121 Care & Mobility Ltd

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection on 12th June 2018. Following this inspection, we received a number of additional concerns which prompted further regulatory action. On the 10th and 11th July 2018 we carried out a further unannounced inspection so that we could fully assess the potential of ongoing risk to people.

121 Care and Mobility Limited is a domiciliary care agency, it provides personal care to people living in their own homes. The service provides support visits to people in Whitstable, Herne Bay, Faversham and surrounding areas who are mainly older people, and some younger adults. At the time of the inspection they were supporting 292 people. Not everyone using 121 Care and Mobility Limited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of the inspections in June and July 2018, the registered manager's registration was being processed by CQC. The registration is now completed and there is a registered manager at the service. 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 and associated Regulations about how the service is run.

At our previous inspection on 21 and 22 February 2017, we rated the service as Requires Improvement having found breaches of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk because the service was not assessing health related risks and ensuring measures to keep people safe were in place. Audit systems were not utilised effectively to identify and respond to shortfalls identified by people and staff. We asked the provider to take action to meet the regulations. We received an action plan on 11 May 2017 which stated that the provider would be meeting the regulations by 01 July 2017.

At this inspection, we found that the previous breaches had not been met and that there were further breaches of Regulations relating to: not ensuring that people were kept safe, failing to ensure care plans were reviewed regularly to reflect people's needs; not consistently protecting people's dignity; not meeting the requirements of the Mental Capacity Act; not protecting people from risks; not ensuring that systems and processes for safeguarding people had been put in place; and not responding to safeguarding risk in a timely manner, not meeting nutritional and hydration needs effectively; not ensuring governance systems monitor and improve the quality of the service; not ensuring sufficient competent staff were delivering the care and not ensuring an accurate CQC rating was displayed at all times.

People had not been kept safe from risk of harm. Risks had not been adequately managed and risk assessments had not been updated in a timely manner to ensure that risks had been correctly identified and actions put in place to lessen the risks.

Environmental risks had not been correctly assessed so that necessary infection control measures could be introduced to provide a safe working environment in people's homes, for example during food preparation.

The provider had not carried out adequate individual risk assessments for people joining the service and there was insufficient detail to individualised care-related risk assessments to support people's specific health and care needs, their mental health needs, medicines management, and equipment requirements.

Medicines had not been managed safely and people had not always received their prescribed dosage on time. Medicine administration was not correctly recorded and medication errors had occurred.

People's changing needs had not been correctly recorded. We found gaps in care plans and essential risk assessments for example, to mitigate the risk of choking or falling, had not been completed with key follow up actions and learning by the provider, so that people could be kept safe from dangerous situations that might cause significant harm to them.

The provider did not have adequate processes in place to monitor the delivery of the service and staff communication systems were not effective in ensuring that all of the staff team were consistently updated to any changes.

People's needs and choices had not been assessed effectively. Care plans were in place but there was a lack of essential details which left room for error and confusion and some staff were unaware of changes that had been introduced to plans. We have made a recommendation about this in our report.

The provider followed effective recruitment procedures to check that potential staff employed by the service were of good character and had the skills and experience required. All staff received core induction training at start of their employment covering key subjects to enable them to carry out their duties with refresher training provided at intervals. Sufficient numbers of staff were employed to meet people's needs and provide a flexible service.

People were not consistently supported with meal planning and preparation, and eating and drinking as required. Choking risks had not been adequately assessed and staff had not sufficiently ensured that people had been supported to maintain healthy eating where guidelines had been put in place for health purposes.

People were supported to attend routine and follow up appointments if required. However, we reviewed care plans that showed a lack of detail around people's health needs, especially where clear professional guidelines from trained professionals would ensure that people could be supported to reduce and manage their health risks more effectively.

Consent had not consistently been sought and the principles of the Mental Capacity Act 2005 (MCA) had not been complied with.

People told us they felt supported by the staff team. People liked staff and told us they were 'really kind and thoughtful'. People told us they felt their choices and homes were respected by the staff team. People's independence was supported by staff at home and staff protected people's dignity by explaining what they were doing during personal care.

Information was kept safe in locked cabinets at the provider's offices with copies in people's homes. Staff understood the need for confidentiality; but on occasion, information sharing had lacked dignity and respect.

Peoples care plans had not been sufficiently developed with their input. There was a lack of evidence of personalisation so that people's choices and wishes could truly reflect their needs holistically.

People said that they knew they could contact the provider at any time, and they felt confident about raising any concerns or other issues. Complaints had been logged and we found evidence of follow up by the registered manager. However, complaints information was not available in assessable format for people with communication difficulties. We have made a recommendation about this in our report.

People's care plans contained no evidence of end of life care planning even though a significant number of people were older with complex health needs. We have a made a recommendation about this in our report.

The organisations vision and culture had not been reflected through a clear and credible delivery strategy for delivering high quality care and support. Staff did not appear to work collaboratively and this was having a negative impact on the quality of the service offered to people.

Quality monitoring and audit systems were ineffective and there was a lack of urgency about addressing some of the high and complex risks. The service has not demonstrated a commitment to driving improvement and breaches from the last inspection had not been addressed.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from the potential risk of harm through a comprehensive risk assessment.

People were not protected from abuse as actions identified to safeguard people had not been recorded in care plans.

Medicines had not been managed in a safe way.

Risks from infection were not consistently managed.

Lessons had not been learned and changes made in a timely manner when things went wrong.

The provider followed safe recruitment practices.

There were enough staff available to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

The provider did not appear to have sufficient knowledge of the Mental Capacity Act (2005).

Pre- admission assessments were not comprehensive and evidence based guidance had not been used to support people.

Some risks around eating and drinking were not safely managed.

Staff training and knowledge was not consistently good.

People's health needs were not adequately planned for or provided, the quality of recording was inconsistent and some people with significant long-term health issues did not have detailed medical histories.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People felt that staff were kind, caring and respectful.

Staff had not sufficiently protected people's privacy and dignity.

People were not sufficiently involved in making decisions about their care.

Staff encouraged people to retain their independence where possible

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans had not always reflected people's care needs.

People felt comfortable in raising any concerns or complaints and knew these would be taken seriously.

Care planning around the end of people's lives was not sufficiently detailed.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not demonstrated a commitment to driving improvement and there was a lack of urgency in responding to and addressing high risk.

Quality assurance systems had not been implemented effectively or embedded to improve the quality of the service people received.

The registered provider was aware of their responsibilities.

There had been some signs of improvement and since the inspection, the registered provider has put a detailed action plan in place to address concerns and introduce improvements.

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Detailed findings

Background to this inspection

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

We carried out an announced comprehensive inspection on 12th June 2018. Following this inspection, we received additional concerns about the management of risk from choking, unsafe medicines management, unsafe moving and handling procedure and neglect. On the 10th and 11th July 2018 we carried out an unannounced follow up inspection so that we could fully assess the risks to people supported by the service.

Inspection site visit activity started on 12 June and ended on 11 July. It included visiting the office, reviewing care documents, and visiting people in their homes with a care worker present. We visited the office location on 12 June, 10 July and 11 July to see the registered manager and office staff; and to review care records and policies and procedures. We visited people in their homes on 11 July.

The inspection was carried out by five inspectors and an inspection manager who visited the service's office. We also used two experts by experience who contacted people who use the service by phone, to gain their experience of using the service. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to plan our inspection.

We spoke with the registered manager. We also spoke with 2 area registered managers, 1 diary coordinator, 2 quality care coordinators and nine care workers. We spoke with 14 people who used the service and eight relatives of people who used the service. We also received feedback from a local authority commissioning officer.

During the inspection visit, we reviewed a variety of documents. These included 22 people's care records, which included care plans, health records, risk assessments and daily records. We also looked at 12 staff recruitment files, records relating to the management of the service, such as audits, satisfaction surveys, staff rotas, policies and procedures.

We asked the registered manager to send additional information after the inspection visit, such as the staff training plan and an updated people's contact list. The information we requested was sent to us in a timely manner. After the follow up site visits we asked the registered manager to send us a detailed action plan, details of care plans, staff lists and policy documents. They were also sent in a timely manner.

Inadequate

Is the service safe?

Our findings

Risks to people had not been adequately mitigated or managed safely, and risk assessments had not been updated in a timely manner. At our previous inspection on 21 February 2017 the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We identified that information to help people manage risks around diabetes had not been clear or sufficient. At this inspection, we identified another person who was had 'type 2' diabetes. It stated in the care plan, 'Deals with own diabetic needs. 'X' would like 999 called if Hypo occurs'. However, there was no further information for staff about what 'Hypo' meant. What this might look like for the person was not explained in the care plan or risk information and in the absence of this information or guidance, care staff may not have understood that the person was experiencing low blood sugar hypoglycaemia. This can lead to serious complications for people including loss of consciousness and staff had no information to hand of what action they should take.

At our previous inspection we identified that one person with a specialist pressure relieving mattress had a care plan that made no reference to the setting the mattress should be at to make the risk reduction effective, nor whose responsibility it was to check the mattress setting and what staff should do if it was wrong. At this inspection we reviewed one person who was moved by two staff via a ceiling hoist and was vulnerable to skin breakdown if they did not have their needs met safely. The risks relating to skin integrity and the risk of fracturing bones during transfers had not been assessed in the risk assessment document or care plan. The person had a special pressure relieving mattress that required a setting to be maintained. We asked how this was checked as this wasn't reflected in the person's care plan. A carer told us, "It's set by the district nurse but not checked on a daily or weekly basis." We asked care staff if they knew what the setting should be and were told the usual setting they had observed, but staff acknowledged that the setting wasn't known.

Care plans did not adequately detail how people should be supported safely to eat and drink, or how staff should support people to eat and drink to maintain a healthy diet. One person's plan stated that they required thickener to be added to drinks to reduce the risk of choking. However, the person's risk assessment for eating and drinking stated, '[name] needs to be fed on all meal calls, and to thicken drinks. Two scoops to 200ml.' However, it did not mention the risk of choking, there was no separate choking assessment and there were no copies of, or reference to, the speech and language guidance for the person. recorded anywhere.

Another person with a history of falls was noted to require verbal encouragement with transfers. The same person had a manual handling assessment that also stated they had weakness in their limbs and that the person was not weight bearing. There was no indication as to how the person was to be supported to move safely. Following the inspection, the provider wrote to us and told us this care plan had been updated. We will follow this up at our next inspection.

Another person's care plan stated that staff were not to support the person to stand with the use of a Zimmer frame and handling belt, but should instead use a hoist for all transfers. However, the care plan

contained a personal risk assessment and a manual handling assessment that had not been updated and still mentioned using the handling belt and zimmer frame for transfers. There were no instructions documenting how to use the hoist safely, or details of any risks to be aware of when hoisting people.

Another person lived alone and had become reliant on support staff to help them transfer from bed to a chair in the morning and then back to bed in the evening. A hoist had been provided but the care plan contained no manual handling risk assessments or safe transfer protocol. Senior staff supported a new staff member to carry out the evening transfer. They gave clear instructions and the transfer was completed without incident. However, the new staff member was not told that they must always review the care plan for each visit to ensure that any changes to the plan had been read and understood as per the organisations policies. This meant that any changes to moving and handling procedures, or people's care, might be missed by the staff.

The provider had not fully mitigated the risks to people's health and safety. This is a continued breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received a number of concerns from health professionals and members of the public. During our second site visit on 10 July and 11 July 2018 we looked at people's care plans. One person's care plan showed that there had been a safeguarding meeting nine day prior to our second site visit and a safeguarding vulnerable adults action plan had been generated, with actions assigned to different people and organisations. There had been 10 actions assigned to 121 Care & Mobility Ltd and at the time of the inspection none of these had been added to the care plan. Subsequent to our inspection the registered provider submitted evidence to show that action points were being met and risks to people were being managed and reduced. The registered manager had made referrals to the local authority safeguarding teams when concerns had been brought to their attention and is working with the local authority to improve safeguarding issues.

Medicines were not being managed safely. During one of the care calls we shadowed, staff told us that they did not administer medicines to the person. The person's care plan stated that their husband was responsible for their medicines. However, we saw a carer apply a daily patch to the persons shoulder. We asked about this and the carer told us, "We put the patch on for (husband) as it's too fiddly, but there's no MAR chart." The carer told us that they 'cleared this with the office' and were told it was OK as the medicines were prescribed.

During another visit we also found communication books being used to record medication administration. Staff told us that there was a problem with the pharmacy and when there was no MAR chart available, they should document in the communication book. However, in both cases, people were being put at risk of medicine errors as the MAR chart contained specific information about how to safely administer people's medicines that was not present on the communication book or care plan entries. The accurate administration of each medicine had not been safely recorded. There were not full and accurate entries made on any care records to indicate which medicines were prescribed for the person, when they must be given, what the dose was or any special information, such as giving the medicines with food.

There were no prescription guidelines to state how and when the medicines should be administered, no MAR charts to check they had been administered and no information about the medicine or signs of adverse reactions to be aware of for the person's safety. The guidance document 'Managing medicines in care homes' created by The National Institute for Health and Care Excellence (NICE) states, 'Health and social care practitioners should ensure that records about medicines are accurate and up-to-date by following the process set out in the care home medicines policy. The process should cover: recording information in the

resident's care plan; recording information in the resident's medicines administration record.' However, in practice this was not happening and this was placing people at risk.

Not every person required assistance with taking their prescribed medicines as some people could administer medicines themselves or a family member or friend assisted them. Those who did require the assistance of staff had a care plan. However, these did not always include the detailed information needed to enable staff to administer people's medicines in the way they wanted and needed. On 23 March 2018, we found written in communications book 'Trimethoprim tablets found and administered' but not recorded on the MAR sheet. For another person, we found no MAR sheet. The care note stated, 'Amlodipine runs out' but we saw no evidence that anything was done to replace it.

Where people administered their own medicines or had a family member who supported with this, a list of the medicines they were prescribed were included in their care plan. This was meant to ensure staff had access to this information in case concerns arose such as people suffering side effects or requiring hospital admission. However, some of the lists of people's medicines had not been kept up to date. One person's medicines list in the care plan stated seven. However, the MAR sheet listed nine medicines. This showed that the care records for the medicines had not been reviewed so staff may have had access to out of date information which may have been used inaccurately to inform health care professionals.

Not all infection control risks had been managed safely. One person's kitchen had not been kept clean and maintained to a standard that was suitable for support staff to prepare and serve food. This had previously been managed by the person's family, and at the time when the kitchen risk assessment had been written, the person had not required support with meals and the kitchen had not used by care staff. However, the person's needs had changed and their support had increased to include meal provision several times a week. However, risk assessments and care plans had not been updated and staff were using the soiled kitchen to prepare meals.

The failure to adequately assess and prevent the risk of infection and to safely manage people's medicines is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had received infection control training and understood that it was important to protect people from cross contamination. Staff were provided with appropriate personal protective equipment (PPE) including, gloves, aprons and hand gel to carry out their roles safely when on home visits. The provider kept sufficient stocks of PPE at their office which staff could access regularly.

Lessons had not been learned when things went wrong and action to put right shortfalls had not been taken in a timely manner. New assessment paperwork, that had been identified as a priority during the first site visit of this inspection, had not been rolled out in good time. We asked the registered manager on 12 June when new format care plans would be introduced and information from existing plans updated and transferred and we were told that the roll-out would take several months. The registered manager provided samples of the new paperwork which addressed risk more thoroughly. At the second site visit we asked the registered manager what progress had been made over the previous month and were told that 16 out of 300 plans had been revised. At this rate of progress, care plans would not be completed within the timescale set.

We recommend that the registered provider review all care plans in a timely manner.

We saw evidence from the staff team that some progress had been made in other areas. Staff told us that when things went wrong at the service, they were asked to come into the office to discuss the concerns that

had been raised with their line registered managers and remedial actions were taken. Accident and incident forms were completed and a new electronic monitoring system was being trialled. We were also told that areas of concern were discussed at staff meetings and minutes of the meetings confirmed that a range of issues had been noted.

Staffing levels were adequate to meet people's needs and keep them safe. The registered manager told us that people were informed if their regular carer was off sick, and which staff would replace them. People said that when they first started to use the service, it was explained to them that they would be given an exact time when the staff would arrive at their home. People confirmed to us that if staff were running late, they were informed.

Inadequate

Is the service effective?

Our findings

The provider had not used appropriate tools to assess people's needs. For example, people at risk of malnutrition or dehydration did not have MUST assessments or similar monitoring tools in place. A MUST (malnutrition universal screening tool) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese and includes management guidelines which can be used to develop a care plan. We reviewed people who were at risk of skin breakdown but did not see any Waterlow assessments or similar management tools. A Waterlow assessment gives an estimated risk for the development of a pressure sore in a given patient and is used by care providers to manage the risk of skin breakdown.

Assessments of need, completed prior to people being offered a service, did not provide a holistic overview of the range of people's conditions or an accurate picture of their level of need. One person's assessment stated they were independent with continence management. However, there was a care plan document completed by the local authority prior to the assessment that stated there were times when the person required support with their continence. A visiting health professional had raised a safeguarding alert detailing their concerns around a lack of support after the person was found in an incontinent state and with skin damage. The skin damage could have been caused or made worse by poor support around continence needs.

Assessments failed to implement processes to ensure there was no discrimination when making support decisions, including in relation to protected characteristics under the Equality Act. People's sexuality, religion or cultural support needs were not recorded as part of their assessment; this left them at risk of discrimination and of receiving support which did not meet all their needs.

The lack of effective assessment and use of evidence based guidance to deliver effective care is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff did not consistently demonstrate that they had the skills, knowledge and experience to deliver effective care and support. We visited one person during a care call and there was a special sling in use to enable a person to use the toilet whilst being hoisted. This had been used since April 2018. However, the care plan had not been updated to reflect this. We asked the person's relative if staff knew how to use the sling and we were told, "The two who were here two Saturdays ago didn't know what to do. The slings were put outside the arms instead of inside; I was watching them like a hawk. I demonstrated how it should be done and they said they hadn't been trained to use one." The person's care plan did not describe the safe use of the sling except for a torn-out piece of paper placed loosely in the daily care notes with a hand-written note that only mentioned the type of sling and to keep the person's arms inside. There was no step by step guidance or assessment recorded. Carers acknowledged that the care plans had not been updated. Another relative told us that some carers did not seem qualified enough and seemed to be, "Thrown in at the deep end". The relative said, "They don't seem to have been doing it for long enough." One girl said, "I sat in a classroom for a few days and now I'm out on a call"," Skilled carers can do the call and get all the jobs done in 45 minutes but I've known it to take 90 minutes." Following the inspection, the provider sent us a completed training matrix with details of all courses currently completed by the staff team. Moving and handling training were

detailed on the matrix.

The failure to provide staff with adequate training is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were at risk of not having their nutrition and hydration needs met. One person's care plan stated that they were supported by their family to prepare meals. We spoke to the registered manager about this person and were told that the care package had changed and that staff were now providing three calls a week to support the person with their lunch. The registered manager told us that the person had put a lot of weight on, was prone to eating a diet that was unhealthy, and that staff were struggling to support them to eat healthily. However, the care plan did not reflect this. The only information recorded around supporting the person to eat stated, 'Family deal with cooking meals, snacks and drinks'. The food and drink section of the care plan did not state what support the person required from staff in order to eat healthily, their recent weight gain and how to support them to lose weight. A poor diet and excessive weight could impact the persons existing health conditions.

The lack of effective action to support a person's nutrition needs is a failure to provide safe care and treatment which is a is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff across the organisation had not worked together consistently to deliver effective care, support and treatment. When people joined the service, a senior staff member met with them to assess their needs and provide them with a copy of the provider's service guide and a contract document. The care plan was then produced from the assessment information with one copy kept by the provider and a second copy kept at the person's home. The provider co-ordinated their activities from a central office which was open from seven am until 10 pm. The diary co-ordinator told us that it could be a 'most stressful job' which took time to master. With the demands on the service, additional staff cover was at times 'based on goodwill'. The provider placed a lot of reliance on the care staff completing communication books accurately and then calling the office to update them of any changes to people's needs and one staff told us that, "On the odd occasion you get a mess up." A recent staff survey identified communication as a significant issue with staff raising concerns about 'being kept up to date' and 'messages not being passed'. As a result, the provider was trialling a mobile call monitoring system to ensure that essential 'real time' information was communicated to the care staff with staff logging in at the start and end of their care calls and the registered manager had increased staff meetings so that staff communication could become more effective.

Each person had a designated section in their care plan to record their medical history, details of routine health visits and follow up. However, the quality of recording was inconsistent and some people with significant long-term health issues did not have detailed medical histories. During the inspection we found no evidence in the care plans of referrals and follow up by specialist services such as falls clinics, or dementia assessment services and limited records of GP visits or routine medical appointments. However, following the inspection, the registered manager forwarded us a copy from the provider's electronic recording system that demonstrated an example of follow up with a relative and the person's GP. People were at risk of not having their health needs met as their diagnosed medical conditions were not described, managed or risk assessed effectively in their care plans. Prior to our second site visit we were contacted by a social worker who had concerns about the management of one person's health. We reviewed their care plan and found that some key diagnoses were not included in the care plan and risks around the management of these health conditions had not been assessed or mitigated. Furthermore, we were told by a learning disability nurse who visited the person that illnesses connected to these diagnoses had developed and led to the person being unwell.

Other people had complex medical needs such as heart conditions, high blood pressure, choking risks and diabetic ulcers. One person had a recognised condition around memory loss but we found no input from specialist services recorded in their care plan. We reviewed a number of other care plans that showed a similar lack of detail around people's health needs. Clear professional guidelines from trained professionals would ensure that people could be supported to reduce and manage their health risks more effectively.

The failure to plan for and meet people's health needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Consent had not consistently been sought and the principles of the Mental Capacity Act 2005 (MCA) had not been complied with. The MCA provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In domiciliary care this is called Court of Protection. There were no people who required Court of Protection restrictions at the time of the inspection

Care plans had an MCA section that contained two questions, which had in effect, condensed the five key questions needed to establish capacity as set out in the MCA. In addition, the questions were not related to a specific decision as advised in the government's 'Mental Capacity Act Code of Practice' document. One person's cognition section of their care plan noted that their memory, 'comes and goes' and that they had short term memory loss. However, there were no MCA assessments in place for the person.

The provider's policy stated that staff should, 'know and work within the acts principles.' However, we spoke to one senior staff member about completing capacity assessments and were told that staff would not do them and that they would need a doctor to complete an MCA assessment. This is not in line with the best practice guidance for MCA. Failing to assess people's capacity to make certain decisions puts people at risk of staff taking decisions on their behalf that do not reflect their wishes or are not in their best interests.

The failure to record decisions taken under the requirements of the MCA is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff were matched to the people they were supporting as far as possible, so that they could relate well to each other. The registered manager introduced care staff to people, and explained how many staff were allocated to them. People got to know the same care staff who would be supporting them. This allowed for consistency of staffing, and cover from staff that people knew in the event of staff leave or sickness.

Requires Improvement

Is the service caring?

Our findings

People told us they felt that care staff who supported them were kind and caring. Comments included, "They are brilliant, really kind and thoughtful", "I can't praise them too greatly, they do menial tasks with good grace and are lovely people", "They are fantastic, I am well impressed" and "They are all very polite and call me by my full name which I appreciate".

However despite these positive comments we found some areas of practice that required improvement. People's care plans did not sufficiently document their involvement in planning their care or how the service promoted their independence. The care plans contained basic information about the type of care and support tasks the person needed. There was little additional detail about people's lives, protected characteristics, interests or personal histories.

We did not find any input from independent advocacy services which would benefit people when they lacked communicate skills to articulate their wishes and required independent support with decision making. There was very limited evidence of reviews of care plans and we did not see where people had been involved in their reviews. One person told us, "The care plan? I don't know when they review it." Another person commented, "[The care plan] is due for a review." One relative said, "The care plan's in the folder. I can't remember when we had the last review; it was over a year ago."

The failure to record person centred reviews of care plans is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff did not always demonstrate a good understanding of the need to maintain dignity and confidentiality. When a person was delayed in answering their front door, we witnessed two staff discussing the reasons for the delay across the front garden boundary fence. One staff member addressed the other loudly and did not seem to be concerned that the visit was on public display where sensitive information could be overheard. The provider confirmed that this issue had been addressed with the staff concerned and appropriate follow up action taken on the same day that we had raised it with them."

People felt their choices were respected. One person told us, "Yes, I choose most things such as when I have a shower and all the domestic things." Another told us. "They do respect my choices and that is nice". Relatives also felt that staff respected their choices. One relative told us, "They respect my wife's choices about what to wear and about scent and things like that". A relative said, "They help my husband with a lot of intimate care and they manage it in a respectful way".

People told us that staff respected their home when they visited. One person told us, "They always knock and wait for an answer, and they don't rush me at all". Others said, "They knock and call before coming in and the older ones treat your home like they would theirs" and "They always keep me covered up for washing and dressing and take their time".

Daily recordings were kept up to date although they were brief, task orientated and typically contained the

same daily information such as, "I assisted X with their dressing, showering and dressing then tidied up when tea given – all ok, all clear."

People's individual care records were kept secure. Care plans and daily records, were stored securely in lockable cupboards at the registered office with copies at the person's homes. Staff files and other records were securely locked in cabinets at the provider's offices to ensure that they were only accessible to those authorised to view them.

Requires Improvement

Is the service responsive?

Our findings

When people were referred to the service, a basic assessment of their needs and risks was carried out. People were given copies of the providers key document's including a contract and service guide. A range of risk assessments were also completed including an eating and drinking assessment, a medication assessment and environmental assessment.

There was no introductory information when people joined the service, such as information introducing key staff for people, in an accessible format. We could not find key information in accessible formats such as braille or large print for people with sensory impairment.

Peoples care plans had not been developed and kept up to date when people's needs changed. In one person's care plan it stated, 'X has become doubly incontinent since the last assessment'. Then later in the care plan it stated, 'X goes to the toilet independently'. We found no further information or guidance about this for care staff. One person's care record stated that a family member was responsible for changing the person's stoma bag. However, in the daily records, care staff confirmed on three occasions they had changed the stoma bag themselves. Newer staff coming into the service may not have been aware of the care plans and there would be a risk that people would not receive the care they required.

Some staff did not appear to know the contents of the care plans and in some cases, the plans were not accurate or up to date. We visited a person during a care call whose care plan stated that they had an allergy to eggs. When the person requested a fried egg sandwich for breakfast, the carers started to make it. We asked them about the allergy and the carers seemed unaware of it but then told us that they had checked with person who had told them to ignore the plan because they had always eaten egg. Staff were either not aware of changes to the care plans or had not read them. We found no further input or advice leaflets or evidence of referrals to any healthcare professional. Care staff had not been following the agreed plan of care.

The failure to ensure people's care documents are kept up to date is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not meeting the accessible information standard (AIS) and some people's care plan documentation was not written in a way they could understand. The AIS is a standard that was introduced in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for adult social care services to comply with AIS. There was no evidence to show that people were actively involved in the review of their care plans other than staff taking into account their observed reactions to the care they had received. The care plans were written in a standard format only with no use of multimedia tools. The font used was very small and the management team accepted that more needed to be done to increase the accessibility of information in the care planning and review paperwork.

We recommend that the registered provider reviews their approach to compliance with the Accessible

Information Standard.

People we spoke to told us they felt care staff responsive to their needs. Comments included, "I absolutely have confidence in my carers, you can't fault them", "I do believe that they [office staff] would deal with any problem, but I haven't complained" and "I have never needed to make a complaint".

Relatives said, "Yes, they [office staff] do listen and take note of what we say"; "They have grown to like her and yes, they do let me know about things they [staff] notice so that I can call the GP if necessary", "If I had to complain, I will call the office and ask for a form. My mum is very precious to me so if there was anything of concern, I would raise it" and "Yes, there are opportunities to give feedback; someone rings; they called last week".

People were given a copy of the service's complaints procedure, which was included in the service users' guide. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). People told us they would have no hesitation in contacting the registered manager if they had any concerns, or would speak to their care staff. The registered manager told us that all verbal and written complaints had been investigated and the outcome reported to the complainant.

Copies of all complaints, investigations and outcomes were kept. The registered manager told us that they were used as a point of learning to prevent a future occurrence and to ensure improvements were made. Compliments had been received about the care and support provided by staff. One thank you card from a relative said, 'Thank you to all the carers who have helped us. A special thanks goes to [Carer] for their dedication and care they showed us both'.

The service had received a total of 10 complaints and 20 compliments since August 2017 and the registered manager confirmed that all verbal and written complaints had been investigated and the outcome reported to the complainant. The registered manager visited people in their homes to discuss any issues that they could not easily deal with by phone. They said face to face contact with people was really important to obtain the full details of their concerns.

People's choices for end of life care had not been clearly recorded, reviewed and followed up. We reviewed the care plan for one person who was receiving end of life care. We asked if an end of life care plan was in place and were told that it was not as the person had been admitted to hospital. However, a senior staff informed us that the person had been supported to change their medicines to liquid form as they had not been taking their medicines due to their illness.

We read the person's file and there was no mention of end of life care, reference to a life limiting medical condition or any reflection of the person's religious practices or cultural considerations that should be observed as part of their end of life care. When we spoke to a senior member of staff about the person they were unable to confirm the person's diagnosis.

We recommend the registered provider reviews end of life care planning in line with national guidance.

Inadequate

Is the service well-led?

Our findings

last inspection on 21 and 22 February 2017, where we identified two breaches of Regulation relating to audit systems not being utilised effectively to identify and respond to shortfalls, and the safe management of risk. The provider sent us an action plan on 11 May 2017 which stated that they would be meeting the regulations by 01 July 2017. We checked at this inspection and regulations had still not been met.

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The overall range of service audits, checks and systems in place was limited and whilst there had been some signs of improvement with the introduction of a number of new and revised audit documents, the provider had not demonstrated effectiveness in assessing, monitoring and improving the overall quality and safety of the services provided. Current audit systems had not proved effective in highlighting and addressing some of the shortfalls identified at this inspection. For example, one person's MAR sheet audit dated 06 April 2018 stated, 'No further action required' but had failed to identify errors made by staff in the administration of medicines alongside a lack of risk assessments.

Another person had a progressive condition affecting their balance. A falls assessment had recorded that the person had been at risk of falls in the past. However, we found no further details about their current condition or an updated falls risk assessment in the person's care plan. The support plan contained a one-line entry, 'carers are to remind X to use their walking stick', but this was contradicted in the care plan when the person's assessor had described the risks to their balance as 'none'. Comprehensive care plan and risk assessment audits should have been in place to pick up these recording errors instead of leaving the person at significant risk of and personal harm.

Over the previous 6 months CQC had received concerns about the service in relation to repeated medication errors, moving and positioning errors and poor standards of care. The registered provider had responded in a timely manner to each request for further information. However, actions taken had failed to demonstrate organisational learning by addressing the underlying issues, potentially leaving people at further risk of harm. These concerns were looked at during our inspection: We wanted to understand more fully how the provider had responded to reduce risk for people they were supporting.

During the inspection we found further evidence of poor risk assessment and management, superficial care planning and recording, and a lack of communication between the office and care staff. Staff had not demonstrated the required level of knowledge and understanding of the provider's policies and procedures and were not always aware of changes in people's needs.

The provider and registered manager had not managed risk or made changes at a systemic, rather than reactive level. Since the inspection however, the registered manager has responded to our request for an action plan with detailed responses addressing issues across the organisation.

The failure to ensure the systems in place to regularly assess and monitor the quality and safety of the service were used effectively and consistent record keeping were a continued breach of Regulation 17 of The Health and Social Care Act (Regulated Activities) Regulations 2014.

It is a legal requirement to display CQC ratings. This is because the public has a right to know how care services are performing. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. We checked the registered provider's website and found a link to the previous rating under an old registration. This gave an outdated rating of Good instead of the rating of Requires Improvement the provider had been given on 4 March 2017. We asked the registered manager about the display of ratings and were told that the website was being developed and that it would be put right. Since the inspection the website has been amended and the correct rating is now displayed.

The failure to display CQC ratings in the premises and on the services' website is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspections in June and July 2018, the registered managers registration was being processed by CQC. The registration is now completed and there is a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was responsible for overseeing the day to day running of the service.

The registered manager told us that one of the greatest challenges had been to develop a 'more open and transparent culture'. Since being appointed, they had begun to focus on the culture and work on improving staff morale and a positive teamwork ethic. The registered manager had introduced 'drop in days' and made improvements to the staffing structure and lines of accountability within the organisation.

Staff told us that they felt," listened and responded to" because the registered manager was supportive and available. Staff told us they felt valued, and enjoyed working for the service. One staff told us, "I am very happy working here. I worked for another company; this company listens to me."

The registered manager had introduced a regular programme of management and staff meetings with regular newsletters to improve communication. Minutes confirmed that concerns, actions or issues had been discussed and addressed keeping staff up to date with developments within the service. Staff told us, "It's getting more structured and as a result, communication with office staff is better."

Feedback from people about the quality of the service was undertaken through annual survey. The results of the survey undertaken in February 2018 and collated in May 2018 gave some positive responses relating to communication, the management of the service and complaint handling. However, some people clearly commented on the need for improved communication with office staff as we found during our inspection. One person said, "They respond when I call, but sometimes they should call first, like telling me when the carer is going to be late". Another said, "They could communicate a bit more, when someone is very late for example".

The registered provider had put action plan together to address this, by informing office staff that they needed to continue to work harder on improving communication with people. This was being monitored as an on-going action by the provider. The registered manager was aware of when to send notifications to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent to tell us about incidents and we had used this information to monitor the service and to focus on how incidents had been managed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider failed to ensure that people's care documents had been kept up to date in order to provide consistent care that met their needs. The registered provider had failed to carry out an appropriate and effective assessment of peoples needs and to plan their care or treatment in line with evidence based guidance with a view to achieving the person's preferences and ensuring their health and wellbeing needs had been met The registered provider had failed to ensure that person centred reviews have been carried out and that every reasonable effort had been made to meet people's preferences and enable them to participate in making decisions relating to their care. . This is a breach of Regulation 9 (1)(3)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments At the time of the inspection, the registered provider had failed to display their current rating and the rating appeared to be good rather than requires improvement. A link had

been provided that took the reader to the updated website with the correct rating however this was misleading.

This is a breach of Regulation 20A(2) (a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to provide appropriate support, training, professional development supervision and appraisal as is necessary to enable them to carry out their duties they are employed to perform. This is a breach of Regulation 18(2)