Care Quality Commission

Allfor Care Services Limited

# Allfor Care Alpha Care Recruitment West and Home Care Service Limited

## Inspection report

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27 July 2021

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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 responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Allfor Care Alpha Care Recruitment West and Home Care Service Limited is a domiciliary care agency providing personal care and support to people living in their own homes. The provider offered a service to adults with disabilities as well as children and young people with autism and/or disabilities. At the time of our inspection 77 people were using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Risk management plans had not always been developed to provide care workers with appropriate guidance on how to manage associated risks when a specific issue had been identified in relation to a person's health and wellbeing.

The provider had a process for the administration of medicines, but this was not always followed to ensure accurate information was provided and people received their medicines as intended.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Care plans did not always reflect people's support needs in a person centred way. People's communication needs were not always accurate. The end of life care wishes were not always identified for people receiving support.

The provider had developed a range of quality assurance processes but these were not always robust enough to help enable them to identify where there were issues and when improvements were required.

Safeguarding concerns were recorded but lessons learned following an investigation were not always documented. The provider had a recruitment process but appropriate references were not always requested to enable the provider to assess an applicant's previous experience and knowledge. Care workers had access to personal protective equipment and had completed infection control training.

People were supported to access healthcare and other support when required. Care plans identified people's nutritional and hydration support needs.  Care workers had completed training the provider had identified as mandatory to ensure they had the appropriate skills to meet people's care needs.

Complaints were responded to in a timely manner. Most relatives felt that the service was well run but some

felt there were issues with communication with the office staff. The provider worked in partnership with healthcare providers and local authorities to help ensure people received safe care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 29 April 2020) and there were multiple breaches of regulation.  A targeted inspection was carried out in December 2020, which also looked at the whole well-led key question. The service was not rated at this inspection but the rating for the key question of well led did improve from inadequate to requires improvement. They had also made improvements to meet breaches of regulations except for the regulation in relation to good governance. At this inspection we found the provider was still in breach in relation to good governance and was now in breach of regulations in relation to safe care and treatment, need for consent and person-centred care.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 22 July and 27 July 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key  questions of safe, effective, responsive and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained as requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for  Allfor Care Alpha Care Recruitment West and Home Care Service Limited on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, consent to care, person centred care and good governance at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not always safe.<br><br>Details are in our safe findings below. | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective.<br><br>Details are in our effective findings below | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br><br>Details are in our responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not always well-led.<br><br>Details are in our well-Led findings below. | **Requires Improvement** |

# Allfor Care Alpha Care Recruitment West and Home Care Service Limited

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience carried out telephone interviews with people receiving support and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 22 July 2021 and ended on 30 July 2021. We visited the office location on 22 July and 27 July 2021.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with the registered manager and the office manager. We received feedback from four care workers.  We reviewed a range of records which included the care plans for seven people. We looked at the records for five care workers in relation to recruitment and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
Following the inspection we spoke with one person who used the service and seven relatives about their experience of the care provided .We continued to seek clarification from the provider to validate evidence found. We looked at audits and information relating to visit times recorded on the electronic call monitoring system.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was not rated. The service was last rated following an inspection in February 2020 and was rated requires improvement. At this inspection this key question has now remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• Risk management plans had not always been developed to reflect risks associated with the care provided to people.
• The care plans for two people identified that one person had swallowing issues which required their food cut into small pieces and the second person had been identified by the speech and language team as being at risk of choking. We found both people were supported with eating during their care visits but risk management plans for choking were not in place. This meant guidance had not been provided for care workers on how the reduce identified risks.
• The care plans for two people indicated they both experienced seizures and their risk management plans stated care workers should monitor the person for signs and triggers of seizures when providing support. The risk management plans did not identify what the specific triggers and signs were for each person for their seizures. This meant care workers were not provided with adequate information to enable them to reduce identified risks.
• One person had a risk management plan for choking and indicated care workers were to help the person eat their food. The registered manager confirmed the care workers did not assist the person to eat so the risk management plan did not provide a current assessment of the persons risks based on the care they were receiving. Also care workers were not provided with accurate guidance on how to support the person in relation to the identified risk around seizures.
• The care plans for three people indicated care workers supported them to access the community. One person was supported to attend appointments and the other two people were helped to go shopping, but risk management plans had not been developed for these three people to safely access the community.
• The provider had developed COVID-19 risk management plans for people receiving support and care workers but these were not specific to the person or the care worker. The risk management plan for people receiving care detailed COVID-19 symptoms and guidance on the use of personal protective equipment (PPE) but did not identify the person's characteristics and medical conditions which increased their risk of COVID-19. The risk management plan for care workers did identify their medical conditions and characteristics which increased their risk, but there were no plans to mitigate these risks or guidance from the provider. A COVID-19 symptom tracker had been completed for care workers but this record only identified if the staff member was experiencing any symptoms on the day the form was completed. This meant the care worker risk assessment and symptom tracker did not identify any actions to mitigate risks.

The provider did not ensure risk management plans were developed to provide care workers with guidance on how to mitigate the identified risk. This placed people at risk of harm. This was a breach of regulation 12

(Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• The provider had a process for the management of medicines, but this was not always followed.
• People's care records were not always clear about whether staff or relatives supported people with their medicines. The care plan for one person indicated the relative of the person receiving support managed their medicines. However, another document stated that care workers were to ensure the person took their medicines but did not include guidance on how to do this. The lack of clarity about who was responsible for administering medicines meant we were not assured medicines were always being administered safely and as prescribed.
• In relation to another person receiving care, their medicines risk assessment and administration agreement stated that their medicines would be administered by a relative. We reviewed MAR charts that had been completed since January 2021 which indicated that care workers had administered the person's medicines in the morning for the majority of days each month.
• In relation to these two examples, the information provided in relation to the administration of the person's medicines was not accurate which meant the provider could not ensure these were administered as prescribed in a safe manner.
• Where a person was prescribed a medicine to be administered as and when required (PRN) there was no guidance for care workers to assist them to identify when the medicine should be given.

We found no evidence that people had been harmed however, the provider did not ensure systems were in place to ensure medicines were administered as prescribed and in a safe manner. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe when they received care in their home. Relatives also confirmed that they felt their family members were safe during care visits with comments including, "The carer is very good. Sometimes it's a different carer who's fine too" and "They look after my family member. They hold my relative's hand when they go out."
• We saw the safeguarding records for the service, and we found that concerns had been recorded on a complaints form. The registered manager confirmed there was a safeguarding record form but the most recent example of its use was from a concern in 2018. In the case of one safeguarding concern we found that the provider had recorded what action they had taken but had not identified any lessons learned or preventative measures. This meant they might not be able to prevent the issue from reoccurring. We discussed this with the registered manager, and they agreed that the lessons learned would be identified for safeguarding concerns.

Staffing and recruitment
• The provider had a recruitment process in place but on some occasions appropriate employment references were not always requested. We reviewed the employment records for five care workers, and we saw that one care worker had previously been employed by two other care providers. We found references had not been obtained from the care providers but from employers from outside of social care. This meant the provider could not assess the applicants previous experience of providing social care. We discussed this with the registered manager and confirmed the importance of accessing applicants' skills and knowledge and they would request references from any social care providers that had employed the applicant.
• The recruitment records included records of new care workers shadowing experienced care workers, completed criminal record checks, proof of identity and evidence the applicant had the right to work in the UK.

- We asked people and their relatives if the care workers arrived at the agreed time and stayed for the full visit. A person receiving care said, "They just come. They arrive on time but that is depending on the London traffic." Relatives told us, in general care workers arrived at the agreed time with one relative commenting, "They arrive on time. Sometimes they are a few minutes late. When the bus is late, they'd send a message."
- People and relatives also confirmed care workers stayed for the agreed length of time of the visits.

Preventing and controlling infection
- People we spoke with confirmed that care workers wore face masks and gloves. Care workers confirmed they had enough supplies of personal protective equipment (PPE) and had completed infection control training with one care worker commenting, "The field supervisor supplies us in the field regularly and I collect some when I visit any of the branches."
- The registered manager confirmed PPE was either sent to people's homes to be used during visits or could be collected from the office. We saw adequate supplies of PPE in the office.

Learning lessons when things go wrong
- The provider had a process for the recording of incidents and accidents but the lessons that had been learned following the incident were not always recorded. We saw the incident and accident forms included information on what happened, the actions taken and any comments from care workers but did not include any lessons which had been learned from an investigation to reduce future risks. We discussed this with the registered manager and they confirmed the lessons learned would be recorded.
- Where an incident report involved a local authority, we did see an email to the local authority which included what lessons had been identified and how they would implement any actions to mitigate risks.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was not rated. The service was last rated following an inspection in February 2020 and was rated requires improvement. At this inspection this key question has now remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

• The provider had a process for the assessment of a person's ability to consent to their care but this was not always followed.
• The mental capacity assessment in relation to personal care and shopping for one person indicated they were unable to retain information, use the information to make a decision and communicate their decision. This indicated the person was unable to make decisions in relation to these aspects of their care, but the assessment then stated the person had capacity. The person's care plan also stated the person had capacity which was confirmed by the registered manager. The meant the mental capacity assessment process had not been completed in line with the principles of the MCA to ensure the person's right to make decisions about their care were always respected or that they received care in the least restrictive way possible.
• This person also had bed rails in use but there was no mental capacity assessment and best interest decision in relation to their use. There was also no record of the person consenting to their use which meant the provider could not ensure the person had consented or that the use of the bed rails was the least restrictive option.
• The mental capacity assessment for another person indicated they did not have the capacity to consent to their care in relation to personal care, domestic support and shopping. However, they had signed a form stating they consented to their care plan which included these three aspects of care. The registered manager confirmed the person had capacity to consent to their care but their family was involved in making these decisions. This conflicting information meant that there were risks that people's rights to make

decisions about their care were always  respected
•In relation to this person we also saw a best interest decision form had been completed in relation to personal care, prompting medicines and support with meals which had been signed by one of the registered managers and stated that care should be provided in the person's best interest. There was no indication to show the person's relatives, which the care plan indicated had the Lasting Power of Attorney (LPA) for health and welfare, had been involved in the best interests decision making process. An LPA can be issued in relation to either financial matters or health and wellbeing and legally enables a relative or representative to make decisions in the person's best interests in the particular area where the LPA has been issued. This meant there were risks that  the person was not being supported with decision making in an appropriate manner and in line with the MCA.

We found no evidence that people had been harmed however, the provider did not ensure people were supported to make decisions about their care in line with the principles of the MCA. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• Care plans identified people's nutrition and hydration support needs. Relatives confirmed that, if required, care workers either went shopping for their family member and prepared meals or they heated up meals provided by the person's family.
• Care plans included a section on nutrition and hydration which identified if the person required support in relation to preparing meals, eating meals or if they needed any specific equipment such as adapted cutlery.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's care and support needs were assessed before the care package started. The provider used information provided by the local authority in addition to information obtained from an assessment of the person and input from their relatives.
• The initial needs assessment identified the person's support needs in relation to personal care, nutrition, mobility, social isolation and communication.

Staff support: induction, training, skills and experience
• People and relatives told us they felt care workers had received appropriate training to provide the support their family member required. Their comments included, "Yes, I think so because they have to feel their way how to handle things.  They couldn't do much better.  He needs to be hoisted.  They are skilled at using the hoist", "This second carer told me he knows how to deal with autism" and "As far as I'm aware, they've had training for my family member's epilepsy."
• We saw the induction and training records for all the care workers.  It demonstrated they had all completed an induction programme when they started their employment and the majority of care workers had completed the training identified as mandatory by the provider.
• The training records showed that some of the care workers had completed PEG training to meet the needs of the people they supported. A PEG (Percutaneous Endoscopic Gastrostomy) is a way of introducing food, fluids and medicines directly into the stomach through a thin tube that has been passed surgically through the skin and into the stomach.
• Care workers completed a supervision agreement with the provider which confirmed they should receive six supervision meetings per year. The records showed that the majority of care workers completed regular supervision and spot checks.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other

agencies to provide consistent, effective, timely care
• People were supported to access support from other organisations including healthcare.  One relative told us, "The occupational therapist and physiotherapist come around. I asked them to show the carers how to use the sliding sheets. The district nurse told them how to use certain things. I gave them the doctor's number in case it's needed."
• Care plans identified the professionals who were involved in the wider care and support of the person which enabled the provider to provide updates and request additional support when required. These included the social worker, GP, community support and any other clinicians.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was not rated. The service was last rated following an inspection in February 2020 and was rated requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs; End of life care and support

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• The provider carried out an assessment of a person's communication needs based upon the accessible information standard. This identified if the person was living with a hearing or visual impairment, had difficulty communicating verbally or if they used sign language or lipreading. The assessment also identified the best way to send the person information including easy read or large print text.
• We reviewed the accessible information assessments for three people which indicated each person required information provided in large print and in an easy read format. We looked at the needs assessments and care plans for these three people which did indicate they required information provided in this format. The documents for each person including their care plans had not been produced in an easy read or large print. We asked the registered manager if these people required documents in the identified formats and they confirmed they did not. This meant the assessible information standard assessment did not reflect the person's need in relation to the provision of information.
• The provider had developed an easy read version of how to make a complaint which was included with the care plan. The copies of the guide we saw were not clearly printed and the pictures used were not easy to see and were not standard easy read pictures. This meant the person may not be able to read or understand the guidance provided.
•Care plans were not always written in a person centred way and did not always accurately described people's needs. The care plan for one person indicated that care workers should support them to eat their meals, but the registered manager confirmed that the person was not supported by care workers with this activity, and a family member assisted them. Therefore, the care plan did not reflect the person's current care needs and provide accurate guidance for care workers.
• We reviewed the care plan for one person, which was in an easy read format, that did not provide care workers information on how care would be provided to meet the person's preferences. In the section related to personal care the care plan stated that the person's relative and the care worker should provide support but there was no guidance as to how that care should be provided to ensure the person was comfortable with the care.
• The care plan for one person indicated the person was living with a learning disability but the local

authority referral did not identify that this was the case. The care plan did not provide consistent, accurate information on the person's support needs as it stated they did not exhibit any memory problems but then stated they frequently forgot who was visiting and became confused.  Care workers were provided guidance on how to support the person in relation to their memory. We asked the registered manager if the person was living with a learning disability and they confirmed they were not. Therefore, the information in the care plan did not accurately reflect the person's current support needs.
• People's care plans did not always provide information on their wishes in relation to end of life care. Where the section in the care plan for end of life care wishes had been completed it did not contain any information on the person's wishes or preferences. We saw the information which was provided related to gaining the person's consent to any care to be provided but did not reflect any information that related to the person. Therefore, this meant care workers were not provided with information on how to provide the support the person wants.

The provider did not ensure that care plans were always written in a person centred way and reflected the person's care needs and wishes as well as their communication support needs. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We reviewed one persons' folder which included guidance on their communications needs and identified they used Makaton and sign language to communicate so staff had clear information about how they communicated. Their care plan was also in an easy read format.
• Relatives told us they felt the care workers carried out the tasks identified for each visit to meet the person's care and support needs. Their comments included, "I ask them to do certain activities and they do writing in books (copying text) and reading to my relatives. My relative would choose the book.  They do the activities before my family member gets tired.  They then take them to the garden.  My relative would show what they like to do" and "The carers talk to [family member] and describe what they're doing and repeat themselves a lot and my relative acknowledges what they're saying.  They'd say, 'Do you remember…?' and refresh my family member's memory a lot.  They understand my relative and [my relative] understands them."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were supported to maintain relationships and access the community to prevent social isolation. The care plans identified who was important to the person as well as if they lived with anyone.
• People's care plans identified if they took part in activities in the community and if they required care workers to provide support to access these activities.

Improving care quality in response to complaints or concerns
• The provider had a process for people to raise complaints or concerns relating to the care provided.
• People receiving support and relatives confirmed they knew how to make a complaint. One relative said, "The manager came to us and told us how to make a complaint." Where relatives told us, they had previously made complaint they confirmed their concerns were responded to and they were happy with the outcome.
• We reviewed four complaints records which included the details of any investigation which was carried out, actions identified and if the person who raised the complaint was satisfied with the outcome.
• We did note that any lessons learned from the investigation were not recorded on the complaint form, but we reviewed the quarterly audit for January to March 2021 and this identified lessons learned.

Requires Improvement

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.
At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.
At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

At our last inspection the provider had failed to effectively operate systems and processes to monitor and improve the quality of the service and mitigate risks. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider did not always have robust quality assurance processes and issues identified at previous inspection had not been resolved. The service has been rated as requires improvement on the last two rated inspection which occurred in January 2019 and February 2020. The provider had not always maintained improvements where concerns had been identified following an inspection and where they had implemented changes these had not been sustained as similar issues were identified at each inspection.
• The daily records of care which were completed by the care worker for each visit were audited each month, but these checks were not always robust enough to identify any issues with the way care was provided. For example, the daily records which included a MAR for one person indicated the care worker had administered medicines on 19 days during March 2021 which was not part of the care plan. The audit of the daily records did not identify that the medicines administered were not part of the care plan. This meant the audit was not adequate to identify where care provided did not reflect the person's care plan.
• The provider carried out an audit of the care and support plans, but we identified these did not reflect the issues we identified during the inspection. For example, the audit forms included a question asking if all risk assessments and risk management plans were in place. The audits that had been completed for people we identified as not having specific risk management plans developed, stated all risk assessment were in place. Therefore, the audit was not robust enough to provide direction when information required updating.
• The provider did not always ensure people's identified risks in relation to their health and wellbeing were managed and mitigated. We found there were still a range of issues in relation to risk which included a lack of effective risk management plans.
• Quality assurance checks were carried out each month on the MAR charts completed by the care workers, but these checks did not identify when care workers were not administering medicines in line with the care

plan. This meant the care workers were not provided with adequate information to help ensure the person was being supported in a safe and appropriate manner.
• The provider did not have a robust system to ensure care visits occurred at the planned time and according to people's preferences. During the inspection we reviewed the records for the visits carried out by care workers which occurred in June 2021 which included the planned start time and the actual time the care workers arrived at the person's home. We identified a number of visits to different people which started up to an hour later than the planned start time. The registered manager explained the electronic call monitoring system (ECMS) was checked and if a visit was not carried out as planned, they would contact the care worker for the reason but the regular visits we found which were over an hour late had not been identified by the provider's monitoring system . We reviewed two weeks of visit records for all the people receiving support and we gave a list of visits to the registered manager to provide information on the reason why the visits were not as planned. While the registered manager was able to explain some of the reasons for care workers not completing the care calls as planned, at the time of the inspection the provider was unable to demonstrate they had reviewed the ECMS regularly for calls which did not occur as planned and identified the reason for this. Therefore they had not been able to take action in real time to resolve any issues to ensure the person's care was provided to reflect their preferences.
• We saw that the records for one person indicated that their visit times had been altered but the information on the call monitoring system did not reflect the changes. In relation to two other people, the registered manager explained there was an issue with the agreed arrival time which resulted in the visit regularly starting later than scheduled, but action had not been taken to review the reason for the delays and discuss changing the visit time with the person so that it could occur as planned. This meant the checks on the late visits had not resulted in action being taken to assist care workers to arrive as planned and ensure people's preferences could be met.

The provider had not ensured quality assurance checks were robust enough to help them identify where information was not accurate, and improvements were needed. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Quarterly spot checks were carried out with people receiving support to monitor the quality of the care being provided. The feedback from these spot checks was reviewed and there was a summary and any identified actions resulting from the checks. One relative said, "They call me asking me if I'm O.K., is the carer coming on time and is the carer O.K.? I don't call them because I have nothing to say. If my relative is happy, I'm happy."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• We received a range of comments from relatives which reflected that some relatives were happy with the service whist others felt there was an issue with communication. Two relatives commented, "The office is not very good. I need to call them three or four times for one request. People at reception are not good. They say: 'It's not on the system. We'll call you back', but they don't call back. I have to schedule one or two days. They should let me know the carers beforehand. The office work is not good" and "The care is really good, but the company's communication is not great. I misplaced his care book a few months ago. I am still waiting for them to get back to me about replacing his care book." Other relatives provided positive feedback about the service which included, "The service is well organised. They give me a call how I'm getting on, how my relative is getting on, how the carers are getting on" and "They couldn't do much different."
• People receiving care and relatives felt the care workers provided care in a person centred way which respected the person's privacy and dignity and was provided in a kind and caring manner. Their feedback included, "I'm lucky I have the carer we have. They understand my relative's needs. The carers are brilliant.

There are no issues.  It's smooth sailing.  Everything is straight forward" and "The care worker is really good for my relative.  He talks to him.  My relative listens to him more than he listens to us.  He is more patient than us.  Our relative gets more attention from the care worker.  They play football together. He's calmer than before. The care worker's got the knowledge and understands my relative's needs.  He's doing the job."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• People and relatives we spoke with confirmed they knew how to contact the office if they had any concerns. Their comments included, "I have a phone number and the manager's.  I would contact the main office.  They answer me straight away" and "I do have telephone numbers.  Normally I talk to someone.  They ask me how I am feeling if I'm not happy."
• Relatives confirmed information they received was clear and easy to understand with one telling us, "The information is clear.  I wear a hearing aid. If I don't hear something clearly, they would repeat it for me."
• The provider had a process to respond to complaints and concerns in a timely manner and any lessons learned were identified in the quarterly audits.  The complaints records included any investigation and correspondence with the person who raised the complaint with the outcome. The registered manager demonstrated a clear understanding of the importance to keeping people informed of the progress and outcome of any complaint.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Staff had clearly defined roles and responsibilities within the organisation.
• The registered manager told us they had a good understanding of their responsibilities as the registered manager for the service. They said they were responsible for overseeing what is done in the office, monitoring the care packages and visiting people in their homes to confirm the care meets their needs.
• Care workers had regular contact with the office. The registered manager explained they had regular contact with care workers using WhatsApp to remind them of their responsibilities in relation to their role. For example, messages included information on the use of PPE, what to do in case of an emergency in a person's home, hot weather and hydration guidance and the appropriate completion of records.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• We asked the registered manager how they supported people's cultural characteristics when planning and providing care. They told us they tried to match the care worker to a person with a similar cultural background. The care plans included information on the person's cultural background and religious preferences including language and food.
• The registered manager explained their office based staff spoke a range of languages to support people who contacted the office and make communication easier.
• People we spoke with confirmed they were involved in the planning of their care and they told us, "They ask me what I need and I tell them." Relatives also confirmed they had been involved in planning their family member's care with comments with included, "I'm involved in all his care.  All the professionals call me" and "I explained exactly how I wanted the care to be for [my family member]. The two now are perfect for my relative.  It's like trial and error until they find someone right."

Working in partnership with others

• The provider worked closely with other organisations. The registered manager confirmed thy attended two local authority provider forums for regular updates on each area and accessed the support provided. They also worked with the behavioural support teams, phycologists, GP, occupational therapist and social

workers.

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<br><br>The provider did not always ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences.<br><br>Regulation 9 (1) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider did not act in accordance with the Mental Capacity Act 2005 as they did not always ensure service users' mental capacity was assessed and recorded where they were unable to give consent.<br><br>Regulation 11(1) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not ensure care and treatment was always provided in a safe way for service users.<br><br>The risk to the health and safety of service users of receiving care and treatment was not always assessed and they did not do all that was reasonably practicable to mitigate any such risks. |

The provider did not always ensure the proper and safe management of medicines.

Regulation 12 (1)

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 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity<br><br>The provider did not have robust arrangements to assess risks to the health and safety of services users and do all that was reasonably practicable to mitigate any such risks.<br><br>Regulation 17 (1) |

**The enforcement action we took:**

We have issued a Warning Notice requiring the provider to comply with Regulation 17 by 20 November 2021.