Allcare Community Care Services Trafford Limited

# Allcare Community Care Services

## Inspection report

Business Centre High Street East
Wallsend
Tyne And Wear
NE28 7AT

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This comprehensive inspection took place on 2, 3 and 4 May 2018. This service is a domiciliary care agency based in North Tyneside. It provided personal care to people living in their own homes throughout North Tyneside, Newcastle and Gateshead. Services were provided to adults with a range of health and social care needs, predominantly older adults and end of life care. At the time of our inspection there were approximately 65 people receiving a service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

This was the first inspection of the service. The inspection was prompted in part by intelligence we had received from the police and a whistle blower. We made the decision not to announce the inspection due to the potential level of risk involved.

There was no registered manager in post. The operations director was referred to by staff and people who used the service as 'the manager.' The nominated individual for the provider organisation was preparing to apply to become the registered manager. A nominated individual is a 'registered person' with CQC. They can also be the registered manager where services are small but it is not usual practice. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The operations director and the nominated individual told us that quality assurance and monitoring

systems were in place. During the inspection, we did not find adequate evidence to corroborate that checks on the quality and safety of the service had consistently taken place or that they were completed robustly enough to identify the issues we highlighted during this inspection.

Record keeping was poor throughout the service. We found there was a lack of accurate and thorough details recorded which meant we could not ascertain if issues had been correctly identified and followed up properly with the necessary action. We found multiple incidents had not been fully investigated, escalated or reported to the relevant external authorities as required.

Accidents and incidents, some of which were of a safeguarding nature had been identified by staff and recorded on a central system, however they had not been considered by the provider as reportable events and therefore people had been placed at risk because proper safeguarding procedures were not followed. Deaths and more serious incidents which are required by law to be notified to CQC were also not reported. Furthermore, due to poor record keeping and auditing, incidents were not properly monitored to look for trends or to reduce the risk of similar occurrences.

Assessments were not always carried out for all risks which people faced in their daily lives. Risk assessments did not contain comprehensive information about the risks or explain what action staff should take to reduce risks. We also found examples of individual people's homes which did not have a support plan in place for staff to refer to whilst visiting people. This meant people were at risk of harm through not receiving the appropriate care and support.

People told us they received their medicines safely and when they expected it. However, we found there were gaps in staff training around medicines and no practical competency checks had been carried out to ensure staff remained competent to manage people's medicines safely.

Staff training was overdue for some staff and refresher courses in other key topics had not been routinely carried out. Staff who should have completed a robust induction programme, such as the 'Care Certificate' had not achieved this. This demonstrated that the provider had not assured themselves that people were supported by staff who had the skills and competence to provide safe care. In addition, multiple staff supervisions were overdue. This meant that staff had not been formally supported in their role or given a formal opportunity to talk about their issues, learning needs or any plans for development.

Complaints were not managed in line with the provider's complaints policy. Although some complaints had been briefly recorded on the central system, they were not properly investigated and detailed investigation notes were not made. We found that the procedures were inconsistently followed meaning some complainants were not aware if their complaint was being addressed or if there had been an outcome. We also found that complaints were not responded to in a timely manner and they had not been monitored to identify any trends.

Staff were not safely recruited. We found 17 staff files which contained references from inappropriate people or no references at all. Some staff had disclosed information on their DBS check in relation to previous cautions or convictions and no risk assessments were completed to show this had been investigated or control measures had been put in place to reduce any potential risks to people.

Staff felt there were enough of them employed at the service to look after people safely and to meet their needs. People said the staff did not rush them. Most people also told us that overall, they had regular care workers who were reliable and punctual.

People told us they felt safe with the care staff who visited them. Most relatives confirmed this. Most staff had been initially trained in the safeguarding of vulnerable adults and those we spoke with were able to demonstrate their responsibilities with regards to protecting people from harm. However, most staff were overdue a refresher course. Policies and procedures were in place to support staff with the delivery of the service, although we found that office staff did not always work in line with company policies.

People told us their care workers used personal protective equipment. This was to protect people from the risks of infection and cross contamination as staff sometimes visited multiple people in one day.

People and relatives told us their care workers treated them with dignity and respect. They said staff displayed kind and caring attitudes. Everyone we spoke with said the staff were friendly and nice to them and were there had been minor issues, the office staff had dealt with it.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We found care plans contained some individual specific information, however the information we reviewed for six people was mostly generic without in-depth person-centred details. The documentation focussed on tasks rather than on how people preferred their care to be delivered.

Care workers encouraged people to maintain a healthy and balanced diet. People told us their care workers made meals of their choice in line with their likes and dislikes and respected their preferences. External health professionals were involved with people's care needs to ensure their ongoing well-being.

We have identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Thorough and robust risk assessments were not in place to address people's needs and reduce the risk of harm.

Incidents of a safeguarding nature were not properly investigated and dealt with in line with company procedures and external agency expectations.

Staff recruitment was not safe because the recruitment process was not robust.

Policies and procedures in place were not always followed to ensure the service was safe.

### Is the service effective?

**Inadequate**

The service was not effective.

New staff had not completed a robust induction programme and existing staff were not kept up to date with training.

Staff supervisions were not routinely carried out and many staff had not received any formal support for months. Staff competency checks were not formally carried out.

People did not always experience a positive outcome from the support they received.

People were supported with meals and drinks and were given choices.

### Is the service caring?

**Requires Improvement**

The service was not entirely caring.

The provider did not enable staff to provide a holistic service due to the shortfalls in the service.

People and their relatives told us they had not been asked to

provide information about their likes and dislikes.

People told us staff were nice to them and treated them with respect.

People said their privacy and dignity was protected.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Complaints were not managed in line with the provider's policy which meant complaints had not been dealt with properly.

End of life care plans were not routinely in place and staff had not received training in this aspect of care.

Care plans were generic and contained little person-centred information.

People told us the service was responsive with regards to flexibility, punctuality and providing information.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The service has breached multiple regulations and areas of the service have failed to appropriately meet people's needs in a safe, effective and responsive manner.

Audit and governance systems were ineffective.

Record keeping was poor.

The provider had inadequate oversight of the service and there was no registered manager in place.

# Allcare Community Care Services

**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 site visits took place on 2 and 3 May 2018. Our arrival on 2 May was unannounced. The inspection consisted of two adult social care inspectors, an assistant inspector and one expert by experience. The assistant inspector conducted telephone interviews with staff and the expert by experience contacted people who used the service and relatives with advanced permission on 4 May 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This inspection was prompted in part by information shared with us from the police about an ongoing investigation. The Care Quality Commission (CQC) was made aware of past injuries sustained by a person who used this service which is why we explored particular aspects of current care and treatment during the inspection.

Prior to the inspection we reviewed all the information we held about Allcare Community Care Services, including any statutory notifications that the provider had sent us and any safeguarding and whistle blowing information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of deaths or incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

Additionally, we liaised with three local authority contracts monitoring and safeguarding adults teams and two local NHS Clinical Commissioning Groups (CCG) to gather their feedback about the service.

During the inspection we spoke with five people who used the service and four relatives to gain their opinion. We spoke with staff, including the nominated individual, the operations director, care coordinators, the recruitment manager and six care workers.

We reviewed care and management records related to the quality and safety of the service. This included looking at six people's care records. We checked 40 staff files which included recruitment and training information.

After the inspection we invited the office staff to provide us with their feedback in confidence via email.

Inadequate

# Is the service safe?

## Our findings

During the inspection we found that accurate, completed and robust risk assessments were not in place for all people who used the service. This meant people were placed at serious risk of harm.

One person did not have a detailed record of all the risks they faced, such as diabetes, mobility, medicines, falls, catheter care, stoma care, skin breakdown, choking and weight loss. There was limited information recorded about the risks which the office staff had identified such as mobility, medicines and stoma care but these did not contain enough detailed information for care staff and there were little or no control measures in place for all risks. Furthermore, we found that information was not available in the person's home for care staff to refer to, such as a comprehensive support plan.

A second person did not have a detailed record of all the risks they faced, such as diabetes, use of oxygen, falls, continence management, aspirational pneumonia, choking and medicines. We found there were no risk assessments at all in this person's care record. A third person's care records also contained no risk assessments and they were at risk of issues associated with Chronic Obstructive Pulmonary Disease (COPD), stoke and falls. This meant that people were at risk of not receiving safe care and treatment because information was not always available to staff.

Incidents which affected the health, safety and welfare of people who used the service were not always reported to external bodies as required. We found multiple incidents which has not been referred to the appropriate local authority safeguarding teams or the CQC as necessary. The operations director gave us a brief explanation as to the outcome of most of the incidents which appeared to be minor, however the local authority procedures includes low level incidents. No records had been made of investigations or outcomes to clarify the level of seriousness. We shared this information with the local authorities for their monitoring purposes.

A more serious issue involving an allegation of neglect had not been properly investigated or reported to the Commission as legally required. No records were made to show that a thorough and robust investigation had been carried out with all care workers who attended to personal care during the 10-day period identified, what action had been taken and if any lessons had been learned. This meant that staff who may have delivered unsafe care had not been dealt with appropriately. We are continuing to deal with this incident outside of the inspection process.

We found staff training was not up to date and staff had not always completed training in topics which would be relevant to the needs of the people they cared for. For example, end of life care, catheter care, diabetes management and nutrition/choking awareness. This demonstrated that people were being cared for by staff who did not have the skills and competence to deliver safe care and treatment.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Safe care and treatment.

The staff files we examined contained references which had been completed by members of the current office team. Some of which were the only reference obtained. Other staff had no references acquired at all. This meant that appropriate and robust recruitment checks had not been carried out to ensure the suitability of staff.

We found staff who had positive disclosures on their Disclosure and Barring Check (DBS) with cautions or convictions had not been subjected to a robust risk assessment to ensure their suitability to work with vulnerable people. For example, disclosures included, fraud, being drunk & disorderly in a public place, driving whilst disqualified, drink driving and failing to stop. DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role. We considered that the provider had not made every reasonable effort to gather information about potential employees to ensure they were of good character.

The operations director appeared to be running the branch on a daily basis. Everyone we spoke with during the inspection, including staff, people and relatives referred to the operations director as 'the manager'. This demonstrated that they were known to everyone in that role and as a person who carried out tasks which would normally be the responsibility of the registered manager.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Fit and proper persons employed.

There was a recruitment policy in place. Staff had completed an application form, attended an interview, been asked to supply references and had external checks by the DBS carried out. However, we found in some cases the recruitment manager was the interviewer, the appointing officer and had supplied a reference for the candidate as they'd known them from previous employment. This is not in line with best practice as it does not give an objective view of the candidate's suitability for the role. The nominated individual told us they would ensure new impartial references were obtained for all staff where necessary.

We reviewed care workers' rotas at random for the past four weeks and they showed that care staff had appropriate hours and suitable breaks. There were no visits overlapping on the rotas which implied that staff had enough time to get from one visit to the next. People told us they didn't feel rushed and that their care workers had enough time to complete all the tasks they required assistance with. However, the information we received prior to the inspection and some feedback from staff indicated that staff were working excessive hours and visits were crammed into rotas. We were told visits were verbally added to care staff's rotas when other staff were off sick and that office staff quite frequently covered care visits outside of their working day in the office to ensure a visit was made because there were not enough care workers employed to cover the amount of work taken on.

People and relatives had mixed opinions about the staffing levels. Some comments included, "They keep chopping and changing" and, "Sometimes they are short of staff." Whilst others told us, "We have regular staff, one lot one week and one lot the next" and, "The three regular ones (care workers) are excellent."

The operations director told us the provider had planned to implement electronic call monitoring soon to enable the office staff to improve the quality of the service and ensure no visits were missed. There was currently no system in place to prevent a missed visit and they relied upon people contacting the office if no care worker turned up. The operations manager told us they had never missed a visit. However, we found information recorded by office staff in 'out of hours' records which indicated three calls had been missed. There was no follow up information recorded so we could not see what investigations or actions (if any) had been taken. For example, one person went without an overnight service from 10PM until 5AM when a relief

care worker could be allocated at short notice. Furthermore, feedback we received from social workers indicated that relatives had complained to them about missed visits.

A 'missing person' policy was in place. Staff had specific procedures to follow if a person was not at home when their care worker was expected to arrive. We saw in 'out of hours' records that these procedures had been followed and all efforts had been made to attempt to find the person or inform their family. However, one relative said those procedures had not always been followed in their experience.

People and most relatives told us that they felt safe with the care staff who visited them. One person said, "I feel safe, they come by my bedside when I get up." Another person said, "I get my rota, it tells me who is coming." One relative told us, "It's a very safe service." However, one person said, "Some of the girls (care workers) have long painted nails, I have to remind them to put on gloves. I am afraid they will scratch my skin."

Two social workers told us they were currently working with two families who had concerns about the service. One commented that a relative told them that they were concerned that the issues raised possible safeguarding and risk management issues. The other said, "(The relative) has concerns about the care her mother is receiving from this provider." A senior social worker told us a safeguarding strategy meeting would be held with the provider and the family to consider these issues.

Care workers used specialist equipment to move and position people. This included hoists, slings and standing aids. Staff told us they would report anything that appeared unsafe to the office. They also told us they looked out for other risks which may arise in people's homes such as new pets and loose flooring. This meant care workers were aware of new risks which could arise within people's homes and they acted to avoid harm.

A lot of the care packages provided to people included end of life care and therefore district nurses and the palliative care team worked alongside care workers to manage people's medicines. Where appropriate care staff 'prompted' people to take their medicines and we saw that paperwork was completed by staff to show what support had been given. Medicine administration records (MARs) were in place and those we reviewed were accurate and up to date with no unexplained gaps in the recording.

A policy was in place to protect people from the risks of infection and cross contamination. Care workers wore a uniform and used personal protective equipment (PPE) such as disposable gloves, aprons and hand sanitising gel to reduce the possibility of spreading germs. The people we spoke with confirmed this.

Inadequate

# Is the service effective?

## Our findings

The Care Quality Commission (CQC) expect providers to introduce the 'Care Certificate' for new staff employed after 1st April 2015. The Care Certificate is a benchmark for induction of staff who are new to the care industry. The guidelines suggest the Care Certificate is completed within the first 12 weeks of employment. Whilst it is not mandatory, providers should be able to demonstrate that staff are competent in the 15 standards within this timeframe.

At the inspection, despite being told that all eligible staff had completed a robust induction process, we were not given any evidence to corroborate this. There were no records to show that new staff had completed a robust induction. The service's training matrix did not include figures about induction which meant we were unable to establish which staff were required to complete it. One care worker had a care certificate in their personnel file but no supporting evidence whilst another care worker only had training awareness certificates from 2015 whilst employed elsewhere. Within all the staff files we looked at, we found no information to demonstrate that staff had undertaken all 15 standards, completed theory and practical assessments and been signed off as competent by a qualified trainer and a registered person as legally required under the Care Act 2014. After the inspection, the nominated individual sent us records of 'safe to start' forms which showed that staff had been signed off to safe to start working by the office staff.

The service's training matrix showed gaps in care workers skills regarding health and safety, infection control, nutrition and hydration, dementia awareness and end of life care. Furthermore, we found most staff were overdue safeguarding training and many staff were overdue a moving and handling refresher course. The operations director told us the matrix had not been kept up to date, however there was no corresponding information in staff personnel files to corroborate that this training had taken place. This showed that staff had not been supported to participate in training which would be beneficial to them in their role to meet the needs of the people they cared for. After the inspection, the nominated individual sent us an updated training matrix which showed staff were booked onto safeguarding and end of life care training sessions.

We asked to review staff competency checks in tasks such as medicine administration and moving and handling. We were told this was reviewed by the office staff during spot checks. The spot check forms given to us did not contain any information about the competency of staff around an observation of practical tasks such as administering medicines or using manual handling equipment. This meant the provider was unable to demonstrate assurance that people were protected from the risks of receiving care from staff who were not fully trained, competent or supported to deliver safe care and treatment.

Spot checks were carried out with staff on an unannounced basis. The form prompted office staff to check matters such as punctuality, appearance, uniform, ID and the use of PPE.

Whilst reviewing staff personnel files we found there were no records of supervisions in the section labelled as 'supervisions' in the contents. We asked the operations director for examples of staff supervisions to demonstrate staff were supported in their role but these were not made available to us. On the second day

of inspection, we were given 26 staff supervisions which were dated between January and March 2018. We contacted three care workers who had a supervision record and asked them to confirm these meetings had taken place. One care worker told us they had never had a formal supervision session since starting work eight months ago, another said they had had a supervision but could not remember when it was and a third told us they had just had a supervision the day before. This meant we were unable to corroborate that the supervision sessions had taken place and if so that they were a supportive process which staff would benefit from.

There was no tracker in place to centrally record when staff had received a supervision or when their next one was due. The provider's policy stated that supervisions should be held three monthly on a planned basis in an environment that is confidential. We considered that staff supervisions had not been appropriately planned or consistently conducted with staff. Those which were conducted had not been a meaningful experience for the staff to ensure they were supported in their role and to ensure they remained competent. The poor quality of staff supervision demonstrated that any training, learning or development needs had not been formally identified, planned for or supported.

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

Most people and relatives thought the staff were trained but on occasions did raise some concerns with us. One person said, "Yes they are trained, the only thing is, I have oxygen bottles and a couple of the girls (care workers) don't know how to use them, they should be shown." Another person said, "I think they are trained." A third person said, "Yes, they are trained, I have a nebulizer and oxygen." A relative said, "Yes they are trained and knowledgeable which was very reassuring in the early stages (of the service)." However, one person said, "I think they are frightened to touch us, I told one young girl (care worker) that I needed to have cream on my bottom and she just said, "I'm away.""

One relative told us, "My [relative] has a specialist pump for people with Parkinson's, I've shown the carers how to use it." We found no information in staff files or on the service's training matrix to confirm staff had been appropriately trained to use this individual piece of specialist equipment by a trained and competent professional. Other relatives we spoke with thought improvements could be made. Their comments indicated that more training was needed in dementia, general personal care and oxygen therapy.

The staff we spoke with were not comprehensive in their responses to our questions about their training and development. They did not indicate that they had completed either the care certificate or a similar thorough induction nor did they mention being qualified to national standards or working towards it. One care worker told us, "I am always on training and currently doing a refresher on safeguarding. So far I have done moving and handling and medication training." Another care worker told they had just completed end of life training but couldn't think of any other training they had completed. Another care worker said they had been trained to use a suction machine and attended a specialist feeding training session at the RVI hospital. They all told us training was carried out regularly but they could not expand on this. Most staff told us they felt supported by the office staff.

People had not always experienced positive outcomes from the care and support they received. For example, one person had suffered serious harm because of alleged neglect. The person suffered pain from severe skin damage caused by poor personal care and catheter care. We looked at this specific incident during the inspection and found no evidence that a thorough investigation was carried out by the provider to ensure all staff were involved were trained and competent. We found that the provider had taken some action in response to this incident, which included making a referral to the relevant authorities. During the

course of the inspection a police investigation was in progress into this incident. We continue to liaise with the police and other stakeholders and are managing this incident outside of the inspection process.

A social worker told us that they were working with a family who alleged that that their relative was not changing their underclothes and that they were not being showered regularly. The feedback from staff was that the person was declining assistance. The family and the social worker said the support plan was not very detailed and did not specify tasks and they required a review. Another social worker also told us that they were working with a family who were not happy with the quality of care their relative had received.

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

The operations director told us there was no-one who used the service who were subject to restrictions under the Court of Protection, in line with the Mental Capacity Act 2005 (MCA) legislation. The Court of Protection advocates on behalf of people who are deemed to lack mental capacity and makes decisions on their behalf. We saw that services were provided to people who lacked mental capacity but there were no records in the care files we reviewed to inform staff about who had the legal right to make decisions on people's behalf, such as copies of a Lasting Power of Attorney (LPA). A LPA is a legal document that allows a person to appoint someone to help them make decisions or to make decisions on their behalf. It gives the person more control over what happens to them if they have an accident or an illness and can't make their own decisions. The operations director told us they would refer people back to their care manager for advice about complex decision making.

People told us that their care workers always knocked on their door before entering and always asked for consent before carrying out any tasks. One person told us, "They always ask me what I want for my meals." Another said, "I tell them what I want. I tell them what to do." A third person said, "They ask me all the time (for consent)." However, care plans were not always signed to show people had been involved in their assessments and had formally consented to the care and treatment they received.

People told us their care worker ensured they had enough to eat and drink. They said their care workers prepared a meal for them or made something for them to have later. They told us their care worker asked them what they would like to eat, and prepared a meal of their choice. Comments included, "I am happy with the meals, I drink coffee and they put the kettle on"; "I get as many drinks as I want"; I have water in the fridge which the girls (care workers) are always changing for me" and, "If I run out of groceries, they will let me know and get milk for me if I'm short."

Overall, entries made in the daily report books indicated care workers had regard for people's nutrition and hydration needs and provided sufficient support to manage a balanced diet. Where necessary, care workers were required to complete food and fluid intake charts to assist families and external health care professionals monitor a person's intake to ensure their health and well-being. One person's food and fluid intake chart did not refer to the use of thickeners, however their care plan stated that all fluids should be mixed with six scoops of thickener per 200ml to reduce the risk of choking. From these records we were unable to ascertain if the person had received this.

The service supported people to maintain their general health and wellbeing and ensure their needs were

met. Daily report books showed care workers had reported any issues and concerns to the office staff regarding people's needs. In response to this, we saw office staff had contacted family, a GP or a district nurse on someone's behalf. The records also showed that the service was involving and referring people to other external professionals such as a social worker or care manager. One relative told us, "They are very good, any changes, they pass onto the district nurse." Another said, "If they think he needs the nurse they tell me, like if he gets a blocked catheter."

Requires Improvement

# Is the service caring?

## Our findings

We found that although people and relatives made positive comments about staff conduct and attitude, the staff were not wholly supported by the provider to deliver a caring service. Due to the shortfalls we found at the service, the ability of staff to provide a holistic approach to people's care was restricted by safety issues, a lack of induction, training and supervision and ineffective governance and leadership. This meant that people were not always at the centre of the care they received.

Care plans contained limited information about people's likes and dislikes. They had not been written in a format which ensured people's needs were met in a way which reflected their individuality and identity. We saw there was little or no reference in care plans to people's routines, preferences, interests and hobbies to enable care workers to get to know people and understand the way they liked things done. We found the care plans were quite generic in style and content and focussed mostly on the tasks to be completed. The staff who regularly visited people clearly knew them well but detailed information was not available for new staff to get to know people in advance of a visit or at a glance in their home records.

Staff had not attended equality and diversity training which would make them aware of and encourage them to promote individuality and ensure people's personal preferences, wishes and choices were respected.

We asked people if care workers knew their likes and dislikes. One person told us, "Not really, only getting washed, I only know one or two (care workers)." Another person said, "More or less." We asked another person who gave lots of positive feedback if they felt involved in their care planning. They said, "No, they come and do what they have to and go." They told us that the provider has not asked for their opinion and had not communicated with her relative. Another person said, "They chop and change (the staff) so I don't know all their names." However, two relatives we spoke with felt involved in the task based aspects of the service and felt that the office had took notice of their suggestions. For example, one relative said, "My aunt stopped taking her medicines, so it was made clear from the start what the carers needed to do." Another relative said, "I've made suggestions and the people from Allcare have taken them on board, we have an instruction sheet now in the file for the staff."

We asked people and relatives if the staff were caring. People told us, "They are friendly, I have never met a nasty one"; "They talk to me all the time, they are very friendly"; "They are kind, very pleasant, when I see her (care worker) it makes my day" and, "We get on very well, we have a laugh and a joke." A relative said, "My aunt loves them all, she thinks they are wonderful, they are very friendly, she loves their company."

The staff we spoke with displayed kind and caring attitudes and they told us they liked their role. Comments included, "I enjoy supporting people and particularly those on end of life care"; "I look after some lovely people and the people are well cared for"; "I am just nice to people and it helps that the same [staff] go in to do the calls"; "I like all aspects of my job"; "I really enjoy my job and am passionate day to day" and, "I make sure I do my utmost and get job satisfaction by putting a smile on my clients face."

All the people and relatives we spoke with considered the staff respected them, their dignity and privacy. People told us, "[Care worker] is confident, respectful and good (at maintaining privacy)"; "They are very patient, watching me push my frame to the bathroom" and, "They are respectful all the time." A relative added, "They treat him with dignity, they help him out of bed and into a chair."

Most people told us they felt independent with staff supporting them to live at home. One person said, "I'm independent, I've got a trolley to help me, I've bought lots of things for myself." Another person said, "I can't grumble, I try my best (to be independent) they don't need to encourage me, I tell them." However, one person said the staff "sometimes took a little bit of independence away" but told us, his son and 'the manager' said he needed the service.

The provider had produced a 'service user guide' which informed people what they could expect from the service and gave general information about company policies and procedures. This included emergency contact numbers for the office staff.

Most people had family who acted on their behalf as informal advocates. The operations director told us no-one had any legal arrangements in place in line with the principles of mental capacity act, therefore we did not see any legal arrangements recorded in people's care records. The operations manager was aware of how to access an independent advocate if they felt it was needed through a local authority care manager or a direct referral. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

Requires Improvement

# Is the service responsive?

## Our findings

The provider had not ensured that an effective system was operated correctly to identify, receive, address, record and respond to complaints properly and in a timely manner. Furthermore, there was no audit of complaints and therefore complaints had not been monitored over time to ensure compliance with company policies and regulations or to look for trends and identify areas of the service that may need to be addressed or improved.

General 'complaints' which has been logged by the office staff on the 'customer contact log' did not contain any information about investigations, outcomes or lessons learned. This information had not been cross referenced with the central 'complaints file', which we found contained very little information. This meant we were unable to determine the seriousness of the complaint and if any action had been taken to rectify the complainant's issues, either formally or informally.

We reviewed the complaints policy and found that the provider had not ensured office staff were following the policy and the procedures associated with it. For example, the policy stated, all complaints would be investigated, "minor complaints" would be dealt with by senior staff on duty and an impartial and accurate record would be kept of all complaints, investigations and subsequent actions. A system in place to use 'template' letters to acknowledge and respond to complainants had not been used. We found the policy and procedures had not been followed to ensure people received the highest quality care.

Prior to this inspection we received information about a complaint which was made to the service in March 2018 about the care and neglect of a person receiving care from Allcare. In part, this complaint prompted us to inspect the service earlier than planned. We found there was no information about this complaint either in the person's care records or in the central complaints file. When asked, the nominated individual told us they did not think a complaint had been received about this. We had been made aware that the complaint was received by the operations director because the complainant had a brief acknowledgement email from the operations director assuring them that the complaint would be investigated and that 'Allcare' would respond as soon as possible. A further response was never received by the complainant. We shared a copy of this complaint with the nominated individual for further investigation.

We considered that this specific complaint was not dealt with correctly and as such staff involved in the incident have not been properly investigated and the issues raised about staff competence may not have been addressed. This placed other people receiving care and treatment from these members of staff at serious risk of harm.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Receiving and responding to complaints.

People and relatives informed us that they knew how to raise a concern or complaint and a few told us they had done so. Most of the people and relatives we spoke with said they would ring the office staff if they were unhappy with anything. One person said, "I tell them if I'm not happy, I go above their heads, I'm not afraid

to speak out." Another person said, "I would be quite happy to ring up if I needed to, they would sort it." A relative said, "I have rung up three times, some things are unavoidable." Another relative said, "One man (care worker) came once or twice, he fell short and I reported it, he has left now" and, "My concerns were responded to in a positive way."

Relatives felt that staff were responsive and that referrals were made to health professionals when appropriate. They told us they were informed about health concerns regarding their relations. A relative told us, "Any changes or skin sores and they pass it to the district nurse." Another told us, "I keep a good record and have regular contact with the carers."

Office staff provided a responsive service outside of normal business hours. They were available if people or staff required any assistance 'out of hours'. However, we found there was no formal recording system in place to track what matters had arisen and how they had been dealt with. The operations director told us that the office staff emailed each other if there was any information to pass over for action. We reviewed some of those emails. Whilst the staff had passed important information to each other, there was no way of recording what action had subsequently been taken. We considered that this was not the most secure and contemporaneous way of keeping 'out of hours' records and the records had not been centralised for monitoring and audit purposes.

The care plans we looked at contained some person-centred information about people's support needs and the tasks which they required assistance with. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to them. However, we found that overall the care plans were brief and more task based, with less specific information to guide staff on what is important to people, the routines they liked to follow and how they liked things done. Social, cultural and religious needs had been overlooked.

Care plans were reviewed quite often by office staff, we saw from the start of a care package, services were reviewed on a regular basis. For example, after 24 hours, one week, one month, three months and six months. However, the records we looked at did not routinely demonstrate that people, their relatives and staff attended review meetings. The information was presented in the form of a 'tick box' form with the person rating the service on a 1-10 scale. Care plan documentation was not always signed by the person where they were able to, and where people were unable to sign themselves, their legally authorised representative had not signed on their behalf. This meant that people may not have been consulted about their care, and therefore the quality and continuity of care may not have been maintained.

People told us that the service was flexible and they had been able to re-arrange visits at short notice to accommodate appointments. Staff told us that where people's needs had changed, the service had been able to respond quickly with additional support. Likewise, some services had been decreased for people who regained independence.

A large amount of the care packages delivered to people included end of life care. We saw little information was collected about people's wishes and preferences in relation to their end of life care and how they would like to be cared for as the end of their life approached or when death occurred. This meant staff may not have been aware of the person's wishes at this important time to enable them to provide safe care and appropriate support at the end of their life or after death. Additionally, staff had not received end of life training. The nominated individual told us they would arrange for this to be resourced and delivered as soon as possible. They later sent us confirmation that end of life training had been arranged for staff.

The care staff worked alongside other agencies, such as palliative care teams and district nurses to deliver

end of life care. We were told by staff that their involvement besides personal care was mainly around providing 24-hour comfort, emotional support and reassurance to relatives that people were not alone.

Inadequate

# Is the service well-led?

## Our findings

The findings from our inspection demonstrated multiple breaches of regulations. This meant that people were at risk of serious harm or abuse.

During the inspection, we asked to review a range of audits which related to quality assurance and safety monitoring. We were presented with very limited information. We considered that the information given to us did not demonstrate that systems and processes were in place and that they were operated effectively enough to ensure compliance with the regulations.

Audits and checks on the service were not consistently or comprehensively completed. There were no action plans completed to address any issues that may have been identified and therefore we were uncertain that these had been followed up. This meant we could not be sure that the provider had monitored progress against action plans or taken timely action without delay when progress was not achieved as expected.

Audits which had been completed such as staff and care record audits were brief in their detail and in some aspects of the service, the management team had failed to recognise the issues we have identified during our inspection. This demonstrated a lack of oversight by the provider.

We found that record keeping was poor across aspects of the service. For example, care records did not contain completed or robust risk assessments. Some care plans were not signed by people or their representatives to give consent for care and treatment. This meant some staff may have found it difficult to understand people's needs and they may not be able to provide appropriate person-centred care and treatment which would keep them safe from avoidable harm or abuse.

Handover records were of poor quality. We found the system in place of office staff emailing each other did not provide a secure, well maintained or contemporaneous record of the issues which occurred outside of office hours. This meant we could not ascertain if appropriate action had been taken to address any concerns or issues raised.

Client contact logs were maintained by office staff and completed when people who used the service or their representatives contacted the office. We found this information was brief and it did not contain explanations or outcomes to the matters raised. We could therefore not be sure that appropriate action had been taken. These logs had not been audited by the provider to ensure they were an accurate record of all decisions taken in relation to the care and treatment of people who used the service.

Record keeping in relation to complaints, accidents and incidents, safeguarding incidents, audits and notifications were either missing or lacked thorough details and completeness. We found multiple incidents of a safeguarding nature which had not been formally investigated in line with company policies and safeguarding policies or reported to the relevant authorities. We shared this information with the relevant safeguarding authorities for their monitoring and investigation purposes.

We asked the nominated individual about risk assessments being missing from care records, we were told that the records had been updated in March 2018 and had not been filed. This demonstrated that there had been an undue delay in the adding and filing of information related to the care and treatment of people.

We also asked the nominated individual about the lack of information available to us during the inspection and we were told that together with the operations director, they would be able to provide us with the evidence required over the next few days. This demonstrated that the nominated individual (who intended to become the registered manager) did not have adequate oversight of the service.

We asked to review staff meeting minutes. The only information given to us was the notes taken at one office staff team meeting dated 1 May 2018. There were no records made available to us in relation to care staff meetings and senior management meetings which may have demonstrated that the service was monitored by the provider and matters arising were addressed. This also meant that the provider had not given care staff the opportunity to get together with their peers to discuss common issues or to share ideas and best practice.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

The failure to notify the Commission of deaths as legally required meant that we could not be confident that the service was operated in line with the legal requirements. Furthermore, external agencies were unable to appropriately monitor the service due the lack of information shared with them.

This is a breach of the Care Quality Commission (Registration) Regulations 2009, entitled notification of deaths.

During the inspection we discussed our immediate findings with the care management team and we brought several issues to their immediate attention which they told us they would address. We later spoke with the nominated individual to discuss the inspection findings. They told us that they were committed to working with the Commission and partner agencies such as local authorities to make the necessary improvements.

People's individual care records were stored securely in the 'managers office' which we saw were kept locked to maintain confidentiality and computers were password protected. Staff demonstrated that they were aware of the legal requirement to keep information about people safe and secure under data protection laws. However, on our arrival the operations director could not initially find central safeguarding records, complaints and information on incidents. We were later given these files, which we were told had been located in the main office area.

People had been asked for their feedback about the service during reviews of their care packages. We saw people made positive comments and said they would recommend the service to others. The nominated individual told us that no surveys had been formally issued to people, relatives or staff as the service has not been operational for a year, however plans were in place to send questionnaires out.

The service did not have a registered manager in place. The previous registered manager resigned that position in January 2018. The nominated individual intended to apply to be registered with the Commission.

We asked people and relatives about the management team. They told us, "We can say it as it is to each other"; "I talk to [operations director], I have a very good relationship with her" and, "The manager has

helped with getting more lady carers."

We asked people and relatives if they thought the service was well managed. Comments included, "I occasionally ring the office, they sort things out, they are really good"; "I'm happy with the service, if I wasn't I would say, they take notice of you, they don't forget"; "I think the service is well managed, I would recommend them, the staff rotate, we know them, they are very helpful, they look after him"; "It's well managed to a certain degree" and, "I think it is well managed, I understand the pressures and the volume of work, they don't miss a beat."

A basic business continuity plan was in place which covered the most common eventualities such as, staff shortages, transport, extreme weather and IT failure. The operations director told us that the plan was tested in February 2018, during heavy snowfall. The provider authorised a 4x4 car to be hired and this was used to transport care staff to their visits. People were rated in order of priority of need and families were contacted if necessary to provide any cover where possible. This meant people with the highest level of needs received a service during severe disruption.

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 16 Registration Regulations 2009 Notification of death of a person who uses services<br><br>The provider had not notified the Commission of the deaths of people who used the service since they were registered in July 2017.<br><br>(Registration) Regulation 16(1)(a)(b)(3) |

**The enforcement action we took:**

We issued the provider with a fixed penalty notice for the sum of £1250 which has been paid.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to ensure the health, safety and welfare of people by ensuring that a risk assessment was robustly completed and implemented. They failed to ensure that all reasonable action had been taken to mitigate risks to people. There was limited information available to care staff around good practice and there was inadequate information about control measures to make sure the risk was as low as possible.<br><br>The provider had also not ensured that staff had the relevant qualifications, competence and skills to provider safe care and treatment.<br><br>Regulation 12 (1) (2)(a)(b)(c) |

**The enforcement action we took:**

We issued the provider with an urgent notice of decision to restrict them from accepting any new referrals for care packages and we asked them to provide us with specific information as a condition of their registration. This remains in place until CQC are satisfied that the necessary improvements have been made at the service.

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not demonstrate that monitoring and quality assurance systems and processes were in place and operated effectively to ensure compliance with the regulations. The registered person did not demonstrate that they had adequate oversight of the service.<br><br>Audits and checks on the service were not consistently or comprehensively completed. There were no investigations or action plans completed to address any issues that may have been identified and to evidence that these had been followed up.<br><br>Record keeping in relation to complaints, accidents and incidents, safeguarding incidents, audits and notifications were either missing or lacked thorough details and completeness.<br><br>Regulation 17(1)(2)(a)(b)(c)(d) |

**The enforcement action we took:**

We issued the provider with an urgent notice of decision to restrict them from accepting any new referrals for care packages and we asked them to provide us with specific information as a condition of their registration. This remains in place until CQC are satisfied that the necessary improvements have been made at the service.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider failed to ensure that every reasonable effort was made to gather information to ensure staff were of good character.<br><br>Recruitment processes were not robust enough to ensure staff working with vulnerable people were properly checked and vetted in line with best practice.<br><br>Regulation 19(1)(a)(b)(2)(a) |

**The enforcement action we took:**

We issued the provider with an urgent notice of decision to restrict them from accepting any new referrals for care packages and we asked them to provide us with specific information as a condition of their registration. This remains in place until CQC are satisfied that the necessary improvements have been made at the service.

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not ensure that new staff were provided with a comprehensive induction programme to prepare staff for the role. Staff training was not provided in topics which would benefit all staff in their role and had not been completed at regular intervals of their employment.<br><br>All staff were not appropriately supervised and supported in their role through competency checks and formal supervision sessions.<br><br>Regulation 18(2)(a) |

**The enforcement action we took:**

We issued the provider with an urgent notice of decision to restrict them from accepting any new referrals for care packages and we asked them to provide us with specific information as a condition of their registration. This remains in place until CQC are satisfied that the necessary improvements have been made at the service.