First Choice Homecare & Employment Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 23 and 27 February and 1 March 2017 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

At the last inspection on 19, 20, 21 and 26 July 2016 we found breaches in relation to safe care and treatment, consent, person centred care, good governance and notification of incidents. The service was rated Requires Improvement overall. The provider sent in an action plan to tell us what they were going to do to make improvements. We found that not all improvements had been made.

First Choice Home Care and Employment Services Limited is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our previous inspection the service was providing support to 332 people in the London Boroughs of Waltham Forest, Redbridge and Newham. The majority of the people using the service were funded by the local authority. At this inspection they were supporting 249 people, but were no longer supporting people in the London Borough of Redbridge.

There was a manager in post at the time of our inspection who had worked for the provider since December 2016 and was in the process of applying to be a registered manager. The previous registered manager had left in October 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People who lived with specific health conditions did not always have the risks associated with these conditions properly assessed and care plans were not always developed from these to ensure their safety and welfare. Although improvements had been made since the previous inspection, not all risk assessments we viewed contained sufficient detail and did not provide staff with information or guidance on how to minimise the risk.

We saw some improvements had been made in the management of people's medicines however appropriate policies and procedures were not in place for all the records we reviewed. The branch manager was in the process of ensuring medicines records were checked on a monthly basis and was being implemented at the time of the inspection.

The provider had a good understanding of the policies and procedures in place to safeguard people from abuse and avoidable harm. Incidents were reported and followed up and apart from one incident, we saw evidence that disciplinary procedures were followed.

Where issues had been raised relating to late and missed visits, there was evidence that monitoring had been put in place to make sure people had their visits on time. The provider was working closely with the

local authority to ensure care workers logged in and out and attended all of their visits.

The provider had a robust staff recruitment process and completed the necessary checks to ensure staff were suitable to work with people using the service.

Requirements of the Mental Capacity Act 2005 (MCA) were not always followed. Where family members had signed to consent to the care and support of their relatives, the provider was not always able to demonstrate that the relative had the legal authority to do so and was therefore not working in line with the MCA.

We saw that supervisions for staff were in the process of being carried out and saw evidence that showed staff who were overdue had been prioritised and scheduled in to receive one. Not all supervision records we viewed had been completed in line with the provider's expected procedures.

People were supported to have sufficient food and drink and specific information, including people's cultural preferences had been recorded in people's files. Care workers told us they notified the office if they had any concerns about people's health and we saw evidence of this in on call reports and action that had been taken.

People and their relatives told us that their regular care workers were kind and caring and knew how to support them. Staff understood the importance of respecting people's privacy and treating people with dignity and respect.

Care records had been improved since the previous inspection as more person centred information had been included, including people's cultural and religious needs. The provider was in the process of reviewing and updating all care records since the recruitment of a new branch manager.

People and their relatives knew how to make a complaint and were able to share their views and opinions about the service they received. There were monitoring systems in place to allow people and their relatives the opportunity to feedback about the care and treatment they received.

Improvements had been made and the provider now met the CQC registration requirements regarding the submission of notifications about serious incidents, for which they have a legal obligation to do so.

We could see that there had been an improved approach to quality assurance since the previous inspection and audits were in place to monitor the quality of the service, but were not always consistent to monitor the care provided to people. A number of audits to improve the service were in the process of being implemented at the time of the inspection.

We found one continued breach of the regulations relating to safe care and treatment and made one recommendation relating to consent. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

Appropriate policies and procedures were not always followed for all the records we reviewed to ensure people received their medicines safely and effectively.

Risk assessments continued to lack sufficient detail and guidance for staff to reduce the likelihood of people coming to harm.

People were protected from the risk of potential abuse because the provider followed their disciplinary procedures and staff had a good understanding of how to recognise and report signs of abuse.

Robust staff recruitment procedures were followed to minimise the risk of unsuitable staff being employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did still not have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA) as people's consent to care and support was not always recorded accurately.

Records showed training was in place with new staff receiving an induction and current staff having an annual refresher. Not all staff had received practical training in moving and handling.

Staff supervisions had started to be carried out however they were not always completed in line with the provider's policies and procedures.

Information about people's health and dietary support needs had been improved and recorded in their files.

Is the service caring?

Good

The service was caring.

Care workers promoted people's independence, respected their dignity and maintained their privacy. Dignity and examples of best practice was discussed during the staff induction.

People felt involved in decisions about their care. They were given a choice and were encouraged to be independent.

People we spoke with told us they were happy with the care they received and the staff that supported them were kind and compassionate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records had been improved since the previous inspection as more person centred information had been included. The provider was in the process of reviewing and updating all care records since the recruitment of a new branch manager.

There was a system in place to deal with people's complaints. We saw concerns raised were followed up and people and their relatives were given the opportunity to give feedback about the care and support they received.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had made improvements and now met their legal obligations to inform the Care Quality Commission of notifiable incidents.

We could see that there was an improved approach to quality assurance and audits were in place to monitor the quality of the service, but were not consistent in all the records we viewed. A number of actions to improve the service were in the process of being implemented at the time of the inspection so we could not comment on their effectiveness at this inspection.

There were mixed views with people and their relatives, including staff about how well the service was managed.

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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, and to check that improvements to meet legal requirements planned by the provider after our inspection on 19, 20, 21 and 26 July 2016 had been made. We looked at the overall quality of the service to provide a new rating for the service under the Care Act 2014; prior to this inspection, the rating for the service was Requires Improvement.

This inspection took place on 23 and 27 February and 1 March 2017 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of four inspectors, with one present on all three days of the inspection, one on the first two days and two on the final day. It also included two experts by experience who were responsible for contacting people during and after the inspection to find out about their experiences of using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report. We considered information which local authorities had shared with us after the previous inspection. In addition to this we reviewed the provider's action plans that had been submitted to CQC since the last inspection.

We called 128 people using the service and managed to speak with 26 of them. We also spoke with seven relatives and 22 staff members. This included the director, the business development manager, the branch manager, the executive assistant to the board of directors, four care coordinators, three field care supervisors, the workforce development manager and ten care workers. We looked at 21 people's care

plans, eight staff recruitment files, staff training files, staff supervision records and audits and records related to the management of the service.

Before, during and after the inspection we spoke with three health and social care professionals who worked with people using the service for their views and feedback.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection of the service we found that people's safety was at risk. Medicines were not managed safely and the risk assessments we viewed were inconsistent as some were not detailed and did not provide staff with guidance on how to minimise risk. During this inspection we found that the provider had made improvements to address the concerns, however improvements were still in progress as care records were still in the process of being reviewed.

Our previous inspection identified that systems for the proper and safe management of medicines were not operated effectively. The provider submitted an action plan stating that their medicines policy had been updated and they would introduce monthly medicines audits to ensure mistakes were rectified early. At this inspection we found that their policy had been updated and that some improvements had been made, but not in all the care records we viewed.

Where people were supported with their medicines, a medicines risk assessment was carried out which recorded what medicines people took, the strength, dose, how they were administered and the reason for taking them. If people were supported by relatives or were able to self-administer their medicines, this was also recorded within the assessment. One person said, "The carer takes it out of my blister pack and does it all for me." Another person said, "No, I do that all myself or my [family member] helps me with that." A relative said, "They give him/her all their medicines and they make sure that he/she takes them while they are there."

We saw daily logs for one person that recorded their care workers were assisting with eye drops, but this had not been recorded in their care plan. Daily logs for another person showed that they were supported with medicines during a sitting service, which was not recorded in the care plan as the family were responsible for their medicines. The branch manager told us that this was a one off as the family member had left the medicines out for the care worker to support during the visit. They told us that they were in the process of updating the file.

Care workers were responsible for recording what medicines people took in a medicines administration record (MAR) sheet if they prompted or assisted people with them. The provider had updated their communication book since the previous inspection which included MAR sheets. For one person who was assisted with their medicines, we saw that the information was being recorded correctly by care workers. The provider had introduced a monthly medicines audit tool, which was used to check if MAR records had been completed correctly. For some of the care records we viewed we saw that when they had been checked, errors had been identified and staff had recorded whether any action had been taken. For one person, a monthly check in October and November 2016 recorded that a MAR sheet had not been filled in correctly and the care worker had been spoken to. However this was not always consistent as not all records had been checked. For this person, their MAR sheet had not been filled in for the period of February up to the date of the inspection. For another person, their records had been checked in September, October and November 2016 but there was nothing after this. The branch manager acknowledged this and told us that they were working to ensure all medicines records were checked on a monthly basis.

We saw records in two people's daily logs that they were being supported with creams but we found no records in people's care plans that this had been recorded. As one person was bed bound we spoke to the director and the branch manager about this to check whether it was a prescribed cream. It was confirmed that it was a body cream and non-prescribed, culturally specific to each person.

Our previous inspection identified that although risk assessments were reviewed on an annual basis, the level of detail within them was not consistent throughout the care files we looked at and did not always identify assessed risks or guide staff about how to mitigate these. The provider submitted an action plan stating that staff would receive refresher training in assessing risk and writing care planning documents. At this inspection we found that improvements had been made, but not in all the care records we viewed.

We saw that where people had stated their independence with certain tasks, the field care supervisor had observed them to make sure they were able to demonstrate their independence and that it could be done in a safe way. For example, one person was observed making and safely drinking a hot drink independently.

For one person who had reduced mobility and was at risk of falls, the risk assessment recorded that the person needed to be supervised during specific movements, including what mobility equipment was to be used to reduce the risk of them falling. The moving and handling assessment highlighted this and advised care workers to monitor their mobility and report any concerns. However the risk assessment should have been reviewed in September 2016 but had not been done. The branch manager acknowledged this and told us that since they had started their employment with the provider, they had decided to implement a review for each person to ensure each care record was of the same standard.

Another person with reduced mobility was also a diabetic. We saw that their assessment had highlighted the importance of putting their shoes on before mobilising and supporting with transfers to reduce the risk of cutting their feet. However the risk assessment had limited information about supporting the person safely with transfers. They were unable to manage stairs and needed full support from care workers with toileting and personal care, including the use of a hoist, but there was no further information about how these tasks were to be managed. The care plan highlighted transfers were required to assist the person out of bed and into a wheelchair for a shower or to be transferred onto a commode, but this had not been recorded in the moving and handling assessment.

Another person was unable to mobilise and the moving and handling assessment recorded they were bed bound. There was information for care workers about the position of the bed and that two care workers should be present for all visits and to make sure they were left in a comfortable position. However there was contradictory information as the risk action plan stated that two care workers were required to support the person when mobilising. We also saw records in their daily logs that they had been assisted in the shower, which had not been recorded in the care plan or risk assessment, and no guidance on how this task was to be carried out safely. We spoke to the branch manager about this who amended the records and updated us on the second day of the inspection.

The above information demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection there were 71 care workers covering the Newham area and 26 care workers covering the Waltham Forest area. Like the previous inspection, new office staff had recently been recruited and there were five care coordinators and two field care supervisors covering Newham, with three care coordinators and one field care supervisor covering Waltham Forest. Care workers we spoke with felt that they were given enough time between visits to make sure that they were not late for calls as they generally

worked in their local area. The majority of people and relatives we spoke with confirmed that they received their visits on time and were notified if care workers were running late. One person said, "She's never late, if there is a problem with the traffic I get a call and she has never missed a call." A relative said, "They've never missed a visit and they're never late." We did receive comments from five people that timekeeping could be an issue. One person said, "She's supposed to come at 10am but is always late. Sometimes she comes at 11.30am." One relative said, "Quite a few times they haven't turned up and they have come at 12pm for a morning visit, which is too late." One person told us that they are usually late at least twice a week. They added, "If they are late they call me and ask me to log in for them." We spoke to the branch manager about this who explained that this was not the correct procedure for care workers and would look into this matter further.

We looked at a sample of electronic monitoring data for 11 people for periods between December 2016 and up to the date of the inspection. For seven people, we found that there were generally no concerns or consistent signs of lateness and were given explanations when data was different to what was scheduled. For example, we saw evidence that the local authority had been contacted when there had been issues with gaining access, as there had been three visits where the care worker had logged in over an hour late.

However, for one person their care plan stated they had four visits per day, with two care workers for each visit. There were five occasions when only one care worker was scheduled and the care coordinator was unable to explain why. We brought this information up with the branch manager during feedback on the third day of the inspection. Data for another person showed that approximately half of the morning visits throughout February 2017 took place about 20 minutes late, with five visits being 27-28 minutes late. We also saw that despite the electronic monitoring system being in use, there had only been manual log outs for the whole month. Due to this it was difficult to confirm the full length of time for each visit.

For another person, we had received some information from the local authority prior to the inspection about late and missed visits. We saw evidence of lateness in February 2017, with seven visits being between 32 and 45 minutes late, and 3 visits between 53 and 72 minutes late. There were alleged late and missed visits on 18, 21 and 28 December 2016 and after the investigation, the provider had accepted this and agreed to reimburse the calls. Where calls had been manually logged in and out without evidence a call had taken place this showed a misuse of the system.

People we spoke with told us that they felt safe when receiving care. Comments included, "Yes I feel safe. They help me to wash and dress and I do feel safe when they are doing this", "I am safe and I am very comfortable with her" and "Oh yes, they are nice ladies and I'm not rushed, I do feel safe." A relative told us that they felt their [family member] was safe. They added, "The carer is very gentle with him/her, they always chat and my [family member] is very happy."

Care workers we spoke with had a good understanding about safeguarding adults and were able to explain what kinds of abuse people could be at risk of, potential signs of abuse and what they would do if they thought somebody was at risk. Staff were confident that if they raised concerns they would be dealt with appropriately. We looked through their safeguarding records since the previous inspection and saw that when safeguarding concerns had been raised, they had been recorded and investigated. Apart from one incident where we saw that a care worker had been actively working when they were suspended, we saw that disciplinary action was taken if necessary and saw confirmation that other members of staff were not working when they had been suspended. One care worker said, "If I raise concerns, I'm confident that they will be dealt with."

The eight staff files that we looked through were consistent and showed that the provider had robust

recruitment procedures in place. We saw evidence of criminal records checks and photographic proof of identity. Records contained details of people's Disclosure and Barring Service (DBS) reference number and the date of the disclosure. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. We saw evidence that one member of staff had recently had their DBS reviewed in line with the provider's own policy. For another member of staff whose DBS was due to be reviewed, they had been contacted about this to begin the application process. The provider asked for two references and people could not start work until they had been verified. References gave the referee opportunity to comment about competence, reliability, punctuality and motivation and we saw positive responses from the files viewed.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection identified that staff did not have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA). The provider did not have a clear understanding that there should be signed consent forms in place, that care plans should be signed by the person to show their agreement to the care and support provided and that there should be a clear indication of an assessment of their capacity if they are unable to do this. At this inspection we found that slight improvements had been made, however we still identified some issues.

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

We saw some improvements where people with capacity had signed their own care plans and assessments. Where we saw care plans that had not been signed, we saw records that showed the review or assessment had recently been carried out and the paperwork was in the process of being drafted before returning to the person to get a signature. The provider had amended their forms since the last inspection which highlighted if people were unable to sign but could show signs of consent, either verbally or with gestures, and had been included in their action plan. However, they were not always being completed. It also allowed a relative to sign to say they had the legal authority to consent on the person's behalf, but not all records had further information to say what evidence they had of this.

For one person who was capable of making their own choices and decisions, it had been signed by a relative and the new part of the form had not been completed and the reason for why the relative had signed was not recorded in the care plan. We spoke to the director about this who told us that it was cultural for the relative to sign as they were involved in the person's care. Another person's assessment had been signed by a relative, but a home risk assessment had been signed by the person, with no further information as to why they could sign one document but not another.

For people who lacked capacity, there were inconsistencies in how the provider obtained their consent. For one person, it was recorded in records from the local authority that a relative had the Lasting Power of Attorney (LPA). For another person, there was a third party consent form signed by a relative confirming that they had full legal consent of the person. A note was stuck on their file stating that another relative had a LPA and the provider was awaiting a copy for their records.

Another person's records had been signed by their relatives. The provider confirmed that there was no evidence in place to confirm they had the authority to sign on their behalf. The branch manager told us that they made a telephone call during the inspection to the relative and told us that they had applied for the LPA. For two other people who lacked capacity, their records had been signed by relatives with no further reference about any relative having the LPA or that it had been applied for.

We recommend the provider seeks advice and guidance from a reputable source about their responsibilities around the MCA and ensuring people's rights are protected.

The majority of people we spoke with told us that they were happy with the care they received and care workers had the necessary skills and knowledge to meet their needs. Comments from people included, "He helps me with my shower, changing my clothes and will do everything he needs to before he leaves", "They do everything I need. If I ask them for something extra they will do it", "My carer comes on time, she is never in a rush and looks after me" and "I get well looked after." One relative told us they felt reassured with the skills of the care workers. They said, "They're pretty good. They are gentle with [family member] and understand their dementia. He/she's not fearful of them and I would know if something was up."

We saw that new starters received an induction which covered the practicalities of the role and a range of policies and procedures. One member of staff said, "I had an induction and read a number of policies and procedures, then signed to state I'd read them and understood them." Interview assessment forms highlighted that new staff had to shadow senior staff before starting on their own and shadowing records were in place to confirm this. We saw care workers had up to four shadowing experiences and covered tasks including personal care, supporting people with their medicines and carrying out moving and handling procedures.

13 topics were covered in the mandatory training programme which included safeguarding, medicines, infection control, mental capacity, dementia awareness, communication and record keeping, moving and handling and principles of person centred care. We saw for one new starter this programme of training was covered over a four day period during their induction. After completing the training courses, assessments were carried out and we saw examples where if a member of staff scored six out of ten, they had to take the assessment again to achieve a pass score of seven. Staff were then expected to carry out refresher training on an annual basis. We spoke with the workforce development manager who showed us the training matrix and where training had expired, contact had been made with the member of staff to have it refreshed. We saw correspondence of the training timetable that was sent out to care coordinators to highlight when care workers were carrying out training. We saw from a supervision record that one member of staff had highlighted that they wanted to carry out further training in dementia awareness and saw that they had been scheduled on for a future course. The branch manager also showed us that office staff had opportunities to take part in external training that was provided by the local authority, with staff members having the opportunity to have training in management of risk in mental health settings and pressure ulcer prevention management.

We received a mixture of comments from staff about the training made available to them. Positive comments received highlighted that staff had been supported with achieving qualifications in health and social care since starting work with the provider. One member of staff said, "The practical training in moving and handling was good. We were able to test it out on each other." However, five of the ten care workers we spoke with told us that they had not had practical training in moving and handling and were only able to watch a video. One of them told us that they had been told that they will be called for a practical session but it had not happened yet. One member of staff highlighted that it took a few months to have any training when they first started and would have expected it within the first few weeks of their employment. One member of staff also told us they did not have an induction or training when they started as they had previous experience, but had also not had an annual refresher.

We were told that staff should receive a supervision every three months but the branch manager acknowledged that this system was still in process as some supervisions had not been carried out since the previous manager left and some were overdue. The branch manager showed us records of supervisions that

had been carried out since January 2017 and those that had been scheduled in and we could see that they were being done, with priority for members of staff who were due one. Eight of the ten care workers we spoke with confirmed they had had a recent supervision. We also saw records that showed an annual appraisal system was also in place and staff were working their way to completing those that were overdue.

We looked at records of supervision sessions which showed care workers were able to discuss key areas of their employment which covered 18 areas, including discussion topics on safeguarding, record keeping, protocol for double up visits and training needs. The supervision form stated that supervisors must discuss at least four key topic areas during the meeting and discuss and review at least one person to facilitate learning and support. However we did not always see this on all the records we reviewed. For six supervision records that were sent to us after the inspection, only one of them met these criteria. One member of staff told us that they had had a recent supervision and when they raised some challenges of the service, they felt they were listened to and their concerns were acted upon.

We saw people were supported to maintain their health and access healthcare services. We saw evidence in the out of hours records where care workers had reported concerns to the office and action had been taken. In one record, we saw that a care worker had called the office to report a person's health needs had changed. We saw the provider had made contact with the local authority to request a review of their care. The branch manager showed us that the on call report was sent to the whole team to highlight the issue and had recorded what immediate action had been taken. Office staff would then follow up with health and social care professionals if needed. We also saw care workers had called ambulances in emergency situations. One care worker told us how they worked with other health and social care professionals. They said, "We had reported concerns so an occupational therapist came to visit to observe us and give us support. We worked with them and the office to assess the concern and make sure the person was safe." Contact details for health and social care professionals were held in people's files so the provider knew who to call if people's healthcare needs changed. For example, one person's care records highlighted the support they received from a chiropodist and what access they had to day care services.

People's assessments covered the level of support people required during mealtimes and we saw that more information was available compared to the previous inspection. It also recorded if people's relatives supported them and the level of support offered. One person said, "I do cook for myself most days but if I don't have enough energy they will cook for me." Another person said, "They help me with my breakfast and dinner. It is fine and I'm happy with it." One relative said, "The carers help with all meals. I leave out a dinner for the evening and they heat it up in the microwave." Care plans made reference to people's preferences and daily records showed people were offered food they liked. One person's care plan stated they were diabetic and they needed to maintain a good nutritional status. Their daily records showed that if an evening meal was refused, it was documented that the care worker would make something light to make sure they had something to eat. They would also leave out preferred foods that had been recorded in their care plan.

Good

Is the service caring?

Our findings

The majority of people we spoke with told us they were happy with the care they received and the staff that supported them were kind and compassionate. Comments from people included, "I feel they do care, they make the effort", They are respectful and kind. They never raise their voice and when we talk, she listens" and "My carer is respectful, kind and courteous. It works both ways and I'm happy with him." One relative told us that the care workers always listened to their instructions. They added, "The ones we have are very good and very friendly. We are very lucky." We saw a compliment in one person's file from a relative that commented that their regular care worker was hardworking, compassionate, tolerant, diligent and a wonderful care worker.

People told us staff respected their privacy and dignity. We received many positive comments about how respectful care workers were when they worked with people. One person said, "Yes they are very respectful and kind. I feel that we can talk and she listens to me." Another person said, "They do respect my privacy and dignity. When I ask my carer to wait outside they do." A relative told us how the care workers also respected their home when they carried out visits. They added, "When they are in my house, they are polite and up to standard, I wouldn't stand for anything less." We saw a monitoring record for one person in their file which highlighted that care workers always respected their privacy and dignity. Care workers had a good understanding of the need to ensure they respected people's privacy and dignity and were able to give us examples of how they did this. One care worker told us that they always made sure one person's privacy and dignity was respected by politely asking family members to leave when they were about to carry out personal care. They added, "Respecting people is something that we do all day, every day."
We saw that this topic was discussed during the induction programme for new starters and when staff had refresher training. A dignity in homecare programme highlighted best practice and expectations. It covered 13 question areas including personal care, hygiene, equality and diversity, social inclusion and end of life care.

People were assigned regular care workers and then had cover care workers when their regular staff were unavailable. We saw in the majority of files that people had a care team profile, which was a list of the regular care workers and those who would cover in their absence. A care coordinator told us that care workers were allocated to people according to a combination of factors, including people's preferences, location and distance to travel between calls. Care workers we spoke with told us they generally worked in their local area which minimised the risk of them running late. People told us it was important to have a regular care worker who knew them well and how they liked to be supported. We received some positive comments which included, "My carer understands my ways and she gets me. I've known her for a long time and she talks to me and keeps me company" and "Now I have one specific care worker. If he is on holiday they do send somebody else. I couldn't live without them." Care workers we spoke with knew the people they were caring for and understood the importance of their work and caring for people in the right way. Care workers gave us examples of how people liked to be supported which showed that they had built up a positive relationship. We did speak to one care worker who told us that a care coordinator had changed a number of regular calls and they were not happy about it. They added, "They keep moving us around. It is not good continuity for people."

People and their relatives told us that they had been involved in the planning of their care and making decisions about how they wanted to be supported. People received a visit from a field care supervisor to complete an assessment of their needs or carry out a review. One field care supervisor said, "We do reviews and book appointments to see service users to produce their care records." One person told us that somebody had recently been out to visit them to have an assessment. They added, "They came to see if I needed anything or if anything had changed." One relative said, "Yes I was involved and we have a new care plan that starts soon." We saw telephone questionnaires in people's files which showed that family members were also consulted about the care their relatives received. For one person, we saw that they had been involved in the majority of conversations, but their relative also had the opportunity to be involved. Their care plan highlighted that their family member played an important part in their life.

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection of the service we found that care plans lacked detail and were not person centred to meet the individual needs of people receiving care. During this inspection we found that the provider had made improvements to address the concerns, however improvements were still in progress as care records were still in the process of being reviewed.

The majority of people we spoke with felt their care was personalised and said they were listened to during their assessment. One person said, "I was given the option of having a male or female carer when we signed up." Another person told us that during the assessment, they were asked if they had any preferences in how they wanted to receive their care. One relative told us that they were involved during the assessment process and commented positively on how they were listened to. They added, "I told them what we needed and they understood."

We saw that people's files now included a section called 'A little about me', which gave the provider the opportunity to find out some more information about the people they supported. It included people's nickname if they had one, birthplace, job history, likes and dislikes, food preferences, favourite television shows and what people were important to them. We saw examples in the majority of files we reviewed that time had been taken to obtain this information about people to help care workers get to know more about the people they supported. For one person, we saw that their preferred name was included, along with a number of leisure interests, their favourite food and music. For another person, it highlighted what the person did not like, but also specific behaviour from people that would make them anxious. This would help care workers understand and make them aware of their needs when supporting them. For people without this information, the branch manager told us all care files were in the process of being reviewed.

We saw information that showed the provider listened to people and tried to support their cultural and religious needs, including having a choice about gender specific care. Records for people that highlighted their preference for male or female care workers had a list of care workers provided to work with them and we saw information in daily logs that these requests had been accommodated. One relative said, "They've been able to do that as my [family member] only wants a male carer."
We saw for two people that their religion was important to them and that they followed the custom and traditions. One person highlighted the importance of fasting during a religious festival and that it was important to them. We saw information detailed in another person's care plan that they visited a temple every Sunday and liked to pray and sing religious songs. We also saw information for people which highlighted their culturally specific food preferences.

We spoke to the branch manager about what improvements were being made to people's care records and the current status of the review process. They told us that they were in the process of reviewing all care records, even if they had been reviewed recently, so each record would be of the same standard. Field care supervisors were responsible for visiting people and carrying out assessments and reviews. We spoke to one field care supervisor who told us that they were working on getting all people's care records up to date. They added, "There are a number of documents that are missing or not in place at the moment but we are

working on this based on their priority." Some care workers we spoke with confirmed this and told us that they would have to call the office or read the daily logs to find out what needed to be done. We saw records for one person that had been recently reviewed a few days prior to the inspection. We could see from their previous assessment that had been completed in July 2016 that it was more detailed. The branch manager showed us records that at the time of inspection 30 reviews had been completed, 24 were being drafted and the rest were scheduled for a review to take place.

Daily log records were not available for all the care records we viewed as they were kept at people's homes. The branch manager told us that the returning of daily logs on a monthly basis was in progress and some had been archived. For a selection of daily logs we were able to view we could see that generally there were detailed accounts of what care and support people received. However we saw records for two people who received an extended visit on a weekly basis. One person had a three hour visit each week for accessing the community with the person stating they wanted to use it as flexibly as when needed. There was no information in the care plan or the daily logs about what type of support they received. The last three visits in the log book recorded 'met client ok, did escort', '3.20pm escort' and 'did escort, left fine.' Another person had a four hour sitting service each week. There were no guidelines as to what staff should be doing during this visit. Records in the daily log recorded 'met client well, sitting service done. Left well with family' and 'did some housework during the respite.' We were unable to tell if these people were getting the support they needed during these visits from the records available.

People using the service and their relatives told us that they were aware of the complaints process and knew how to contact the office if they needed to raise any concerns. The majority of comments we received highlighted that people were happy and felt that the provider listened to their complaints and concerns and took action if necessary. Comments included, "I have complained about the inconsistency in timekeeping but that was mainly last year. The new one is very good", "I did complain about one of the carers and they dealt with it straight away" and "I have all their numbers and can call when I need to. The office is very helpful." One relative told us how they thought the service had improved recently. They added, "I do call if there are concerns but it has got better and they have improved." We did receive some comments which related to poor communication when waiting to hear back from the office. One person said, "I do feel comfortable making a complaint but the response was terrible. I was never called back and passed from pillar to post."

The provider had an accessible complaints procedure which was given to people when they started using the service. We looked through their log of complaints since the previous inspection. Complaints for Newham and Waltham Forest were kept in separate folders. We could see complaint forms had been completed appropriately which gave an overview of the complaint, who was responsible for dealing with it and what the current status was. Each complaint included information evidencing action that had been followed up. For example, one complaint involving late and missed visits showed a home visit and telephone check were carried out with ongoing monitoring in place. The care worker involved was brought into the office for a supervision to discuss the issue raised. For another complaint, we saw that the provider had addressed the issue, spoken with staff and liaised with the local authority about the outcome. We saw records that the person involved had been visited and the monitoring form highlighted there were no further complaints and the issue had been addressed. A letter of apology had been sent to the person and the provider told us the final outcome was in the process of being shared with them.

We saw a number of compliments throughout the records we viewed commenting on the care that people had received. One person had said during a monitoring visit, 'My carer is very good. She is always coming in with a smile on her face.' Another record said that the service had improved since the manager came out for a visit.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a newly appointed branch manager who had been in post since 12 December 2016 and was in the process of applying to the Care Quality Commission (CQC) to become a registered manager. The previous manager who was present at the last inspection had left in October 2016.

The registered provider is required by law to notify the CQC of important events which occur within the service. At the last inspection the provider had not submitted statutory notifications to the CQC relating to safeguarding concerns. At this inspection we found that improvements had been made. We reviewed their safeguarding file and found that all safeguarding incidents had been notified to us. One incident had occurred in October 2016 but was not notified to us until January 2017. We spoke to the business development manager about this who explained it happened around the time of the previous registered manager leaving. As soon as they were made aware by the local authority that the investigation was ongoing they notified us. We saw that the incident had been followed up and had been closed by the time of the inspection.

We received a mixture of opinions from people and their relatives about how well managed they thought the service was. One person said, "It's pretty good. I know someone is coming to see me to see that I'm alright or if I need anything." One relative told us how they had made improvements. They said, "I'm very happy with them, the management has got better, people are understanding more and feel our [family member] is cared for. There are no signs to make me feel worried." Another relative said, "We're happy with the service. The only thing is the missed calls which recently happened and I will contact the office about it. But [family member] is very happy." Negative comments we received related to communication issues. One person said, "They don't listen because nobody ever calls back when asked to." Another person said, "You have to wait to get another phone call sometimes and this can be too long." The branch manager told us that they were looking at their on call system and how it could be improved.

We also received mixed opinions from staff about how well they felt supported in their roles. One member of staff said, "The manager is very supportive. Always ready to listen and give support. I feel comfortable bringing up issues as she has previous experience and understands the job that needs to be done." Another member of staff said, "I enjoy working for them and I think it has improved since last year. If you need anything, they listen." Negative comments we received related to support and communication. Comments included, "I didn't feel supported in the beginning as there was no guidance. There doesn't seem to be a clear structure in place", "There is a lack of support which is why there is a high turnover of staff" and "Even though I've seen some improvement recently, there is a lack of organisation." Four of the care workers we spoke with commented about the lack of communication from the office, which had led to calls not being covered and gaps in the rota.

The branch manager was in the process of implementing a programme of quality assurance throughout the service but it was still in the early stages due to her length of employment with the service. We saw that 104 telephone monitoring questionnaires had been carried out since December 2016. The branch manager told us that they were completed by the care coordinators and any changes to people's needs were recorded

onto their system. People were asked a range of questions related to the service, including the competency of care workers, timekeeping, privacy and dignity and general management of the service. The majority of questionnaires were positive and we saw evidence that where concerns had been raised, they had been followed up. One relative said, "They call all the time to ask about the carers." Comments of a less favourable nature related to timekeeping and communication with the office.

The branch manager told us that people's daily logs, medicine administration records (MARs) and financial transaction records were in the process of being returned monthly for auditing but it had not been fully implemented yet. We saw that some logs had been checked once they were returned but this was not consistent for all the records we reviewed. We saw examples where people's MAR records had been audited and where errors had been found, action had been taken and improvements were found at later audits. However monthly medicines audits were not seen for all records during the inspection. For one person who was supported with their finances, their financial transaction records had been checked up until November 2016 but nothing afterwards. For another person, there were no logs available despite them receiving care since August 2016. The branch manager acknowledged this and said it was an area that was being focussed on for improvements.

The two field care supervisors we spoke with told us about their responsibilities and that they were in the process of carrying out spot checks on staff. One field care supervisor told us they were going out more regularly to carry out spot checks and review the service. Another field care supervisor added, "When we carry out a review, it is an opportunity to carry out a monitoring questionnaire or spot check on a care worker." The branch manager said, "Moving forward, I want to do group supervisions and have regular care worker meetings. We are also looking to produce a quarterly newsletter for people and care workers." They also added that they would be implementing a monthly audit of complaints to check that pending actions had been carried out.

We saw that weekly reports were sent from the local authority highlighting the log in rates of care workers. We were able to see the last three weeks of data supplied by the local authority and the branch manager said they were working to improve the log in rate of care workers. The executive assistant told us that reminders for care workers were included on their rotas, which gave reminders about logging in and out, calling the office if they were running late and reporting any concerns. The branch manager said they were in the process of implementing what action to take if care workers continued to not log in or out when they were able to.

We saw that regular staff meetings took place, which included the care coordinators and field care supervisors and senior management meetings with the business development manager, workforce development manager and other senior members of staff. We saw areas covered included safeguarding, training and development, staff welfare, people using the service, quality monitoring and health and safety. Meetings that took place were separate for staff that covered Newham and Waltham Forest areas. One member of staff said, "We do have team meetings every two weeks to discuss the service overview and current issues. It would be good if we were able to add agenda items to the meeting though."

The provider carried out an annual survey and we looked at the findings of the service user feedback and outcome survey report for 2016. 250 surveys were sent out to people and 128 were returned. The outcome of the report was largely positive and showed that 95% of people rated their relationship with their care worker as very good or excellent, 98% of people would not want to change their care worker and overall 93% of people rated the service as very good or excellent. The survey had highlighted five areas that needed to be addressed from the findings. One of them was that support plans needed to reflect the expectations of the people and their outcomes, and we could see that the process for all care records to be reviewed was being

implemented. One member of staff said, "I can see the improvements that are taking place. The reassessment process has given us the opportunity to get to know our service users and get more person centred information." The annual care worker survey was last done in June 2016 and the branch manager told us they were planning on sending out a new one in the future.

The executive assistant told us that they had just introduced a feedback questionnaire for people about their visit from a field care supervisor. It asked to confirm if the visit took place and they could rate the visit and their current service. We saw one completed questionnaire that had been carried out the day before the inspection.

The branch manager told us how they were planning to deal with the issue of late and missed calls. At the time of the inspection, their electronic monitoring system did not generate an alert if a care worker had not logged in after a specific period of time. One care coordinator, who told us that they were responsible for about 90 people, confirmed this. They added, "When I look at the screen I check to make sure they have logged in and if not I call the staff or the family. Presently we are trying to set up an alert." The branch manager told us that alerts would be set up for all people. They also told us that they were liaising with the relevant local authorities to make sure every person had the facility for care workers to log in at the start of their call.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not do all that was practicable to mitigate any such risks. Regulation 12(1)(2)(b) The provider did not ensure that care and treatment was provided in a safe way as systems for the proper and safe management of medicines were not operated effectively. Regulation 12(1),(2)(g)

The enforcement action we took:

We served a warning notice