Avant Healthcare Services Limited

Avant (Ealing)

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

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

Avant (Ealing) provides a range of services to adults in their own home including personal care in the London Borough of Ealing. At the time of our inspection approximately 150 people were receiving personal care in their home. The care had either been funded by their local authority or people were paying for their own care.

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

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

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

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

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

Records relating to care and people using the service did not provide an accurate and complete picture of their support needs.

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

There was a process in place for the recording and investigation of incidents and accidents.

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

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

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

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

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

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

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

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

The provider had systems in place for the recording and investigation of incidents and accidents.

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

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

Is the service effective?

Requires Improvement

The service was effective.

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

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

If the person's health changed the provider would ensure the relevant healthcare professional was contacted.

Care plans identified if the person required support from the care

worker to prepare/eat meals and care workers recorded how they supported the person in the record of each visit.

Is the service caring?

Good

The service was caring.

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

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

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

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

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

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

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

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

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

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

Avant (Ealing)

Detailed findings

Background to this inspection

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

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

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

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

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager, managing director, a non-executive director and the human resources and training manager. We reviewed the care records for eight people using the service, the employment folders for five care workers, training records for all staff and records relating to the management of the service. We also contacted by telephone eight people who used the service and five relatives. We sent emails for feedback to 39 care workers and received comments from three.

Requires Improvement

Is the service safe?

Our findings

We asked people if the care workers arrived at their homes on time and if the care workers were going to arrive late if they contacted the person to let them know. The majority told us that their regular care workers were punctual, but when other care workers attended to them, they did not arrive on time. They also said they were not always informed when there were changes in their care worker. They told us "In general, yes. Twice I think [carer has been late] and once they rang to say they were running late and asked if they could come in later on, and I said that's fine. One person tried to come at 4.10pm once and I told them to go away – wasn't going to sit there in my pyjamas at that time", "Sometimes they do [arrive on time] – 8.30am or earlier. If she can't get here she lets me know and I get someone else in her place. If she gets here, she gets here", "They sometimes get delayed, yes, and they ring me if so" and "Sometimes if they're a bit late they phone; it doesn't bother me at all", "Not every time. Today she was only about an hour late"

One person told us "She comes at awkward times, sometimes. But she's very good and if she can't come she rings me and checks I'm all right." We asked the person to clarify this and they explained the care worker has to fit her visits around her children's needs.

Relatives also commented "Absolutely, although the agency was very clear that we need to allow up to 30 minutes' leeway", "[They] always ring and let me know", "Yes, never been late" and "They weren't [always on time] and I did tell them. One time they did call but normally I rang them before they had chance. "

We also asked people if the care workers who visited them stayed for the agreed length of time. People felt if their care workers finished the visit early they let them leave, some stayed for a chat and care workers made sure the person had everything they needed before they left. often stayed longer and helped them with extra tasks if asked. They told us "Yes, they always write in my log book, every one of them and someone periodically checks it", "One thing that sometimes happens is that one of them arrives after the other, so there's nothing for them to do", "Yes indeed, every single time", "Yes, about 30 minutes and they'll always make me a coffee while I finish getting dressed", "Yes; but I tell them to go if they've done their job" and "Yes, and if I've got something to chat about she'll sit down and listen for a bit." Relatives commented "No, that hasn't happened. We've been paying for an hour and [person] has been washed, dressed and given lunch within about 40 minutes" and "Yes; books in and out on the phone and completes the log."

During the inspection we reviewed the records for the electronic call monitoring system (ECMS). This system was used by care workers to record their arrival and departure time for each visit. We looked at the time sheets for all the visits completed on the 22 July 2017 and 25 July 2017. We then reviewed the timesheets for 12 care workers we had identified having a level of visits which were made earlier or later than scheduled. We saw of the 10 care workers who completed visits on 22 July 2017 four care workers had at least one occasion where a visit was scheduled without any travel time from another visit. From the 11 care workers who completed visits on 25 July 2017 we saw eight care workers had at least at least one occasion where travel time had not been identified between two visits. This meant the time they either left one visit or the time they arrived at the next visit would be affected and could impact on the care provided. The above shows that the provider had not appropriately deployed staff to ensure people received visits at the time

agreed with them and that the length of the visits was also as agreed with them.

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

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

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

During the inspection we looked at the MAR charts completed for two people who received medicines from original packaging, eye drops or had a cream applied. We saw the MAR charts for one person had not been completed once per month to indicate the medicines had been administered. This had been identified during the MAR chart audit. The MAR charts for another person indicated in March and April 2017 the supply of one medicine had run out for three days in one month and six days in the other month. The MAR chart had been originally left blank by the care workers and then completed by field based manager who had carried out the audit at a later date with the letter F to indicate the medicine was finished. The medicine was in fact out of stock and the pharmacy provided the next prescription a few days later.

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

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

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

We asked people who used the service if they felt safe from abuse or from harm when they received care in their home. They told us "Oh yes. The first thing they do is use my key safe to get in; I never have to go to the door to them", "No abuse, no. They're very gentle and I'm not afraid of them at all", "Oh yes, and they probably sense they couldn't get away with anything like that with me anyway", "Very safe, no threat whatsoever", " Yes, I feel safe", "Sometimes things go missing" and "Good Lord, no abuse." Relatives were

also asked if they felt their family member was safe when receiving care. One relative told us "Yes, definitely."

We saw the provider had effective policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. During the inspection we looked at the record for one safeguarding concern that had been raised. We saw the records included details of the concern, any correspondence, the outcome and any actions taken. Records indicated that all care workers had completed training in relation to safeguarding vulnerable adults.

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

The provider had a process in place for the reporting and investigation of incidents and accidents. The registered manager explained information about an incident or accident was recorded on the computerised system with details of what happened and what actions were taken. During the inspection the registered manager told us there had been no incidents and accidents involving people using the service so we were unable to review any records.

We saw the number of care workers required to attend each visit was identified from the referral information provided by the local authority. This was also discussed with the person using the service and relatives during the initial assessment to ensure the information was accurate. The number of care workers was also checked as part of the review of the care plans in case the person's support needs had changed.

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

During the inspection we looked at the recruitment records for five care workers and we saw all the required paperwork was in place. This meant that checks were carried out on new care workers to ensure they had the appropriate skills to provide the care required by the people using the service.

One relative told us "The care workers were not using shoe covers and gloves when showering [person]. I took it up with Avant and I'm happy now but it took a while." The provider had appropriate processes in place in relation to infection control. The care workers were provided with appropriate equipment including aprons and gloves to use when providing support. The care workers had also completed training in relation to infection control as part of their induction.

Requires Improvement

Is the service effective?

Our findings

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

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

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

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

If the person had been assessed as not having capacity there was a question identifying if a Lasting Power of Attorney (LPA) was in place. A Lasting Power of Attorney in health and care matters legally enables a relative or representative to make decisions in the person's best interest as well as sign documents such as the support plan on the person's behalf.

During the inspection we saw the records for one person indicated they had been assessed as not having capacity but did not take into account that capacity is decision specific. The care plan and other documents did not indicate how care workers should support the person in making decisions. The records showed that there was no LPA in place and the person was unable to sign the care plan due to the lack of capacity.

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

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

We asked people if they thought care workers that visited them had the appropriate training and skills to provide their care. We received a range of comments which included "Oh definitely, yes, I think this one has and the others do too. They've all got the same way of doing things if anyone else ever turns up", "They fulfil their remit okay. It would be nice if some of them could do the washing up a bit better!", "Definitely. They help me with certain things and I feel safe", "Normally they do. Sometimes my regular carer turns up with a trainee and shows them what to do" and "Oh yes, they seem to." Relatives also told us "Very good care, no problems", "Yes, we have a regular person but occasionally they have to send someone else and they're all just as good" and "Handling is okay but communication is an issue because of the language. I did ask for a [language] speaker but that hasn't happened. "

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

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

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

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

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

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

Good

Is the service caring?

Our findings

People commented to us that they felt the care workers treated them with dignity and respect when they provided care. They commented "Yes, most definitely. They shower me ... and I'm quite comfortable with that and so are they. I look forward to them coming and it's company for me", " If I'm talking away to them, they always chat with me and answer all my questions; we have a good relationship", "Yes, they're all very polite", "They always call me 'Sir' or Mr", " Yes; they're nice people" and "Oh yes; they're very good." Relatives told us "The care worker used to call her [title and name] and now uses her first name; I suppose my family member may have agreed to that" and "Exceedingly so."

We asked care workers how they helped maintained a person's privacy and dignity when they provided care. They gave a similar range of comments based upon ensuring the person was covered during personal care and maintaining confidentiality. They told us "By making sure that people have privacy when they need and want it, treating them as equals and providing any support they might need", "In many ways, allowing choice and providing client centred care, closing curtains and door while providing personal care, covering while washing or toileting, making sure people are dressed appropriately, never discuss clients in public places and data protection" and "Trying to exclude family members or others from certain processes, respecting client's privacy, doing job confidently and fast."

We asked people using the service if they felt the care workers supported them in maintaining their independence. They commented "Yes, they're very, very good. They come and help me shower or bath then tidy up the flat; I don't have to do anything", " Yes; I get up with my [family member] and wait for the carer to come. She gets everything ready for me to get dressed, washes my hair 3 times per week", "Yes, they help me keep the flat clean and tidy, do the hovering etc. But I really need someone to help with sorting things out at a deeper level – paperwork etc – and it's not really in their skill set to do that", "Oh, I've still got my independence; still do my own shopping etc.", "Yes and we have an arrangement that I can cancel either the Saturday or the Sunday so that I can go out with a friend on that day. I let them know week to week" and "Yes, they help me with a shower and with my cream [for medical condition]." We also asked relatives of people using the service if they felt their family member's independence was supported. They told us "Absolutely, she needs that support and encouragement [to have a shower] and doesn't resist because it's not someone from within the family" and "Yes, albeit very slowly [doing anything independently]." The care plans we looked at identified when the person could complete an activity independently and when a care worker needed to provide additional support.

People told us they felt care workers were kind and caring when they received support. Their comments included "They're good, most definitely. The first thing they do is say 'How are you today? What have you been doing?", "Oh yes, very kind and we have a good laugh. It's nice to have a chat; makes you feel better in the morning", "I've never had any issue, they're sort of polite, fairly 'obedient' [laughing]", "Very easy to get on with, like having your best mate round. Nothing's too much trouble", "The regular one is always friendly", "Very thoughtful in her manner. We chat" and "Some are very friendly and some are a bit quieter." Relatives also commented "[The care worker is] upbeat, bright and cheery. Lovely, but a bit brisk, and I think [person] would appreciate it if [carer] was a bit warmer" and "All very cheerful, however young they are."

In regards to whether people had the same care worker or if they regularly changed, we received a range of comments including " I have the same three or four people all the time", "I'm beginning to get to know some of them, there are four, maybe five and when I ask them to do things, they sometimes seem confused. They seem to think they're coming to give me medication but I don't have any", "I've had a lot of different carers but down to about four people now and I'm getting used to them. I have the same one morning and different ones afternoon", "I have the same carer now because I have insisted on it", "I don't have a regular person yet; I've been told I'm in a queue for one. Different people come to me every day. They've told me I can choose who I want after a bit of time and "Mainly yes, except in holiday times and things like that." We also spoke with relatives of people using the service who told us "Yes, most of the time", "Lots of different people", "Yes, we requested that because of [medical condition] and even when we 'up' the care later we want the same one and they've told us we can" and "A different one every day for a while, it was very difficult especially as [person] doesn't speak English."

We saw the care plans identified the person's cultural and religious needs as well as the name they preferred the care workers to call them by. Care workers were provided with information about the personal history for some of the people they were supporting where the information was available. This meant care workers had information so they were aware of people's cultural or religious needs that could affect the way care should be provided. We saw from the rotas that the person's preference for the gender of the care worker was respected.

Requires Improvement

Is the service responsive?

Our findings

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

The sections of the care plans related to each visits provided information which was focused on the tasks which needed to be completed during that visit. The information did not identify how the person wanted their care provided for example the care plan would say the care worker should help with personal care but did not include any specific information on how the person wanted this care provided. The registered manager told us they were providing training on producing care plans which identified people's wishes in relation to how their care should be provided.

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

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

We asked people if they were involved in the decisions regarding their care and support needs. We received a range of comments "The care company came in and the social worker and I told them [what I wanted]. I think I've had two visits to ask me if I want anything changing and if everything's all right", "Oh yes, and I do need it [support]", "Not really involved; it was more down to my social worker and I think she did well to get anything for me because of the funding situation", "It feels like it was done behind my back, but I'm quite happy now", "When I started they went through everything and there's a lot of information" and "I do. Sometimes they ask me questions about that and I tell them about the time problem." Relatives commented "I have Lasting Power of Attorney and always discuss things with [relative] and she has her say", "Yes [person] was fully involved" and "I am the main carer so I make the decisions. My [relative] wouldn't understand now."

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

The registered manager told us before the start of a new care package the person would be contacted to confirm the name of the care workers who would be visits and the time they would arrive. The person would

also be contacted by telephone after the first visit to ensure their care needs had been met or if any changes were required to the care plan.

People we spoke with told us they knew how to make a complaint. They said "If I had a problem with any of them I would just pick up the phone and tell them at the office", "Yes, I suppose I do", "It's very difficult for me to complain [because of medical condition]" and "I'd phone the office and speak to them." A relative said "I'm happy to take my complaints to the service itself, wouldn't have any hesitation."

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

We asked people using the service if the care workers completed the support tasks agreed with the service during their visit. The people we spoke with confirmed the care workers completed the tasks identified to be completed during each visit. Their comments included "Yes, in general ", "Yes and they log it in the file" and "Yes [listed these] and they record it in the log book, yes." Relatives confirmed "Yes, but in a short time" and "Yes and they fill in the record."

We asked people if they felt the information they received from the provider was clear and easy to understand. People commented "Yes, they phone me and explain things; I don't have to read anything", "Someone comes in to chat about the carer and check over the book, ask if I'm okay. I don't have any letters [from the company]", "I'm not really sure of their rotas; the care company sends me the information in emails but I don't often open them to read", "Yes" and "I don't really know. My [relative] deals with most things – finances etc." Relatives also commented "Very clear and they're very good at communicating by email – notes, invoices, any conversations you've had and agreements made over the phone are recorded", " In [home language]; I can understand, yes" and "Yes, the information came in a book I think."

Requires Improvement

Is the service well-led?

Our findings

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

The dietary requirements section for three people stated there were none but the needs assessment identified they were living with diabetes. This meant the information provided for the care workers was not consistent across the care plans.

The care plan and needs assessment document for one person stated they did not need any support in relation to continence but the care activities identified the person required support with their continence care. The mobility section of the care plan for this person stated they could walk unaided but another part of the care plan stated the person used mobility equipment to help them move and the person required supervision when walking. This indicated an inconsistency with the way information was recorded.

The records for another person stated the care workers needed to feed the person but the care plan stated there were no dietary support needs and there was no information provided to identify any specific requirements in relation to how the food should be prepared.

The assessment for another person stated they could become dizzy but this was not identified in the care plan. The moving and handling assessment for this person did not record the company responsible for the provision and maintenance of the hoist, hospital bed and wheelchair used.

The records for another person identified they were living with a specific medical condition but the referral paperwork stated they had a different medical condition which was not referred to in the care plan. This provided care workers with the incorrect medical history which may have an impact on their care.

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

The issue with the accuracy of the records meant the provider could not ensure people received the appropriate care they required.

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

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

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

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

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

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

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

We asked people if they felt the service was well-led and we received mixed comments. The majority of people had a positive experience of the service and were happy with the interaction with care workers and office staff. These comments included "Yes, definitely. No complaints at all", "Oh, definitely well-run", " Given the point that they seem to fulfil their remit, it seems well-run; they're probably doing a reasonable job", "Yes, sometimes the 'boss' comes in and discusses the paperwork and that" and "I've never liked the agency from the beginning; I found they were not very nice."

Relatives also commented "They're official procedures are very tight. Whenever I've dealt with the company they are always clear, courteous and respectful", "As regards carers coming in and doing their job, it's fine" and "Generally it's okay. We had a struggle for the first few months but okay now."

All the people we spoke with confirmed they knew who to contact at the office if they had any questions in relation to their care. People told us "I have the number handy, yes", "I can contact the office, I have the number", "I daresay it's on the log book and I should be able to contact them via email if I needed to" and "Yes, a number but no specific name, I just ring the office." Relatives commented " I have a couple of names and know the number" and "Yes [name given]; they are good and said any time I have any problems, to email them if I can't get through on the phone, and that has worked well."

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

An audit of the complaints received was completed quarterly which included any trends in the concerns received and identified any people how had made a complaint more than once and this person would then

have their care monitored more closely to prevent any reoccurrence of the issues raised.

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

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

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

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

At the time of the inspection the service had a registered manager in post.

We asked care workers if they felt supported in their role and if they felt the service was well-led. A care worker told us "Both my managers are very supportive. My managers are excellent. I feel supported and they take my view seriously. I have a very good work relationship with my managers and I feel like they listen to me. I feel I can call and report any problems without feeling intimidated."

The provider had systems in place to enable people using the service and their relatives to comment on the quality of the care they received. A questionnaire was sent to people using the service and their relatives twice a year. We saw the results of the recent questionnaires received from people using the service where 24 questionnaires had been completed. The majority of people who responded were happy with the care they received from the service.

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

A regular newsletter was sent to people using the service, their relatives and care workers which included the names of the recent care worker and office staff member of the quarter, general news relating to health and social which may affect the people using the service and other information about the service provided.

The registered manager told us they had arranged for a person using the service to take part in interview panels for new care workers. They are also considering attending a companywide meeting to feedback to staff on their experiences.

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

We asked people if they felt the information they received from the provider was clear and easy to understand. Most people we spoke with told us the information was easy to read and clear. People using the service were given a 'customer guide' which included a profile of the provider, their aims, how the care would be delivered, how to make a complaint and the standards people could expect from the service. This meant people using the service were made aware of the provider's aims, what to do in an emergency and standards of care provided as identified by the provider.

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

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

The registered manager told us there were regular meetings between senior staff and care workers to gain their feedback on their working environment and concerns they may have. Senior staff at the service attended monthly meetings to discuss how the service could be rated as Outstanding by the CQC. There were monthly meetings with all the managers and weekly meetings for field based managers and other office based staff. This meant all staff received regular updates in relation to good practice to help them provide a satisfactory standard of care and support to people who use the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not always meet their needs or reflect their preferences. Regulation 9 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care was provided in a safe way for service users. Regulation 12 (1) The registered person did not ensure the proper and safe management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have an effective system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those service) Regulation 17 (2) (a)

	The registered person did not have an effective process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. Regulation 17 (2) (b) The registered person did not have an effective system in place to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)

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