Sevacare (UK) Limited

Mayfair Homecare - Westminster

Inspection report

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11 January 2017
12 January 2017
17 January 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 10, 11, 12 and 17 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. At our previous inspection in November 2015 we found the service was not meeting legal requirements regarding medicines, the suitability of care workers, safe care and treatment, person-centred care and good governance. At a follow-up inspection in June 2016 we found that improvements had been made, but the service was still not meeting requirements relating to safe care and treatment, person centred care and good governance.

Sevacare - Westminster provides a domiciliary care and rehabilitation service to 140 people in the London Boroughs of Camden and Westminster. Since our last inspection, Sevacare - Westminster has stopped providing care to people in the London Borough of Islington, and is now only supporting people in Westminster on a private basis. Shortly after this inspection, the service changed its name to Mayfair Homecare - Westminster.

The service had a registered manager in place. 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.'

Most people told us that they were satisfied with their care workers and their consistency. People told us that they were treated with respect and felt listened to. The provider followed up concerns about people's health, and had a policy in place to respond when people did not answer the door to care workers.

The provider carried out a detailed assessment of people's care needs and possible risks to their health and safety. There were risk management plans in place for people, but sometimes these did not reflect their needs, and there was some inapplicable information on these. The provider did not always assess the risks associated with certain health conditions, or ensure that equipment was safe for use. Most people were satisfied with the timeliness of care workers, but there was no system for monitoring this in detail, and in some cases we found that care workers were late for calls.

There were measures in place to ensure that care workers were competent for their roles. This included a detailed training programme and regular observations and spot checks of care workers whilst they delivered care. Care workers received adequate training and supervision to ensure that they were able to administer medicines competently, but in some cases information on people's medicines was not in date, and it was not always clear who was responsible for administering medicines. When medicines were given on an "as required" basis, there was no clear protocol for care workers to follow. Although there were systems of audit in place for people's care logs and medicines, these did not always detect errors with care plans and risk assessments.

People were asked if they were satisfied with their care and care plans were reviewed regularly. Care plans contained detailed information about how people needed and liked to receive their care, although in some cases these did not fully reflect the care people currently received. There were systems in place for recording people's consent to their care, but in some cases people's capacity to make decisions had not been assessed, and the provider did not always ensure that people had the appropriate legal authority to consent to care on behalf of others.

We have made a recommendation about how the service document's people's capacity to make decisions and how the service monitors the timeliness of calls. We found one breach of regulation regarding safe care and treatment. 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

The service was not safe in all respects.

The provider had assessed ways in which people could be at risk, however risk management plans did not always accurately record what steps care workers took to mitigate these risks.

Care workers were able to recognise signs people were being abused, and the provider took appropriate steps to address suspected abuse.

Most people told us that care workers arrived on time, however in some cases we identified times when care workers arrived late. Care workers followed a "no response" policy to ensure that people were safe when they did not answer the door.

Care workers were able to administer medicines safely. However, accurate information about people's medicines was not always available, and there were no protocols for administering medicines which were taken 'as needed'.

Is the service effective?

Good

The service was effective.

Care workers received adequate training and supervision to carry out their roles and there were systems in place to ensure training was kept up to date.

The provider had implemented measures to ensure people had consented to their care in line with the Mental Capacity Act, however in some cases they had not assessed whether people had the capacity to make decisions for themselves or that relatives had the appropriate authority to sign on people's behalf.

Care plans had detailed information on people's nutritional needs and preferences, and care workers sought medical advice when people appeared unwell.

Is the service caring?

Good

The service was caring.

People were positive about their care workers, and we found that people usually received care from the same care workers who they got to know well. Most people told us that they were involved in writing their care plans and making decisions about their care.

Monitoring visits were carried out twice yearly, and were used to ensure people's views were sought about their care.

People told us that care workers treated them with respect and protected their dignity.

Is the service responsive?

Requires Improvement

The service was not responsive in all respects.

Care plans contained detailed instructions on people's care needs which were informed by a detailed assessment. These were reviewed regularly, including when people's needs had changed. Times of care visits were changed in response to people's needs, however in some cases care plans did not match the care people actually received.

The service had systems in place for recording and investigating complaints, and mangers took appropriate action in response to these.

Is the service well-led?

Requires Improvement

The service was not well led in all respects.

Care workers and people who used the service were positive about managers. Care workers usually received enough time to travel to appointments, and told us that there had been improvement in this area.

Audits were in place to check that care was delivered effectively, however these did not always reflect the accuracy of care plans and risk assessments.

Mayfair Homecare - Westminster

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 10, 11, 12 and 17 January 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. 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. We reviewed information we held about the service, including notifications of significant events that the provider was required to tell us about and spoke with one contracts officer from the local authority.

This inspection was carried out by one inspector who visited the office over four days, an inspector and a pharmacy inspector who visited the office on one day, an inspector who made calls to care workers, and two experts by experience who made calls to people who used the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In carrying out this inspection we spoke with 22 people who used the service and three relatives of people who used the service. We reviewed the care files of 14 people who used the service and medicines records relating to eight people. We looked at 10 care workers files, including records relating to recruitment, training and supervision and audits of training and medicines. We also reviewed information relating to incidents, accidents and safeguarding adults. We spoke with seven care workers, the registered manager, area manager and care services director.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from avoidable harm as the provider was not adequately assessing and managing risks to their safety. Prior to commencing care, the provider carried out a general risk assessment. This included assessing the access to the person's property, the safety of the environment including fire safety, means of escape and whether smoke detectors or fire alarms were in place. The assessment included risks associated with the person's physical and mental health and included a risk management plan, including information about any allergies the person had. Equipment such as hoists was visually inspected at the time of the assessment, but assessors had not checked that equipment that required regular servicing had received this and therefore was safe to use. They did not always verify that smoke detectors or alarms were in working order.

Risk assessments were of variable standard when assessing risks associated with people's health conditions. Where people were living with dementia, assessments contained information on how the condition affected the person, for example with regards to their communication skills or factors which could cause a person to become upset or confused and measures that care workers could take to prevent or address these situations. However, risk management plans were less comprehensive for people who had diabetes. They stated that care workers were to ensure that the person had reduced sugar in their diet, but did not adequately address risks associated with the condition, such as whether the person was at risk from hypoglycaemia, signs that the person may have low blood sugar and measures care workers could take to address this. Care workers did not record any information on how the person's diabetes was managed. Where a person had a diagnosis of seizures, this was highlighted on the risk assessment, but referred care workers to a detailed risk management plan which was not in place. The provider told us that this care plan was in the process of being updated.

There was a significant amount of information on risk management plans which was not in any way relevant to the person. The provider told us that a lot of information was on templates to act as a starting point for the assessor, but this was not removed when not relevant. For example, many risk assessments incorrectly stated that the person had diabetes, or seizures, or that they had oxygen on the premises. Many assessments stated "Care workers are aware that this person has diabetes and that calls are often time-critical" but this was not the case. Some risk assessments stated that the person had a pendant alarm when they did not. All risk assessments stated that care workers were issued with thermometers and were required to measure water temperatures before carrying out bathing or showering, but the registered manager told us that care workers did not carry thermometers and that this would be changed to read that care workers needed to check the water temperature with the person. We saw that risk assessments were checked in reviews to ensure they still met the person's needs, however reviewing care workers had not noted these errors.

These issues constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people were at risk of falls there were detailed management plans for how care workers could

minimise this risk, for example by supervising the person when mobilising, ensuring equipment was safe to use, that the environment was free from clutter and whether floor coverings were safe. These plans had clear instructions on how best to support people, for example "[person] has a crutch to mobilise, but prefers to link arms with care workers." Prior to commencing care, the provider carried out a detailed moving and handling assessment for everyone who used the service, assessing the person's mobility difficulties, their ability to communicate and understand instructions. For each area of function there was a recommendation about the method of moving and handling, equipment and number of care workers.

People told us they felt safe when care workers visited. Comments included, "I feel safe because of the pleasant way they act" and "I trust [my care worker]." A relative told us "Generally they watch over [my family member]." People knew how to report any concerns if they didn't feel safe, although a small number of people were not aware they could contact the office if they felt unsafe, and one person told us they would not discuss concerns with the office care workers.

Care workers had received training in safeguarding adults as part of their induction and were required to attend refresher training on this. Care workers we spoke with were able to describe different types of abuse they learnt about in their training and understood their responsibilities to report suspected abuse. Comments included, "I know if my clients are behaving differently and I try to find out why" and "There are so many ways that people can be abused, sometimes they are not even aware, but we have to be." We saw that where abuse was suspected or alleged, the provider had taken appropriate steps to report these incidents to the local authority and Care Quality Commission (CQC) and had carried out appropriate investigations in response to these. One care worker told of us when they had reported suspected abuse, and said that action had been taken by the local authority and the provider to protect the person. The care worker said "They could have been [my relative]; I had to help."

Where care workers handled money on behalf of people, for example to carry out shopping, care workers recorded these tasks on financial monitoring sheets which were counter-signed by the person using the service, but these were not audited by managers. In one instance, a person was not signing these sheets which meant that there may be a risk of abuse or error. Records showed that that care workers did not regularly support this person with shopping.

People told us that their homes were kept safe and hygienic by care workers. One person said "They always use gloves to protect themselves and to protect me also" and another told us "The carers always clean up."

The provider had a "no response" procedure in place, which had been agreed with the local authority when care was provided as part of a contract. This required care workers to take steps to ensure that the person was safe and well when they did not answer the door. We observed care workers calling into the office to report concerns, and checked records that showed care workers had contacted the on call service when people did not answer the door. This showed that the provider had followed its policy, which included contacting relatives and when necessary emergency services and hospitals to ensure the person's safety before care workers were given permission to leave the premises.

Incidents and accidents were recorded and logged, including location, time, causes of the incident and any action taken as a result. This included making changes to care plans or carrying out a review of the person's care. Care workers told us that they felt confident responding to emergencies, including having received first aid training.

The provider had appropriate measures in place to ensure that care workers were suitable for their roles. This included obtaining a comprehensive work history, receiving and verifying three references from

previous employers and obtaining identification and evidence that the person had the right to work in the UK. Where personal references had been obtained there was a note to show that the referee was contacted to validate their authenticity. Candidates underwent a verbal test to ensure that they were able to understand and follow a care plan. Prior to starting work the provider carried out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. The provider had systems in place to assess whether the person was suitable if there was information of concern on their DBS check, however none of the care workers files we checked showed any information of concern. Prior to starting work, a checklist was completed by managers to ensure that all stages of the recruitment process had been carried out.

Most people and their relatives told us that care workers arrived on time. Comments included, "They have always been very good with time keeping; if they're late they will ring me up and tell me" and "reasonably punctual but not always." However, five people we spoke with expressed concern about timekeeping, with one person saying, "They don't come until very late." Care logs showed that whilst care workers were usually punctual, there were some calls which occurred significantly after the time recorded on the care plan. Most people's calls were on time or within 20 minutes of the planned time, but in some cases were substantially later than this. The local authority told us there was evidence of poor timekeeping and late visits in the monitoring period July 2016 – September 2016 but said they had not received information relating to the most recent period. The provider told us they were planning to implement electronic call monitoring, and had sought consent from people who used the service to use their telephones to do this, however this was not yet in place.

We recommend the provider take advice from a reputable source on how to monitor and improve the punctuality of care workers.

Most people we spoke with were not supported to take medicines by their care workers. People who were told us that care workers were competent to do this and said they received their medicines without any problems. Records showed that care workers had received training in medicines, and had to pass a written medicines test before shadowing more experienced care workers for a minimum of three days. The provider carried out observations to confirm that people were able to administer medicines before they were signed off as competent to do this task.

Where people received support to take medicines, the provider had completed medicines lists, risk assessments and medicines administration recording (MAR) charts. The provider used a number of sources to inform these documents, including hospital discharge summaries, medicines in people's homes and discussions with people who used the service and their families. The provider contacted people's GPs if there were any queries regarding medicines. The provider recorded where medicines were stored as part of the risk assessment, and we saw clear instructions explaining where and how to apply a cream. Medicines risk assessments contained details of the support required, how medicines were supplied and whether the person was at risk of confusion regarding their medicines. A medicines agreement was signed by the person outlining the level of support they required with medicines, including whether they needed prompting or care workers to administer this for them.

The provider told us that people were visited by care workers in order to check that their medicines were up to date at least every three months, and that care workers would contact the office to inform them of any changes between these visits. However, we did not see any evidence that medicines listed in the MAR chart were updated or reviewed regularly. For example, one person's medicines chart was dated 2014, and it was therefore unclear if medicines on the MAR chart were current and up to date. In another person's folder, the medicines list contained additional medicines which were not included on the MAR chart. Care workers

were unable to say whether or not the additional medicines were ongoing or whether they had been stopped. Another person had inhalers listed on their medicines list which were not on the MAR chart, and care workers did not know if the person took responsibility for the inhalers. In two cases, people were supported with medicines by care workers when they visited, but care workers did not visit daily, and it was not clear who was responsible for administering medicines when care workers did not attend. This meant that we could not be sure that the information on the MAR charts were current and provided the correct information for care workers.

Medicines taken as needed or as required are known as 'PRN' medicines. We saw that one person had been prescribed some painkillers as PRN. We had no assurance that care workers would know when it was appropriate to offer this medicine, and if they did, how they would record the activity. We were unable to ascertain whether this person had suffered as a result of not receiving this PRN medicine. We were told that the agency was developing a PRN protocol that would provide instructions to care workers for PRN medicines. However, this had not been implemented at the time of this inspection.

We saw one example of a medicines incident form. The incident in question was a 'near miss'. We were told that medicines incidents were rare. Care workers carried out monthly medicines audits, although we noted some gaps on the MAR charts that were not picked up on the audit forms. The provider told us that they would be carrying out half-monthly checks of medicines in people's homes.

We recommend the provider take advice from a reputable source on ensuring that records relating to medicines are accurate and up to date.

Good

Is the service effective?

Our findings

People were supported by care workers who had the skills and knowledge to meet their needs effectively. The provider had measures in place to ensure care workers had the skills to carry out their roles. Before starting work, care workers received a three day induction; this covered all mandatory areas of training such as effective communication, nutrition and hydration, infection control, privacy and dignity, dementia, health and safety, fire awareness and first aid, medicines administration and moving and handling. After attending induction, care workers completed a work book to demonstrate their knowledge, and if they did not pass this they were scheduled to attend further training courses. After completing their training, care workers shadowed more experienced care workers and managers obtained feedback of their competence and understanding before they were signed off to work alone. Care workers told us that they found this induction useful, and comments included "It was a very good induction", "I felt ready to start work at the end" and "They made sure we were confident."

Care worker files recorded the training people had received, and when they were due to receive refresher training. The provider showed us an audit of care workers' training, which also showed all care workers were up to date with their training. Training was recorded on a management system, which flagged up when care workers were due to receive training and prevented care workers from being booked to work with people when this was overdue. Training dates were updated centrally, and could not be modified by staff from the branch.

Care workers told us they found the training of a good standard and that they could request additional training as required.

The provider's policy stated that care workers should receive supervision at least three times per year, and that this could take the form of a formal discussion or assessment of practical skills in the workplace. Care workers files we reviewed showed that this was taking place. Care workers supervision covered matters arising from the last meeting, training needs, any complaints and incidents, feedback from monitoring and field supervisions, changes in people's needs, health and safety and a review of policies and procedures. Supervisions finished with an agreed action plan. Care workers told us they received regular supervision. Comments included "these are very useful, I get listened to and supported."

In addition to formal meetings, quality monitoring visits and/or care workers assessments took place at least twice yearly and in some cases monthly. The provider told us that these were based on the performance and needs of the care worker. As part of the assessment, supervisors assessed whether care workers arrived on time, wore the correct uniform, followed plans relating to tasks, manual handling and medicines support and whether they demonstrated good communication, dignity and respect. Care workers told us that they received these checks regularly. One care worker said "These happen randomly, we don't know when they are coming" and another care worker said, "These are unannounced and they give feedback at the end. They tell you where you're going wrong."

The Mental Capacity Act (MCA) (2005) provides a legal framework for making particular decisions on behalf

of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in domiciliary care agencies are to be made to the Court of Protection.

The provider had introduced new forms to demonstrate how it was meeting its responsibilities under the MCA. These recorded whether the person had consented to their care, and if they were unable to sign care workers recorded the reason why and whether the person had taken part in care planning and consented to this. Where people did not have capacity care workers were required to state the reason, and if another person had signed on the person's behalf the assessor had to state where the person's authority to sign came from, and whether proof of this had been seen. We saw that in most cases there was evidence that people had consented to their care even if they had not signed. For example, one person was unable to sign due to a health condition, but care workers had recorded the person had requested their next of kin sign all documents. In some cases relatives had signed on behalf of people receiving care, but the provider had not always documented that the person did not have capacity to sign. In some cases the provider had copies of Lasting Powers of Attorney (LPAs) to show that people had this authority, but these were not always obtained.

People who used the service told us care workers asked permission before supporting them. One person said "They always ask me if I want something before they do it" and another person said "They always ask me what I would like to do." Care workers we spoke with mostly understood their responsibilities under the MCA and had received training in this. Care workers described the importance of asking permission before carrying out personal care and of reporting any concerns about a person's capacity to the office. One care workers member said "It is important that the client knows their rights and is able to make their own decision."

We recommend the provider take advice from a reputable source to ensure consent is obtained within the requirements of the MCA.

Care plans contained detailed information on people's nutritional needs and preferences. This included what people liked to have for breakfast, how they liked drinks to be prepared and what care workers were required to do to prepare and serve meals. When people had particular nutritional needs there were instructions for care workers on what they had to do to support the person. For example, one person was unable to eat solid food, and care workers were advised to ensure that they provided food with a high nutritional content such as porridge. In most cases, care workers had recorded that they had supported people with their meals, however in one case this was not taking place, as the provider told us the person's family now provided food, and that the care plan needed to be updated.

People who used the service told us that care workers monitored their health and wellbeing. Comments included, "She checks on my health and makes sure I'm alright" and "If they think there is something wrong they will report back to the office and they will contact the doctor."

Care plans contained a brief summary of people's health needs and diagnosis, this included an assessment of health care needs, and allergies. Where a person had had a stroke and was at risk of further strokes, there was information for care workers on signs to look for. There was evidence that healthcare concerns were recorded and followed up. One person gave information of concern at a monitoring visit, and care workers had reported this to social services. We observed team leaders taking calls from care workers who were

working with people who had become unwell, and care workers were given clear instructions to seek medical help, such as phoning an ambulance where a person was unable to breathe. This was followed up by team leaders later to ensure it had taken place.

Good

Is the service caring?

Our findings

People who used the service were positive about their care workers, and most people told us that they benefitted from being supported by the same care workers who they got to know well. Comments included "In the beginning it was different ladies but now it's the same, I've got to know most of them", "I know them all by name and I ask about their family and we talk about mine; They're not strangers" and "They know me well." Rotas and logs of support indicated that people received support from the same care workers.

Plans recorded people's preferences about their care workers, such as gender and language needs. For example, some people's plans indicated that they required a care worker who spoke the same language as them, and in many cases the provider was able to provide this. Assessments and spot checks were being carried out to ensure that people's views were sought and listened to. For example, on monitoring visits, team leaders recorded whether people were satisfied with their care, and asked people to rate care workers for attitude, competency, and timing, and whether any workers stood out as particularly good or bad. Where care workers were rated as poor, there was evidence that this had been followed up by team leaders, and in some cases different care workers were provided.

These monitoring visits were also used to review whether people's personal outcomes were being met, whether there had been any changes to people's needs, contact information, or whether the person had needed to contact the office since the last visit. Monitoring visits showed that in most cases people were satisfied with their care workers. Some people told us that they received short notice of visits from team leaders, and that sometimes care workers called to say that they were in the area and would like to visit. One person said "I didn't know they were coming and the carer was there. I didn't have anything to say, but if I did I don't feel I would have been able to say anything."

Most people we spoke with told us that they were actively involved in making decisions about their care, for example by being involved in writing care plans. Comments included "I made the decisions" and "They sat down and had a chat with us and everything was worked out."

There was also detailed information to allow care workers to promote people's independence and allow them to regain skills. This included specifying which aspects of care people could do independently, and instructions such as "supervise the person washing at the basin as independently as possible". People told us "They do help with being independent" and another told us "[My care worker] always asks me; she'll do some and I will do the rest." Care workers spoke of the importance of maintaining independence; comments included, "People get to the stage when they no longer need care, it is important to encourage people to reach this stage" and "I would never take a person's independence away."

People told us that they felt treated with dignity and respect by their care workers. Comments included "They are courteous", "They're not rude" and "They don't do anything disrespectful." Care workers had received training on dignity and respect as part of their inductions, and care plans had detailed information on what people wanted care workers to do in order to protect their privacy, for example by leaving the room to allow them to use the toilet, or to ensure that people are covered with towels when carrying out personal

care.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed and a care plan developed to enable care workers to meet these. Prior to starting care, the provider carried out a detailed assessment of the person's current situation and care needs. This included living arrangements, health care needs, communication, hearing and eye sight, movement and mobility and continence needs. Care workers documented people's expectations of their care, preferences regarding their care workers, long term goals and objectives. There was information on care plans about people's life stories, such as their present or former occupations, family life and current activities and interests. Plans were adapted around people's needs, for example when a person attended a day centre on some days, calls were scheduled to take place earlier to prepare the person to go out. The provider had checked with people in advance of the Christmas holidays to see whether any changes were needed with people's visits during this time.

Care plans contained detailed, step-by-step instructions for care workers to follow to ensure that care was delivered in line with people's needs. This included how people liked to be greeted, whether people wanted a tea or coffee before receiving personal care, and information to ensure that people were comfortable during care, for example reminding care workers to remove hearing aids before bathing, or to use a dry flannel to protect the person's eyes when washing their hair.

Care workers told us that they found care plans were useful documents, and that they were given time to read people's plans before providing care. One care worker said, "This is the most important thing before you start providing care."

All plans had been reviewed in the previous 12 months, and there were evidence of people's plans being reviewed when people's needs had changed. Issues raised at these reviews were followed up by care workers. For example, at one review it was identified that the person required a wet room in order to receive personal care, and care workers had contacted the local authority to request this on behalf of the person.

We found that some plans did not always accurately reflect the hours and support that people received. For example, one person's plan stated that they received one hour support in the morning, but was actually receiving a 45 minute visit. The provider told us that they had since reviewed this person's care plan to reflect this. Another person's plan said they needed to receive 45 minute visits but these were substantially shorter, which the provider said they would raise with the local authority. In another case a person told care workers that their 8:30am visit was too early, and that visits had changed to be later but the care plan had not yet been updated to reflect this.

In some cases, plans stated that particular tasks needed to be carried out, but that these were not taking place. For example, one person's plan said that care workers needed to check if their pad needed changing, but this had not been checked on the majority of visits, and in another person's draft task plan it said they were to be supported with toileting, but this was not on the care plan. The provider told us that in these cases the support was not always needed, but the care plan did not reflect this, and care workers had not recorded that they had checked with the person as to whether this support was required at that particular

time.

Most people we spoke with had not found it necessary to make complaints, but one person told us of a concern, and said "We reported it, and it was sorted out and since then we have had no problems". People told us that they could contact the office if they had any complaints. We saw that the provider had systems in place for ensuring complaints were effectively investigated and addressed. Managers had recorded when a complaint was received, the nature of the complaint, what the outcome of the complaint was and whether it raised any safeguarding concerns. In all cases, there was evidence that managers had taken complaints seriously and had taken appropriate action. Managers also maintained a list of compliments which had been received about the team.

Requires Improvement

Is the service well-led?

Our findings

Most people we spoke with knew the registered manager and knew who was responsible for their care. Comments included "I have the office number and all the people that work here", "I have a binder here which has the name of the manager", "I am in touch with them so regularly" and "They do periodically check up to make sure everything is fine." A small number of people we spoke with did not know who was responsible for their care. Care workers we spoke with were positive about the support they received from managers. Comments included, "I am happy with the agency, they have taught me a lot", "They listen to you and they try to help", "You can always say something and you can always see them" and "I have a lovely manager."

Managers were meeting their responsibilities to inform the Care Quality Commission (CQC) of particular events which affected the service, including allegations of abuse against people who used the service.

The provider told us that 10% of care notes were audited by the branch each month, and the audits we saw reflected this. Audits always took place within two weeks of the end of the month when logs and records were returned to the office, which meant that any issues detected by these could be followed up promptly. There was evidence on audits that issues of concern were being followed up with care workers, for example one audit had shown that entries were missing on one person's care notes, and the care worker was brought in for case supervision. We saw evidence of this taking place during the course of our visit, when team leaders called care workers to discuss recording issues.

Branch audits were carried out on a weekly basis of a sample of files. These were used to check the correctness of the risk assessment, assessment of needs, current care plan and date of last review. One care plan we looked at had been critically assessed by a team leader with changes and suggestions made for care workers and inaccuracies highlighted and corrected. For example, the team leader had written "the person's dizziness has now improved" and "They use a crutch, not a stick". However, this critical review of plans did not appear to be widespread practice. Some files we looked at had not been audited during 2016, and audits of files were not effective in identifying issues with risk management plans or cases where care plans did not accurately describe people's support needs.

Care workers were scheduled to carry out care visits based around geographical areas. We looked at 10 care workers rotas over a one week period, and saw that eight care workers had enough travel time to allow them to arrive on time for their calls. One worker had one visit which they could not attend on time, which the provider told us was due to covering annual leave. One worker's rota contained 28 calls for the week, of which 13 of these calls could not have been reached on time. The provider told us all but one daily call was related to covering annual leave, and that they would review this worker's rota. This meant that in the majority of cases care workers had enough travel time to allow them to reach calls on time. Most care workers agreed that they received enough travel time, with one care worker telling us "This has been a problem in the past, but the office will sort it out", and another telling us "Sometimes I don't get enough travel time, I will report this and they try to change it."

Team meetings were being held regularly, and an agenda for these was made available for care workers, although in some cases minutes of these were not available as they had not yet been typed up, including for one meeting which had taken place 11 months ago. Team meetings were also used as a way of discussing changes or concerns to the care workers team. For example, when changes were made to how the service supported people in Westminster, a care workers meeting took place where care workers could discuss their concerns about the changes and managers explained the opportunities for care workers, such as transferring to a new provider or remaining within the service in a different borough. Where one person's care package was challenging for care workers, managers held a team meeting and used this to clarify expectations for the care workers team, discuss this person's needs and care workers responsibilities and to offer support to care workers who may have been affected by the person's behaviour that challenged.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users and do all that was reasonably practical to mitigate these risks. 12(2)(a), (b) The provider did not ensure that the equipment used for providing care or treatment was safe for such use 12(2)(e).