised records system care workers could use their phone to securely access a summary of information relating to the person and the care to be provided. We saw these records did not indicate when the information was added and by whom. This meant there was no way of identifying if this information was up to date and accurate. We saw some of the summary information did not correspond with the information in the most recently reviewed care plan. The computerised system also included the times visits should be carried out but some of these records did not match the information on the timesheets.

The provider had a range of audits in place but some of these were not effective because these had not identified the areas for improvement that we found during our inspection.

The registered manager showed us a spread sheet used to audit the records of people using the service to

ensure the records were in place and up to date. We identified instances where the records relating to people using the service did not provide accurate and up to date information regarding the person's support needs or the care provided. The audit system in place was only used to identify that the required documents were in place and not if they were accurate. This meant the provider did not have a suitable process in place to assess the quality of people's care records so any shortfalls could be identified and addressed.

The MAR charts were audited by the field based manager and if they identified an issue with the way the care worker had completed the MAR chart they would write on the MAR chart what action they had taken to resolve the issue. We also saw they had filled in record boxes which the care workers had left blank when they had not recorded the administration of a medicine. The actions taken following the MAR chart audits were not recorded elsewhere to monitor any possible trends or recurrent issues. The registered manager explained a new medicines audit system was to be introduced in August 2017 with a separate form to record the actions taken if any issues were identified with the completion of the MAR charts.

The communication books used by care workers to record the care provided during each visit were also audited by the field based manager. Any issues and actions identified were recorded in the communication book which was being audited and was not noted elsewhere. The registered manager confirmed a new audit record sheet was being introduced to record any issues and the action taken to resolve.

An audit of late visits was carried out by selecting random records and an email was sent to the relevant staff to identify the reason for the late visit and complete any required actions. The registered manager confirmed there was no central record made of the findings of this audit so that any trends and patterns could be identified and addressed.

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

At the time of the inspection a registered manager was in post. This registered manager was also registered for another location of the service and we were told a new manager had been recruited and was in the process of registering with the CQC.

All the people we spoke with confirmed they knew who to contact at the office if they had any questions in relation to their care. They told us, "I contact the manager at the office if I'm not happy", "I know who to speak to if I need to but I haven't" and "I've got the names of two people in the office I can contact if needed."

During the inspection we asked people using the service if they felt it was well-led. We received a range of feedback with both positive and negative comments. Some people had a more positive experience of the service and were happy with the care workers but others felt there were issues in relation to the organisation of the service. These included "It's much better now", "No, overall it's a really shoddy operation", "Well, they could do better. They don't return messages and they send carers when I've cancelled. They waste time", "I don't think its run well. They don't have cover when carers are off sick or on holiday. The people who run it are useless", "I've got nothing to say against them. The service has improved. Better carers now", "The girls that do the job are alright but the office is the issue. It's the organisation is a problem", "Its ok. Just timing of the carers can be a problem" and "I've been treated well so I think it's good." This meant there was an issue with consistency in the way the service was provided.

We asked care workers if they felt supported in their role and if they felt the service was well-led. Their comments included "Yes. Communication, as managers communicate with carers and clients with any

change. Person centred care, we respect all client needs and provide them person centred care", "To an extent, I believe communication may need to be developed between clients, carers and management. As I believe at times miscommunication occurs", "Yes, I always get my rota on time via email. I receive email and phone call updates when my client has been suddenly admitted to hospital" and "In the area I work with I can communicate well with my service manager. Any issue I had was dealt with professionally and I always get response in regard to my emails and issues with my rota. Any concerns I have with clients I can communicate freely to both of them and they response accordingly."

The provider also had other systems in place to monitor the quality of the care provided.

An audit of the complaints received was completed quarterly which included any trends in the concerns received and identified any people how had made a complaint more than once and this person would then have their care monitored more closely to prevent any reoccurrence of the issues raised.

Checks were also carried out to monitor the number of people identified as not having capacity during their needs assessment. An audit was also completed to identify the number of people using the service whose visits may have been temporarily suspended and the reason why which could include an admission to hospital.

The percentage of visits during which the care workers used the ECMS correctly to record their arrival and departure times was also recorded and discussed during supervision meetings.

The computer based record system issued reminders to the field based managers when a person's care plan and risk assessments were due to be reviewed. Alerts were also sent when a care worker was due to attend supervision or have a spot check carried out.

We saw regular telephone reviews and customer spot checks were carried out and the information was recorded on the computer based records system. If any issues were identified during the telephone call or review visit a complaint would be created on the system and this would be investigated with relevant action taken. Information on any action taken and outcomes would be recorded on the system.

The provider had systems in place to enable people using the service and their relatives to comment on the quality of the care they received. A questionnaire was sent to people using the service and their relatives twice a year. We saw the results of the recent questionnaires received from people using the service where 40 questionnaires had been completed. The majority of people who responded were happy with the care they received from the service.

The registered manager told us a customer forum was held in May 2017 for people using the service and relatives from the three services run by the provider could meet and discuss the care they received and any other issues. The meeting was attended by mostly people who received care from another one of the services. The registered manager explained they are now arranging separate forums for people from each service which are local to them.

The provider kept up to date with best practice through membership of professional bodies such as the UKHCA and Skills for Care and attending any training courses or forums organised by the local authority.

We asked people if they felt the information they received from the provider was clear and easy to understand. Most people we spoke with told us the information was easy to read and clear. People using the service were given a 'customer guide' which included a profile of the provider, their aims, how the care

would be delivered, how to make a complaint and the standards people could expect from the service. This meant people using the service were made aware of the provider's aims, what to do in an emergency and standards of care provided as identified by the provider.

Care workers were sent monthly policies, procedures, best practice and other important information through an email system. They could also access this information at any time electronically to ensure they could keep up to date with best practice and policies.

Regular meetings were held for care workers both at branch level as well as sub team level with their field based manager. We saw notes were produced for each meeting and these were circulated to care workers. The meeting included information from the provider as well as giving care workers an opportunity to discuss the people they supported and other questions they may have about the care provided.

The registered manager told us there were regular meetings between senior staff and care workers to gain their feedback on their working environment and concerns they may have. Senior staff at the service attended monthly meetings to discuss how the service could be rated as Outstanding by the CQC. There were monthly meetings with all the managers and weekly meetings for field based managers and other office based staff. This meant all staff received regular updates in relation to good practice to help them provide a satisfactory standard of care and support to people who use 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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care was provided in a safe way for service users. Regulation 12 (1) The registered person did not always ensure the proper and safe management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have an effective system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those service)

	Regulation 17 (2) (a) The registered person did not have an effective process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. Regulation 17 (2) (b) The registered person did not have an effective system in place to maintain 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. Regulation 17 (2) (c)

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