Lifecare Qualifications Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 9, 10 and 12 April 2018. The first day of the inspection was unannounced.

We last inspected Lifecare Qualifications Limited in September 2017. At that inspection we found breaches of eight regulations. We issued requirement notices for breaches of Regulations 10, 11 and 19 regarding dignity and respect, need for consent and fit and proper persons employed. We issued warning notices requiring the provider and registered manager to be compliant with the regulations by 30 November 2017 for Regulations 9, 12, 13, 17 and 18 regarding person-centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and staffing. The provider had complied with one warning notice and two requirement notices. We found continued breaches of five of these regulations and one new breach of regulations.

When we completed our previous inspection in September 2017 we found concerns relating to the assessment of people's needs. At this time this topic area was included under the key question of 'Responsive.' We reviewed and refined our assessment framework and published the new assessment framework in October 2017. Under the new framework this topic area is now included under the key question of 'Effective.'

Lifecare Qualifications Limited is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older adults and younger disabled adults. At the time of our inspection they were providing care to 174 people.

There was a registered manager 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.

Care plans and risk assessments contained insufficient information to ensure people received safe, personalised care. There was not enough information about people's medicines, mobility or health conditions to ensure they received the right support. People were not asked about their wishes about end of life care. People's preferences for how they wished to be supported were not captured and the impact of their religious beliefs, sexuality or gender identity were not incorporated into their care plans. Care workers recorded when people's needs had changed, and raised this with office based staff, but care plans were not updated to reflect this.

People gave us mixed feedback about whether their care workers attended on time. Some staff told us they were given crowded rotas and this was confirmed by the records seen. Staff were not consistently deployed in a way that ensured people received their care at the right time.

Staff received regular supervisions and training in areas considered fundamental knowledge for staff

working in a care setting. However, they did not receive sufficient training in areas where people had specialist needs.

People told us they had made complaints, but the provider had not followed their complaints policy and there were no clear records of these complaints.

There were no clear systems for the audit or analysis of incidents, accidents, safeguarding concerns, or complaints. Although care plans had been reviewed, and there was a system in place for tracking outstanding actions, there had been a very limited improvement in the quality of the records. Spot checks were poorly completed and did not lead to actions to improve the quality of the service. The systems and processes had not operated effectively to improve the service.

The provider had improved the working knowledge about safeguarding adults from harm. They were now appropriately identifying and escalating allegations of abuse to the appropriate safeguarding authority.

Staff told us they were provided with sufficient personal protective equipment to ensure people were protected by the prevention and control of infection.

People told us care workers prepared their meals for them. Records showed there was clear information about people's dietary preferences and care workers recorded that people ate a varied and nutritious diet.

People told us they felt their care workers treated them with dignity. Care workers and people told us where they worked with each other regularly they were able to establish caring and compassionate relationships.

We identified breaches of six Regulations regarding person-centred care, consent to care, safe care and treatment, staffing, display of ratings and good governance. 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.

The overall rating for this service remains 'Inadequate' and the service remains in 'special measures'.

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

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

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

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks to people had not been appropriately identified and measures in place to mitigate risk were insufficient.

People's medicines were not managed in a safe way.

Staff were not always deployed in a way that ensured people's needs were met.

Staff were recruited in a way that ensured they were suitable to work in care.

Concerns that people may be being abused were raised with the appropriate safeguarding authority.

Staff were given enough personal protective equipment to reduce the risks of the spread of infections.

Is the service effective?

Inadequate

The service was not effective. Assessments of people's needs and choices were not robust and care plans lacked detail regarding their preferences.

Staff received supervision but had not received the training they needed to meet people's needs.

The service was not working within the principles of the Mental Capacity Act 2005.

Staff recorded changes to people's health, and supported people to attend health appointments. However, advice from healthcare professionals was not incorporated into people's care plans.

People were supported to prepare meals in line with their needs and preferences.

Is the service caring?

Requires Improvement

The service was not always caring. The service collected information about people's religious beliefs but did not ensure

care plans reflected the impact these had on people's care preferences.

Care workers' understanding of the impact of people's sexual and gender identity on their lived experience of care was mixed.

People felt they were treated with dignity by care workers.

People and care workers told us where they worked with each other regularly they were able to establish kind and caring relationships.

Is the service responsive?

Inadequate

The service was not responsive. People's care plans were not updated to reflect changes in their needs and preferences.

The service was not following the complaints policy. People made complaints but these were not captured appropriately.

Care workers made clear records when people's needs had changed.

The service did not explore people's end of life wishes with them.

Is the service well-led?

Inadequate

The service was not well led. The provider had not addressed our previous concerns about the quality and safety of the service. Issues with the quality and safety of the service remained widespread and had not been identified or addressed as audits were either not completed or were completed to a poor standard.

The provider was not displaying their rating on their website as required by law.

Records showed senior management did not always value their staff.

People and staff gave us mixed feedback about whether the service felt organised.

The provider did not demonstrate they worked in partnership with other organisations.

Lifecare Qualifications Limited

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.

The inspection took place on 9, 10 and 12 April 2018 and the first day was unannounced. Three inspectors were involved in the inspection. We visited the office location on these dates to see the registered manager and office based staff, to review care records and other documentation. After we had visited the office, two experts-by-experience spoke to people who used the service and their family members 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. The experts had experience of caring for some who received personal care in their own home.

Before the inspection we sought feedback from the commissioning local authorities and local Healthwatch groups. We reviewed the action plan the provider had submitted in response to our previous inspection and other information we held about the service in the form of notifications they had submitted to us. Notifications are reports of events or incidents that provider are required to tell us about by law.

During the inspection we spoke with the registered manager, the quality manager and the deputy manager. After the inspection we spoke with six care workers. After the inspection we also spoke with 21 people who used the service, one family member and three professionals who were also involved in supporting people who received care from Lifecare Qualifications Limited. During the inspection we reviewed 16 people's care records including their needs assessments, risk assessments, care plans and records of care delivered. We reviewed 16 staff records including recruitment, supervision and training. We reviewed call monitoring information, quality audits, action plans, incident reports, meeting records and various policies, procedures and other documents relevant to the management of the service. After the inspection we asked the provider

to send us further documents regarding audits and additional care plan records which they did within the required timescales.

Inadequate

Is the service safe?

Our findings

At our inspection in September 2017 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people had not been appropriately identified or mitigated against and medicines were not managed in a safe way. At this inspection, in April 2019, we found the service had not taken appropriate steps to address this breach and people remained at risk of unsafe care.

We reviewed 16 care files and only one contained enough information to inform care workers about the risks people faced and the actions they should take to ensure their safety. People receiving a service had complex needs and were at risk of harm while receiving care. For example, one person received their nutrition and hydration through a tube inserted into their stomach. Although this was recorded in their assessment, it was not recorded that staff were expected to administer food and fluids through the tube and there was no information or guidance to inform staff how to do this safely. Records showed staff were completing this task multiple times per day. This person also had specialised moving and handling equipment within their home, but the guidance for staff was insufficient to guide them in its safe use. For example, the risk assessment stated, "A new hoist has been installed in [person's] room to safely manage [person's] size and weight. As long as carers take their time with the transfer it should be safe to transfer him." This is not sufficient to ensure staff carried out moving and handling in a safe way.

Another person was identified as being at risk of falls due to medical conditions they lived with. The risk assessment stated, "When [person] is observed stumbling it is important to help me stabilise and reassure me with communication. At this point it is important to get me to sit down. People will then continue to reassure me until the condition passes." The risk assessment also stated, "The steps here seem adequate." There was no information to inform care workers how to help stabilise this person, or how to support them to sit.

A third person had been identified as being at risk of developing pressure ulcers during a review by social services. There was no risk assessment in their file and no guidance for care workers about how to mitigate this risk. In addition, the review noted this person had swallowing difficulties and there was no guidance within their care plan to inform staff how to respond to this risk. Two other people's care files stated that care workers supported them with shopping and handled money on their behalf. There was no clear information for staff within these care files to inform them how to mitigate the risks involved in handling money on behalf of other people.

There were inadequate systems in place to ensure people received their medicines in a safe way. We reviewed care records for 11 people who received support with taking prescribed medicines. None of the files contained adequate information about the purpose or potential side effects of their medicines. The only information contained within the files was the prescription instructions. This meant staff did not have clear information about the purpose or side effects to ensure they were able to monitor people appropriately.

Some of the staff were able to tell us what people's medicines were for. One care worker said, "I know they take one tablet to prevent strokes." However, none of the care workers we spoke with knew what any of the risks or side effects of the medicines they supported people to take were. One care worker said, "I don't know, they've got the blister pack I know what needs to be given. I don't know what they are for. I'm not a doctor. I follow what the chemist does." Another care worker told us, "No, that one [information about side effects] is not in the care plan, the only thing in the care plan is whether we administer it or not and fill in the MAR [medicines administration record] so we know what we have given."

When we inspected in September 2017 the provider had been in the process of introducing electronic medicine administration records (MAR). However, this had been suspended after our inspection report and the registered manager told us they were using paper based MAR in people's homes. We reviewed these and found the medicines listed did not always match the list of medicines included in the care plan. Although audits identified gaps in care worker record keeping, and unclear information about medicines dosages it was not clear that action had been taken regarding this. For example, one person's MAR contained an unclear instruction about the amount of medicine the person should be taking. The audit recorded, "Clarification on dose of evening med should be obtained. Is it 1 tablet or 1 ½?" However, there was no overall summary and it was not clear who was meant to seek this clarification or whether the issue had been resolved by the point of inspection a month after the audit had been completed.

After the inspection the registered manager told us they had re-introduced the electronic MAR system to allow office based staff to monitor medicines administration in real time. Some of the care workers we spoke with confirmed they had been told they must now use their phones to record medicines. However, this action did not address the lack of clear information about people's medicines within the care files.

The above issues are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In September 2017 we found a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not deployed in a way that ensured people's needs were met.

People and care workers gave us mixed feedback about the scheduling and punctuality of visits of care. One person told us, "They come at the time agreed and stay for half an hour." Another person told us, "They come at the agreed time. One hour in the morning, 45 minutes at lunch and one and a half hours in the early evening." However, other people told us they did not receive a consistent or punctual service. For example, one person said, "It was agreed in the morning for one hour, afternoon 45 minutes and in the evening for 45 minutes between seven and eight, but sometimes they come around five to six." A relative told us, "I never know when they're coming."

Although some care workers told us they received rotas which allowed for travel time and ensured they were not late to people, other care workers told us their rotas changed on a daily basis and meant they were often late. For example, one care worker told us, "They [staff completing the rota] don't give us proper time. They give me 7:45-8, 8 to 8:30 they don't give me any travel time and I get no breaks. I don't get that time. I get late, my clients they understand so that's okay." Another care worker said, "They change the rota and they don't contact us. They fit in extras on our phones and we didn't know they were there. If we didn't check we might miss them. So many people miss the visits because they don't call us to let us know that there's an extra on there. No one can do them."

At the last inspection we reviewed the electronic call monitoring information to verify the feedback about

visit times and durations. We attempted to do this again during this inspection. Although staff told us they used an electronic system which allowed them to log visits using codes and their mobile phones the records did not show this was what was happening.

When we reviewed the call monitoring information we found most calls were being logged via telephone calls to the office rather than by using the electronic tags. For example, one person had 32 visits scheduled of which only nine were logged using the electronic tags. Another person had fewer than half their visits logged electronically. Staff records showed some staff received rotas without travel time, and that three staff did not electronically record any visits, and other electronically tagged less than a quarter of their scheduled visits. This meant it was not possible to verify if there had been sufficient progress on staff deployment issues identified as the previous inspection in September 2017. It also meant staff were still being given rotas without travel time between visits and staff were likely to be late and not stay the full length of visits.

This is a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In September 2017 we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was failing to identify and escalate safeguarding concerns appropriately. At this inspection we found the provider had addressed this issue.

Records showed care workers reported concerns that people may be being abused, or at risk of neglect, to the office and office based staff raised concerns with the appropriate safeguarding authority. Care workers we spoke with were confident in the steps they would take to raise concerns about people's welfare. One care worker said, "I would obviously call the line manager and explain exactly what is happening and make the person safe." The provider had a detailed policy about safeguarding adults from harm. This included details of who made decisions within the organisation about raising concerns as well as the contact details at the relevant local authorities. We saw emails were sent to care workers to remind them how to report concerns.

Although it was clearly recorded that concerns were escalated people's care plans and risk assessments were not updated to reflect any changes in people's circumstances or support following incidents. For example, records showed a person's needs had changed following a deterioration in their health conditions. Although the schedule now showed they required two care workers to attend, the information for these care workers had not been updated to reflect the new information about how to support this person. We asked to view records of incidents and were given two sets of records, the safeguarding folder and an accidents book. The records of accidents did not correspond with updates to people's care plans and risk assessments and it was not clear what action was taken to reduce the risk of accidents recurring. This meant it was not clear the service was consistently ensuring that lessons were learnt following incidents.

In September 2017 we had found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records did not demonstrate staff had been recruited in a safe way. The provider had taken action to address this issue.

We reviewed the recruitment records of ten staff who had started working at the service since our last inspection. Files showed that staff were recruited in a way that ensured they were suitable to work in a care setting. Applicants went through a screening and assessment process which explored their knowledge and values. The provider completed checks of applicant's criminal records via the Disclosing and Barring Service to ensure people were not prohibited from working in a care setting. Where people had sufficient employment history employment references were collected. Where applicants did not have an employment

history, or their work history was based outside of the United Kingdom character references were supplied. The provider checked applicants had the right to work in the United Kingdom. This meant the provider was ensuring that staff employed in the service were suitable to work in a care setting.

Individual vulnerability to infection and measures to reduce risks through the effective control and prevention of infection were not captured within care files. However, people and their relatives told us staff wore personal protective equipment appropriately. The provider had a policy regarding infection control and records showed staff were emailed information about how to prevent and control the risk of infection. Care workers told us they were supplied with sufficient personal protective equipment to ensure they were able to follow standard infection prevention and control procedures. One care worker explained, "They [office based staff] are very organised with the gloves and things. They are always calling to check that we have enough gloves and aprons and if we don't have we pick up from the office and share it out."

Inadequate

Is the service effective?

Our findings

In September 2018 we found a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not receive sufficient support and training to perform their roles.

Staff told us, and records confirmed they received supervision in line with the provider's policy. This meant staff received supervision approximately every three months. Supervision sessions were used to discuss their role and responsibilities. Records showed care workers had used their supervision sessions to raise concerns about how some office based staff communicated with them. We saw that these issues had been raised with the staff concerned and appropriate management actions had been taken to improve communication with care workers.

Records showed staff received training in the Care Certificate. The Care Certificate is a recognised qualification that provides care staff with the fundamental knowledge they need to work in a care setting. The provider organisation also had a training company. This gave care workers and office based staff opportunities to access further training opportunities and development. One care worker told us they were nearing the completion of an apprenticeship programme. Another care worker said, "There is loads of training. I had one just today on medicines."

People receiving care had complex needs including health conditions such as stroke, heart disease, diabetes, dementia and significant mental health issues. Despite providing care to people with complex needs records did not show staff received training in these areas. In addition, when we asked for records to show that staff administering nutrition through specialised feeding systems had had appropriate training we were shown records that five staff had worked an additional one hour to receive this training. The person's care records showed another care worker had provided them with support and there was no record they had received sufficient training to meet this person's needs.

This is a continued breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In September 2018 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records did not show the provider had sought consent in line with the Mental Capacity Act 2005.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest 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. The application procedures for people living in the community are via the Court of Protection. We checked whether the service was working within the principles of the MCA.

Records about people's ability to consent to their care and treatment remained unclear. The provider's needs assessment form now included a section to record whether or not the person had capacity to consent to their care. However, there were no capacity assessments, or referrals for placing authorities to complete capacity assessments within people's files.

Care files contained conflicting information about people's ability to consent to their care and treatment. For example, one person had signed to indicate their consent to care, but other records and review notes stated this person lacked capacity to make both simple and complex decisions and included the statement, "My memory is not very good as I don't understand or remember anything. My wife makes all the decisions." Another person's care file recorded their relative made all major decisions, however there was no record to show this family member had legal authority to make decisions on their relative's behalf. The provider submitted a copy of one family member's authorisation to make decisions on their relative's behalf. However, this showed the family member was appropriately authorised to make decisions about the person's finances and property not their care and treatment. This meant the provider had not addressed our concerns and was not working in line with the principles of the MCA.

The above issues are a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In September 2017 we found a breach of Regulation 9(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as needs assessments were not robust and did not lead to care plans which reflected people's needs and preferences. The provider had not taken sufficient action to address this issue.

The provider had agreed a voluntary suspension of new admissions and had only started working with a small number of new people since our last inspection. However, they had undertaken a programme of reviewing and re-assessing the needs of all the people who received a service. We found the needs assessments completed continued to lack detail and were insufficient to ensure people's needs were met. We also found care plans were not updated in a timely way following a re-assessment of their needs.

For example, one person's care file made reference to them being aggressive to care workers and other professionals involved in their care. However, their most recent assessment stated there was no history of aggressive behaviours. Their assessment recorded a change in continence care needs but this was not reflected in the care plan. Another person usually received four visits of care per day and their care plan instructed care workers to follow the direction of family members. Records of care showed the service had provided a 24 hour care package when this family member had been unavailable. There had been no re-assessment or updates made to the care plan to reflect the significant change in the role of the care workers and they had been provided with no clear information about how to support with aspects of care which were usually completed by the person's relatives. This meant there was a risk people did not receive the care they needed as it was not clearly identified or described.

Some care plans contained information about where to locate equipment needed to deliver care, however, the amount of personalisation remained limited. For example, one person's care plan stated, "[Person] does not want to have full strip wash on a daily basis. She would want to have her face and her private parts washed every day. She would like a strip wash a few days in a week. [Person] will let the carers know when she would like to have a full strip wash." Although this told care workers to respect their choice, there was no

information about how to ensure care was delivered in a way that met their preferences as these were not included in the care plan. There was no information about how this person wished to be supported to have a wash.

Another person's care plan stated, "Carers should supervise [Person] while having her shower. [Person] will tell carers that she will brush her teeth after she finishes her breakfast, however, carers should encourage [Person] to brush her teeth before having breakfast. When she finishes her shower, go with her to the bedroom and help her get dressed." There was no further detail to inform care workers how to provide assistance or encouragement in a way that would facilitate this person to shower and clean their teeth.

We reviewed 16 care plans and found only two contained sufficient information to inform care workers how to deliver care in line with the person's needs and preferences. This was reflected in the feedback from people and their relatives. They told us when they were supported by regular staff who knew them they received appropriate care, but when regular care workers were unavailable the quality of the support they received varied. For example, one person said, "No it is different carers. This is where I am finding problems. Every time I am getting someone different." A professional we spoke with told us, "The thing they could improve on is to stop sending different ones [care workers] all the time."

The provider showed us emails and record of telephone calls to demonstrate they raised issues with social workers and other professionals involved with people's care. For example, the service emailed social services departments to inform them if someone refused care, or cancelled a visit due to other events. We were also shown emails with dieticians regarding nutritional advice. The provider showed us this information was emailed to staff involved in providing support to people. Although it was clear the office liaised with other organisations involved in providing support to people, their advice and guidance was not incorporated into care plans. That meant there was a risk that if the care workers supporting people changed they did not have access to the advice and guidance given by professionals.

Care plans showed people receiving a service lived with a range of long term and complex health conditions. For example, people were living with diabetes, dementia, Parkinson's disease, heart disease, lung disease and mobility restrictions following falls and due to arthritis. Care plans did not contain sufficient information about people's health needs to ensure they received appropriate support. For example, one person was living with Parkinson's disease. The section of their care plan called "personal history" contained generic information about Parkinson's disease and its possible progression. However, it was not clear how this person presented and the support care workers were meant to provide to support them to maintain their health.

There was no information within individual care plans about how people living with diabetes were affected by their condition or how they appeared when experiencing variations in their blood sugar levels. When this was raised with the provider they showed us generic information sheets about diabetes that had been shared with care workers. This was not sufficient to ensure that people knew how to respond to individuals who may not present in line with generic information.

Staff told us they would report any concerns about people's health and wellbeing to the office and would follow their advice. Records of care showed care workers responded to changes in people's health and raised concerns with the office. We saw the provider would ask funding authorities for additional time to support people to attend appointments. It was not always clear from the records that changes in people's health conditions led to changes in the support they needed and received. It was also not recorded if staff were expected to support people during appointments, or just during transport to and from appointments. For example, care records showed a care worker noticed and responded to a change in someone's health in

January 2018 but their needs were not reviewed until March 2018. This meant it was not clear that people consistently received the support they needed to maintain their health and access healthcare services.

The above issues with the quality and detail in care plans and assessments is a continued breach of Regulation 9(1)(c)(3)(b).

Where people were supported to prepare and eat meals as part of their care plan there was clear information within the care files regarding their dietary preferences. For example, one person's plan contained detailed, step-by-step instructions for how they liked to prepare their porridge. Another person's file detailed that while they had been advised to follow a specific diet for health reasons, they preferred to eat meals from a local culturally specific restaurant that was not in line with the health recommended diet. Care workers recorded what people ate in food monitoring records and these showed people were supported to eat in line with the preferences described in their care plans.

Requires Improvement

Is the service caring?

Our findings

In September 2017 we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not treated with dignity and did not feel their cultural needs were met. The provider had taken some action to address this issue.

The provider had introduced an equality and diversity information monitoring sheet which included information about people's religious beliefs and sexual orientation. This ensured the provider held this information where people wished to disclose it. However, the information about how these aspects of people's lives may affect their care preferences remained limited. For example, although people's religious beliefs were noted there was no clear information about how it affected how they wished to receive care. One person was noted to be of a particular faith, and a review record showed their relative had mentioned this affected their relationships with the local community. However, there was no information for care workers to ensure they provided support for people in a way that respected their religious beliefs.

Another person's care file contained information that they were regularly visited by people from their place of worship, and they wished to attend their place of worship each week. Care worker records showed they were frequently scheduled to visit this person at a time when they were attending their place of worship. The provider had not changed the schedule to reflect that the person would often not be in.

Care worker responses demonstrated a mixed understanding of the impact people's sexual and gender identity might have on their care preferences. One care worker said, "I accept them and their beliefs, as long as I treat them with dignity that's who they are and I accept them for who they are." However, another care worker responded with laughter when asked if they supported anyone who identified as lesbian, gay, bisexual or transgender (LGBT) and continued to state, "I don't do this kind of people. I don't know about that kind of thing." This meant the provider had not yet fully addressed the fact that not all care workers understood people's experience of care may be affected by their sexual or gender identity.

People told us they felt the staff treated them with dignity. Several people mentioned that care workers "covered" them while supporting them. Care workers told us they ensured that people's dignity was promoted during care by ensuring they remained covered, curtains and doors were closed.

People told us they had built up good relationships with care workers who visited them regularly. One person said, "They are all very good and kind." Another person told us, "She's friendly, we have a chat." Care workers told us they spent time talking to people to get to know them and develop trust. One care worker told us, "You get to know people through the interaction and the helping. They become comfortable with you and then they will open up and tell you about their life experience."

Records showed the updated assessment used by the provider included information on issues that were likely to cause people to become upset, anxious or distressed. Where this section of the assessment had been completed it was noted that people became distressed when their care worker did not attend on time. Care workers were advised to attend visits as scheduled. Although there was no guidance to inform care

workers how to respond to people if they presented in a distressed or agitated state, care workers described the type of actions they would take to respond in a compassionate manner. One care worker explained, "I always have a chat with them, try and cheer them up, try to help them see the light."

Inadequate

Is the service responsive?

Our findings

In September 2017 we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records did not show people received person-centred care. The provider had failed to take sufficient action to address this concern.

We asked care workers what person-centred care meant to them. Although some care workers spoke about providing care that met people's needs, other care workers did not understand what the term meant. One care worker said, "Personal care? I don't know." Another care worker was asked how they would adjust their support if the person was upset or unwell. Their response was very task focussed. They said, "I prepare their food, I prepare their medication. I clean the house, I wash his clothes and iron it at times. If I arrive at the client's house and he lets me in and after that we do personal care, after personal care we do the breakfast in the morning."

The tendency for care to be completed in a task focussed way was reflected in the feedback we received from people. People told us care workers usually completed the tasks required, but felt that care workers did not always show initiative in how they responded to situations. As one person explained, "I have a feeling that it would be nice if they were to be a little bit more relaxed with me." Another person said, "We were asking for a bit more initiative to be shown by the care staff."

Care workers were completing daily records of care. Although some were unclear, most were detailed and recorded the care tasks that had been completed as well as comments on the person's wellbeing and presentation. It was clear from the records when people's presentations and needs were changing. For example, one care worker had clearly captured changes in one person's presentation as they became unwell and then recovered. They had adjusted the care they delivered according to the person's needs. As this information was only captured in the daily notes it was not clear how this was shared with other care workers who may visit if the regular care worker was unavailable.

Records of care delivered showed that care workers were providing care and support to people that had not been identified in the assessment or described in the care plan. For example, one person was receiving support with medicines although this had not been described in the assessment or care plan. Another person's care records detailed that their health had deteriorated and this had changed their preferences for care but this was not reflected in the review or updated care plan.

Care workers told us they reported changes in people's needs to the office. However, they did not always feel their concerns were acted upon. As one care worker explained, "At times they do take action, at times don't deliver the message, you want to speak to your coordinator and they don't always pass the message on. The night messages always get through but if you call in the afternoon sometimes the messages don't get through. I chase things up."

It was not clear from the records viewed during and after the inspection how the provider ensured that care worker concerns were acted upon. For example, we asked to view a care plan that would show the provider

had acted in response to a change in someone's needs. Care worker notes had captured the change in needs, and the funding authority had agreed an increase in the size of the care package. However, the care plans and risk assessments had not been updated and it was not clear what roles the care workers attending should be completing.

The lack of clarity regarding preferences and unclear records regarding responding to people's changing needs meant that the service was not delivering person centred care. It was not recorded how care workers should provide care in an individualised way and despite changes to people's care packages the information for care workers was not updated.

This is a continued breach of Regulation 9(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had made complaints about the service and these had been responded to. One person said, "Things have not been so hunky dory recently. I complained about them changing my regular carer suddenly. It was rectified but I don't understand why they made the change and the reason why they did it without telling me" Another person said, "There was some improvement when the complaint was raised. To my knowledge, the service improved a little" Another person told us they had raised concerns about visit times and missed visits but had not received a response. They said, "Over the last two weeks a carer didn't turn up one day. I rang the office, who promised to get back to me. However a week later I have not had that call."

Despite people telling us they had made complaints, the provider did not have any records of complaints made by people on their records. We asked to view the records of their complaints and the folder we were given contained only concerns raised by one of the funding local authorities. This meant the provider had not been following its complaints policy which stated, "A full record will be held of all complaints received regardless of the level of seriousness and means of communication."

Supervisory staff completed spot checks and telephone interviews to seek feedback about people's experience of care. Records showed that people were asked if their care workers had been late with the last six months. In addition, the form recorded whether people had already made, or wished to make a complaint about this. One form showed the person had made a complaint about this and recorded their view that nothing had changed. Another person stated they did not wish to make a complaint. The complaints were not in the provider's complaint file.

The registered manager told us they did not provide any end of life care to people. There was an end of life policy which referred to ensuring people were supported in line with current best practice guidance around end of life care. Although the provider was not specifically commissioned to deliver end of life care, they did provide care and support to people who were living with multiple, complex, age-related health conditions who were approaching the last stages of their life. The assessments and care plans completed did not ask people, or their relatives where appropriate, for their wishes in relation to end of life care. This meant there was a risk that people's wishes about the end of life care were not captured as they had not been asked about them, so this information was not available when needed.

Inadequate

Is the service well-led?

Our findings

In September 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems and processes were not operating effectively to monitor and improve the quality of the service. During this inspection we found the provider had failed to address these issues.

People and staff gave us mixed feedback about how well run they felt the organisation was. One person responded with "Yes-ish" when asked if they thought the office was organised. Another person responded with, "I suppose so." Other people were positive, telling us they would give it "Ten out of ten" for being organised.

Staff told us they felt things were improving in terms of how the office was organised, and how information was shared with them. We saw, and staff confirmed, the primary way office staff communicated with care workers was via email. Some care workers found this positive, while others said they didn't always have time to check their emails before starting work and would prefer important messages were communicated by telephone.

After our last inspection, the provider had submitted an action plan to tell us how they would meet the warning notices and requirement notices issued. Although it was clear that people had had their needs reassessed and care plans re-written, there had been only a very limited improvement in the quality of records.

We asked the registered manager to send us their best care plan to demonstrate they understood what a good quality care plan and risk assessment looked like. The plan submitted was not of a sufficient quality to ensure the person received safe, personalised care. We also asked for information to demonstrate the registered manager had oversight of the scale and nature of work to be completed. We were sent a spread sheet which detailed when reviews were due. This did not demonstrate the registered manager had knowledge of the quality of the content of the files.

There was a system of spot checks and quality assurance interviews in place. Field supervisors completed spot checks which were then signed off by the registered manager. We reviewed these spot checks and found they were poorly completed. Supervisors did not always complete an observation of the support worker. After the inspection the provider told us spot checks were sometimes completed when support workers were not present so no observation could be recorded. This was not clear from the records. Where issues were identified in the spot checks actions were either unclear or not recorded. For example, despite multiple checks identifying that care plans were not present or were out of date, there was no action to address this.

Likewise, where audits of medicines records identified gaps in record keeping, the action in place was that the care worker was spoken to and advised to complete the records. Future spot checks were not brought forward and the effectiveness of this action was not monitored. The registered manager signed off spot

checks where issues were identified without any actions in place to address them. This meant they had failed to identify or address that their systems were not operating to improve the quality and safety of the service.

Despite signing spot checks and telephone surveys where people referred to making complaints, the registered manager had not identified that these were not captured in the complaints file as required by their complaints policy. People confirmed spot checks were completed, they were phoned for feedback and had recently been sent a survey. However, there was no systematic analysis of the feedback received and comments were not used to drive improvement in the service.

The provider was raising safeguarding alerts with the relevant local authorities. After the inspection the provider submitted an audit an analysis of the nature of alerts raised. This showed most alerts related to neglect. However, there was no plan to address this and prevent future safeguarding concerns. There was no clear system in place for the organisation of incident and accident records. We asked for records of incidents and accidents and were given the safeguarding folder and an accidents book. There was no routine audit or check of these records. This meant the provider had not made any attempt to identify themes arising or any patterns in the incidents, accidents or safeguarding alerts raised. After the inspection the provider submitted analysis that had been completed using online software. However, there were no linked action plans to address themes identified.

The provider had created a new post of quality manager and they had started working in the service in January 2018. They submitted an audit which showed they had audited nine files out of 174. The audit checked all the sections of the file were complete, including assessments, comments on capacity to consent to care, information about other healthcare professionals involved as well as the quality of care instructions and risk assessments. The audit had identified issues in the files reviewed, but it was not clear when this audit had been completed, and whether or not the actions identified had been completed.

To show us that actions were completed after audits, the registered manager sent us a copy of an "insightly task." This was a task allocated to workers using their computer based work system. The record submitted related to one care file and showed the registered manager had asked for the file to be audited, the quality manager had identified issues and the registered manager had agreed to train a staff member and then update the file. This file was submitted to us and the quality was not sufficient to ensure the person received safe care and treatment. The risk assessment described the person's presentation in great detail, but did not inform care workers what to do to mitigate the risks associated with their presentation. This meant the systems in place were not effective at improving the quality and safety of the service.

The issues with the quality and the safety of the service remained widespread and the systems and processes in place had not ensured sufficient action to address them. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had been last inspected on 6 and 7 September 2017 and the inspection report had been published on the CQC website on 27 October 2017. A letter was sent to the provider with the final report informing the provider that they were required to display their rating. It is a legal requirement for providers to display the CQC performance ratings. Providers must ensure that their rating(s) are displayed conspicuously and legibly at the location delivering a regulated service and also the website. Prior to the inspection, we checked the provider's website and saw that the rating was not displayed on the provider's website. During the inspection the provider told us they would update their website to include their ratings, but further checks could not find the rating displayed as required.

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

Care workers gave us mixed feedback about whether or not they felt valued and listened to by office based staff. Some told us they felt they were listened to and respected. However, others told us they had to call the office repeatedly to be heard. The mixed picture regarding the attitude of senior management to care workers was reflected in senior management meeting minutes. While some parts of these meetings recorded management considering training and development opportunities that should be available, other sections demonstrated they did not consistently value their staff. In a discussion around recruitment and staffing allocations it was recorded, "If any carers have less than 16 hours you might as well get rid of them."

We asked the provider to show us how they worked in partnership with other organisations. They sent us copies of emails which showed they asked referring agencies for background information about people they were supporting. They also sent us an email chain regarding supporting one person to access funds for domestic goods. This showed the provider had asked about this in August 2017 and had been sent a form to complete with the person in September 2017. The email chain showed the housing provider had sent several emails chasing the provider and it was not clear if the form was completed and submitted. This did not demonstrate effective partnership working with others involved in people's care. This was reflected in the feedback we received from two professionals who worked in housing schemes. They both told us they were not consistently informed when people refused care which was information they believed was useful and important for them to know.

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 9 HSCA RA Regulations 2014 Person-centred care People's needs had not been appropriately assessed and care and treatment was not designed in a way that ensured their needs and preferences were met. Regulation 9(1)(c)(3)(a)(b)

The enforcement action we took:

We cancelled the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not seeking consent from the appropriate person. Regulation 11(1)

The enforcement action we took:

We cancelled the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks faced by people had not been appropriately assessed and measures in place to mitigate risk were insufficient. Systems did not ensure people were supported to take medicines as prescribed. Regulation 12(1)(2)(a)(b)(g)

The enforcement action we took:

We cancelled the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to identify and address issues with the quality and safety of the service. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

We cancelled the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive sufficient training to ensure they could meet people's needs. Staff were not deployed in a way that ensured they could meet people's needs.

The enforcement action we took:

We cancelled the registration of the provider.