London Care Limited

London Care Holloway

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17, 18 and 19 January 2017 and was announced. We gave the provider 48 hours' notice that we would be visiting their main office to ensure that the registered manager would be available on the day of the inspection.

The service was last inspected on 8 January 2016 and was meeting all the standards that we looked at. However, since the last inspection the service had moved offices and re-registered at a new address. The new location therefore required an inspection for it to be rated under the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

London Care (Holloway) provides personal care and support to people living in their own homes or within supported living schemes. There were 397 people using the service at the time of the inspection.

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

People and relatives that we spoke with were generally happy with the care that they received. They also told us that staff were caring and ensured that their privacy and dignity was maintained at all times. However, concerns and complaints raised by people and their relatives were consistently around staff arriving late to their call, missed visits and the poor communication from the office informing them of any changes. Although the service had a number of monitoring systems in place, rotas that we looked at did not evidence that care staff were allocated sufficient travel time between each call. The registered manager highlighted to us that they had recognised these issues and that an action plan was in place to address them.

In addition people and relatives also told us that generally from Monday to Friday they received regular and consistent staff to support them. However, at weekends this was not always the case and communication was poor on the part of the service when informing people and relatives of any changes or lateness that may occur.

Complaints received by the service were dealt with according to the provider's complaints policy. Full details of the complaint, an investigation report with details of actions taken and responses to the most complainants were recorded. An overview of all complaints was available which allowed the registered manager to monitor for any trends or patterns. However, where some records confirmed that the person or their relative had been spoken or written to and feedback had been provided this was not seen for all complaints that had been received. In addition people and relatives feedback was that although they felt able to complain to the service they never received any feedback on the outcome of the complaint.

The registered manager had systems in place to monitor and check the quality of care being provided. This included spot checks, random weekly checks of care plans and staff files, electronic monitoring systems, overviews of staff training and when it was due, missed and late visits, complaints and safeguarding investigations. However, where significant concerns and issues had been raised around lateness and missed visits, or ensuring people and relatives received appropriate feedback upon raising a complaint, this had not been addressed.

Medicines were not always managed safely. Medicine Administration Records (MAR) that we looked at were incomplete as care staff were not always signing the MAR to confirm that medicines had been administered where required. Therefore, we were unable to confirm that people were taking and receiving their medicine as prescribed. The registered manager explained that safe medicines management was a concern that they had already identified and systems were to be put in place to oversee and manage this.

Each person receiving care had a care plan in place which outlined the person's needs and requirements and how they wished to be supported. Health, safety and environmental risk assessments had been completed which highlighted potential risks and how those risks could be mitigated. As part of the pre-service assessment, personal and individual risks were also identified and in some care plans specific guidance was provided to staff on how to reduce, mitigate or support the person with those risks. However, not all care plans contained this level of detail. Where some individualised risks had been identified, information had not been recorded on how to support the person with the identified risk.

People and relatives told us that they and the person that required care felt safe in the presence of the care staff that supported them. Care staff demonstrated a good understanding of safeguarding and what this meant in order to ensure people were protected from abuse. They knew who to report abuse to and were confident that management would take immediate action. Staff knew what the term 'whistle-blowing' meant and were aware of the external agencies they could contact if they needed to report any concerns.

Care plans had been signed either by the person using the service or their relative. The service had policies and procedures in relation to the MCA (Mental Capacity Act 2005). The registered manager, senior staff members and care staff had a good understanding of the MCA and that they should always presume that people have the capacity to make decisions. The service did not complete any capacity assessments as it was always assumed that people had capacity when referred to the service. However, where a person lacked capacity or changes were noted in a person's mental capacity, this was appropriately referred to the relevant agencies for an assessment or review of the care package to take place.

Staff told us and records confirmed that they received training prior to starting work as well as on-going training as part of their personal development. This included face to face sessions as well as on-line training courses.

The service had safe recruitment process in place which ensured that only suitable staff were employed.

We received mixed views from people and their relatives about whether they knew who the manager was and about the management of the service overall. Some people and relatives told us that they knew who the registered manager was and felt confident in reporting any concerns or issues that they had. However, some people told us that they did not know the manager but classified the care co-ordinators and field care supervisors as the manager and with whom they communicated with most. Concerns were also raised about the poor communication from the office especially where people had raised complaints and concerns but had not received any feedback about the actions taken and the outcome of their complaint.

The service carried out quarterly quality monitoring which included telephone interviews as well as planned quality assurance visits to people receiving care and support. In addition, people and relatives were also asked to complete annual quality questionnaires to obtain their feedback on the service that they received and if there were any improvements to be made. People and relatives confirmed that they had completed these questionnaires and we saw a summary that was compiled by the provider outlining the main issues and concerns that people had raised so that these could be addressed locally.

We identified a breach of Regulation 12, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to managing people's medicines safely, effectively managing complaints and addressing the issues around missed visits and lateness. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Medicines management was not safe and we could not confirm that people were receiving medicines safely and at the appropriate time.

Lateness and missed visits were issues that were highlighted not only by people and relatives but also care staff that we spoke with. Rotas showed that care staff were not allocated any or sufficient travel times between calls.

People told us they felt safe with the staff that supported them. Staff knew about the different types of abuse and how to respond to any signs of potential abuse.

The service had safe recruitment processes in place to ensure only suitable staff were employed.

Is the service effective?

Good

The service was effective. Staff received training in a variety of areas and this was refreshed on a regular basis. Staff told us they were supported well and received regular supervision.

Care plans were signed by the people receiving the care or their relatives where a person was unable to sign. The service always presumed people had capacity and where this was not the case or changes to peoples capacity were noted, appropriate referrals were made to assess and review the person and the support they required.

People were supported to maintain their health and access healthcare services where required.

Is the service caring?

Good

The service was caring. People and relatives were positive about the care and support that they received and stated that care staff were caring and respected their privacy and dignity at all times.

People generally received care from regular carers who knew the people they supported. However, this was not always the case over the weekends where people and relatives told us that there

was a lack of consistency in the care and support that they received.

Staff understood that people's diversity was important and that the support they provided to people should be equal and fair and that people's backgrounds should not impact on the care that they received.

Is the service responsive?

Requires Improvement

The service was not always responsive. People and relatives knew who to contact if they had any complaints or concerns which mainly revolved around care staff arriving late to the call and not being notified by the office of any changes. However, not all records confirmed what action had been taken and if the complaint had been responded to. People and relatives also told us that they did not always received feedback on the outcome of their complaint.

Each person had a care plan that contained information about them, their life and their assessed care needs. Care plans were reviewed regularly.

People's needs and wishes from the service were assessed and support was planned in line with their needs.

The service regularly requested feedback from people who used the service.

Is the service well-led?

Requires Improvement

The service was not always well-led. The service had a number of systems and processes in place for monitoring the quality of care. However, where significant concerns and issues had been raised around lateness and missed visits, this had not been addressed.

Most people and their relatives knew the registered manager or alternatively knew the care managers, care co-ordinators and field care supervisors who had more contact with them about their daily care and support needs.

People and their relatives told us that the service maintained regular contact with them to obtain their feedback on the quality of care that they were received. They also confirmed that they received regular telephone calls and visits as well as completed annual quality questionnaires that were sent by the service.

London Care Holloway

Detailed findings

Background to this inspection

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

This inspection took place on 17, 18 and 19 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to support us with the inspection process.

On 19 January 2017, with prior consent, we undertook visits to people's own homes to speak with them about the service that they received. We visited and spoke with three people who used the service. As part of this visit we also looked at records that were held in people's own homes. In addition to these visits we spoke with people and staff by telephone to obtain their feedback about the service.

The inspection was undertaken by three inspectors. Before the inspection we looked at the information we had about the service. This included notifications of any safeguarding or other incidents affecting the safety and wellbeing of people and feedback that we had received from local authority commissioning officers.

During the inspection we spoke with the registered manager, area manager, one care manager, two care co-ordinators, one electronic monitoring administrator, one field care supervisor, one quality assurance manager, and three care staff.

Telephone calls were also made to a further 20 people, 22 relatives and 10 care staff.

We looked at 20 people's support plans and other documents relating to their care including risk assessments. We also looked at three care records that were kept at people's homes.

We looked at other records held by the service including 18 staff files, staff meeting minutes as well as health and safety documents, complaints records, quality audits and surveys. After the inspection we requested a number of documents from the provider including action plans and team meeting minutes.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that they felt safe with the staff that supported them with their care needs. One person told us, "I feel safe with the carers who call on me and I have no worries about my possessions as I trust them." Another person said, "I am happy, I feel very safe." A third person stated, "I do feel safe with them." Relatives comments included, "In the past we had a carer which we did not feel safe with. We asked for this carer to be changed, we have no issues with safety now," "She [person] feels really safe with the carers" and "Very happy when they come, feel safe, feel comfortable." However, despite these positive comments there were some aspects of the service that were not safe.

Medicines were not always recorded safely. We looked at a sample of eight medicine administration records (MAR) and found numerous gaps in all of the records. For example, on one record, there was no recording done over a four-day period, on another, there was no record made of whether a topical cream had been applied over a 12 week period. On a third MAR there were gaps in recording over a 10 day period. The records could not confirm whether the medicines prescribed had been administered at the specified times. Records did not confirm that people were supported to take their medicines safely and as prescribed.

Care staff working in the community were required to transcribe MAR charts. Where an agreement had been made with a pharmacist, if possible, extra stickers were provided so they could be added to MAR chart. This reduced the risk of error on the part of the care staff. However, where this was not in place there was an increased risk of errors such as writing incorrect details of the medicine and how it was to be administered. There was no system in place to mitigate this risk.

We saw records confirming that all completed recording books which included the MAR were audited once they were received by the office from people's homes. We saw evidence that where MAR chart checks had picked up errors, this was addressed with the care staff in supervision and the care staff was required to complete an impact and consequences training session which gave them a scenario about medicines recording, where they were required to identify the mistakes and issues within the scenario given so that they could develop a better understanding of the importance of accurate recording. We also saw records of disciplinary action that had been taken against care staff who consistently made the same mistakes.

The service completed risk assessments for all people who required support with medicines. People were assessed at one of three levels. Level one was where staff were required to check and remind people to take their medicines, level two was where staff would be required to support the person with taking their medicines as they were unable to open the packaging or needed physical assistance and level three was where a person required full support with their medicines.
Based on the risk assessments completed, the service had developed a rating system which identified those needing assistance at level two and three at medium and high risk. These people were prioritised according to their assessed need especially when allocating care staff to the person's care package.

We spoke with the registered manager about the concerns noted above who confirmed that they recognised recording issues on MAR charts and concern which they had identified through the audits that were

completed. To address this issue the registered manager told us that a medicines lead had been appointed who would be responsible to ensure medicines were managed safely. The role of the lead would be to visit those people identified as at high or medium risk as per the level of support they required with their medicines and oversee safe medicines management. However, the medicines lead had not taken up the post at the time of the inspection.

Staff told us and records confirmed that they had received training on safe medicines management. As part of the training, staff competency was assessed and signed off on a yearly basis. However, the questions on the competency workbook did not appear to be marked or graded so we were unable to confirm whether care staff had correctly answered the questions, although, a senior staff member had signed the booklet confirming that the staff member had successfully completed the course. We highlighted this to the registered manager who confirmed they would look into this with a view to improving the process.

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

People and relatives told us that they were happy with the way in which they and their relatives were supported with medicines. One person, when asked about the support they received with medicines told us, "Yes, happy with this." One relative stated, "The carer gives her medicine, twice a day. The carer is very good and stays make sure she takes them before leaving."

Lateness and missed visits was an issue identified and raised not only by people and relatives receiving a service but also by commissioning authorities as well as the service themselves.
People's comments included, "They do come late, it's the bus route, they do not call me if they are late but they do come" and "Not exactly. I'm blind and I'm always waiting. I've asked for regular ones [name of carer] is good and on time." Relatives comments included, "It's the weekend when there are issues about timing, they do not call" and "They should let us know if the care workers are late, we have to ring the office to chase this."

There were some positive comments that we received from people and relatives which included, "Occasionally late, but they do call me and all the tasks are completed comfortably within the time" and "Yes usually on time, they ring me if they are going to be late." Relatives comments included, "Yes majority of the care workers are on time and if there is an issue they call me" and "Nine times out of ten, if they are going to be a bit late carers will let me know. When carers are sick they don't let us know and this has happened a few times. One time we only found out the carer hadn't been the next day when a replacement came. We have put it on the file; they need to tell us if they can't come so we know."

However, rotas that were given to care staff on a weekly basis did not allow for travel time between calls which meant that care staff would always be late at each and every call. We looked at rotas for three staff members and we saw that they were allocated calls which were back to back and did not accommodate any travel time.

Out of the 13 staff that we spoke with 11 of them told us that their visits schedules made it difficult for them to visit people at the required time as there was not enough time allocated between some visits. Each member of staff we spoke with complained of short or no travel time for care workers to travel from one client to the next. They told us this resulted in not being able to make the agreed appointment times in most instances. Care staff also told us this caused them to feel stressed and drained. They also spoke of the problems the lack of travel time caused for clients who needed two care workers to support them. One care worker said, "It is usual for my double up partner to be late or very late. There have been times when I have

had to start the personal care before my partner arrives as I do not want my client to be lying in discomfort when it is no fault of their own." Another care worker told us, "Weekends are the worst because a lot of staff do not like to work then. I know when I am on that loads of calls will be fitted into my rota, without any breaks or travelling time." A third care worker said, "We have to manage the rota. There are calls back to back and I am running late, but I let the office know who inform the person."

The service had a number of systems and processes in place to monitor care staff to ensure that they attended their visits in a timely manner. This included an electronic monitoring system where care staff would be required to log in when they arrived at the person's home and log out when they left. The system was also able to track care staff and their location through a GPS tracking system linked to the electronic monitoring system. A designated team was allocated that monitored all visits to people where staff had the facility to log in and out. This set-up was in place for the majority of people. All visits were monitored live between the hours of 7am and 10pm, and so enabled any late visits to be checked on and addressed as needed. Where a care worker had not arrived up to 15 minutes from their allocated call the office would receive an alert which would enable them to locate the carer and inform the person that the carer was running late. The registered manager said that a report on these checks was supplied to each care manager every Monday and where issues were identified these were addressed with the care staff directly through supervision and completion of impact training.

There were a number of care packages where care staff were unable to use the electronic monitoring system as they did not have access to a telephone. In those cases, the people receiving care or their relatives were required to complete a weekly time sheet confirming the time of the carers arrival and the time they finished their call. This was then sent in to the office for them to check. During the inspection it was confirmed that from February 2017 all care staff would be allocated a mobile phone which they would use to log in and out and that any manual monitoring systems would not be required.

We told the registered manager about the concerns and issues we had identified around lateness, missed visits and the communication systems in relation to these. The registered manager confirmed that they were very aware of these concerns and were trying to ensure that lateness and missed visits were minimised. A recent internal audit completed by the provider also highlighted concerns around lateness and missed visits. The registered manager informed us that an action plan was in place that been specifically formulated in partnership with a local authority with a view to addressing these issues and concerns. We have identified these issues as a significant concern under well-led.

Staffing levels appeared to be sufficient with 280 care staff currently employed by the service. The registered manager commented that recruitment for staff in a particular local authority was difficult due to travel costs and that they were liaising with the authority to provide incentives for staff to work in that area. A recruitment programme was also in place to recruit a minimum of 15 care staff per month so that the service could meet the requirements of their contracts which were held with a number of local authorities.

Each person receiving care had a care plan in place which outlined the person's needs and requirements and how they wished to be supported. Health, safety and environmental risk assessments had been completed which highlighted potential risks and how those risks could be mitigated.

Individualised risk assessments had been completed which assessed people's personalised risks such as risks to personal care, skin integrity, mobility, health needs, and medicines. Specific guidance was provided to staff on how to reduce, mitigate or support the person with those risks. However, not all care plans contained this level of detail. For example, where a person's risk assessment required them to be repositioned three times per day, this was not referred to in the care plan. We noted that the person's

repositioning chart had several gaps over a 12 week period which meant we could not be sure the person was repositioned in accordance with their risk assessment.

Care staff demonstrated a good understanding of safeguarding and what this meant in order to ensure people were protected from abuse. Care staff knew who to report abuse to and were confident that management would take immediate action. One care staff told us, "Safeguarding is about making sure the needs of the service user are met. If I had any concerns or dangers that I learn about I would tell the field care supervisor or the registered manager. It's about keeping your eyes open." Another care staff stated, "It's about connecting with clients and their needs. If you have any concerns of abuse I would report and record."

Staff knew what the term 'whistle-blowing' meant and were aware of the external agencies they could contact if they needed to report any concerns. One care staff said, "I know what to do, contact the CQC (Care Quality Commission) either in writing or by phone and I don't have to give my name if I don't want to." Another care staff told us, "There is always a higher up boss to push concerns up to and I know the CQC is there for me if I get no satisfaction."

A safeguarding file was available which contained records of all safeguarding concerns that the service received, safeguarding referrals made and statutory notifications sent to CQC. Investigative actions were evident in the records that we looked at and the registered manager provided an update where possible on current safeguarding concerns that had been received.

We looked at recruitment records of 18 care staff and found that the service had systems in place to ensure that staff were safe and suitable to work with people. Recruitment files contained the necessary documentation including references, criminal record checks and information about the experience and skills of the individual. The service in addition ensured that care staff completed a criminal records check every three years so that the service was assured that care staff employed were safe to work with vulnerable people. We also saw that where staff were noted to have a previous criminal conviction or caution, the service completed a risk assessment to ascertain the level of risk the potential staff may pose to vulnerable people dependent on the nature of the crime that was committed.

We saw that the agency carried out checks to make sure that staff were allowed to work in the UK. The registered manager held an employee data overview with had information about the dates of when a visa was approved and the date of when it was due to expire so that the provider could follow up with the staff member to ensure that they continued to work legally in this country. The registered manager told us that where a staff member was unable to evidence their legality to work in this country they would have to stop working until documentary evidence was provided.

Accidents and incidents were recorded on an accident and incident form. All accidents and incidents were reported to the office and a record was made which outlined the date of the incident, details of the incident and what action was taken. The registered manager was able to show us an audit trail of the action that they had taken as well as an overview of all accidents and incidents that had occurred across the service so as to be able to monitor any patterns or trends.

All care staff had full access to personal protective equipment (PPE). We observed that care staff were able to come to the office and collect the equipment that they required.

Good

Is the service effective?

Our findings

People who used the service and relatives told us that they felt care staff had the knowledge and skills to provide effective and good care. One person told us, "Yes they do know what they are doing." Another person stated, "They are skilled, they come here do all my work for me as I can't do it." Relatives comments included, "Yes no problems (skilled and trained). The carers are very aware [relative] doesn't like being crowded, they give her the space she needs. They do what she wants them to do" and "Mixed, some people are experienced and know what they are doing. New carers sometimes take a while to get trained."

Care staff told us and records confirmed that they had completed an induction when they started work. Whilst most care staff were positive about the training they received, some felt it was not long enough. One care staff told us, "There is too much to pack in and the training feels rushed." Another care staff said, "I can see from new staff that they have not had sufficient time to digest what they learnt." Other care staff had more positive comments to make about the training which included, "The training is really good and if I need further training I can always ask" and "We receive training every year and if we have any special needs they provide the training for it."

The service provided a training matrix which outlined all the topics staff had undertaken training in and the dates completed. In addition to the mandatory topics, training was also provided in areas such as diabetes, catheter care, re-ablement, palliative care, dementia care and continence care. Training was refreshed on an annual basis and involved care staff completing themed workbooks which assessed their knowledge and understanding of the specific topic being refreshed.

Once newly appointed staff had completed their training they were required to complete a shadowing period which took place over a minimum two days or longer if the new staff member was not feeling entirely confident in their role. Records of completed shadowing periods were seen on care staff files.

Care staff told us and records confirmed that they received regular supervision and an annual appraisal from their manager, which also included field spot checks. Care staff told us that these processes gave them an opportunity to discuss their performance and identify any further training they required. One care staff stated, "I receive regular supervision where we discuss the job, my clients and anything that is concerning me."

We saw themed supervisions that were completed around areas such as medicines, skin integrity and record keeping. Themed supervisions involved care staff having a discussion with their line manager about a particular theme and then completing a competency assessment to confirm their knowledge and understanding.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do 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 the best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. Care plans had been signed either by the person using the service or their relative. The service had policies and procedures in relation to the MCA (Mental Capacity Act 2005). The registered manager, senior staff members and care staff had a good understanding of the MCA and that they should always presume that people have the capacity to make decisions. One care staff told us, "The MCA is about where people can't make decisions for themselves. Family and social services would then make decisions on their behalf." Another care staff said, "Capacity is about being able to make choices even if they may be wrong or if the person lacks capacity. In that case a family member, social services or an advocate can make decisions for them."

The service did not complete any capacity assessments as it was always assumed that people had capacity when referred to the service. However, where a person lacked capacity or changes were noted in a person's mental capacity, this was appropriately recorded or referred to the relevant agencies for an assessment or review of the care package.

Staff were able to describe the process of gaining consent to us and demonstrated understanding of MCA. They spoke of ways in which they worked with a person whose capacity fluctuated. For example, where a person refused to take their medication, the care worker said, "I will busy myself with the other tasks and then come back to the medication. I find that this usually works." Another example a care staff gave was, "I explain step by step what I am doing even though they may not have capacity. It is just nice to explain to them and give them choice, choice in what clothes they would like to wear or what they would like to eat.

The service provided care to people within their own home. Care staff were not involved in menu planning for people and were not always involved in monitoring people's nutrition and hydration as they would only be present at the person's home at certain times throughout the day for a specific time period. However, where care staff were required to monitor people's food and fluid intake systems were available for care staff to do this as part of their daily recording.

The service did support people with preparing meals or heating up pre-ordered ready meals. People and relatives were positive about the support that they received. Comments included, "They (carers) go to the shop for me and make a good cup of tea," "She is quite specific with what she likes and carers make sure she happy. She [carer] will leave a message to say if she needs shopping" and "He likes the same things. They [carer] always ask him what he would like to eat and they heat it up for him."

Care plans noted information about people's dietary requirements. This included specific information about any cultural or religious requirements or where people had been assessed by the speech and language therapist and required a specific type of meal or where thickening agents were required because the person was at high risk of choking. One care plan stated, "Milky tea with three sweeteners, egg or cheese toastie and rice or curry." One care plan referred to a person having swallowing difficulties. Directions included that the person needed to be supervised for changes in gurgling wheezing or coughing.

Where a speech and language therapist had been involved in a person's care, we saw that care staff had been provided guidance and instruction posters on how to administer the thickening agent, how many scoops of the agent were to be mixed into a set amount of liquid and how the person was to be supported safely when having their meal or a drink. The service told us and care staff confirmed that these directions were displayed at the person's home.

Care plans provided information about people's current health, medical needs and the medicines that they had been prescribed. We saw evidence on people's records of liaison with other professionals such as GP, occupational therapist and physiotherapist. People and relatives told us that they were confident that their carers would respond appropriately if they noted any changes in the person's health and medical needs. One relative told us, "In the last two years a few times she [person] has been admitted to hospital and each time the carers were very good and supportive. They told me what to take, they were really helpful." Another relative stated, "The carers inform me if he is not well. The office do call me I must admit. They called the ambulance once for him and waited with him until I came, they are good at that."

Care staff knew who to contact if there were any concerns about people's medical health including emergency contacts. The agency also worked very closely with social workers, district nurses and other medical professionals to ensure people received the appropriate care and support.

Good

Is the service caring?

Our findings

People and relatives told us about how good their carers were and that they were caring and responsive to their needs. People and relatives had established positive relationships with the care staff that supported them. People's comments included, "They are very good, very caring," "This care worker is brilliant, wherever they are I will follow this person, just brilliant" and "Yes, they help me. They go the extra mile to help me out like getting me some milk if I've run out." Relatives told us, "The care workers are like friends to me and my relative. In the past a few years ago we did have some real issues, now I can fully trust them with my relative," "They (carers) communicate very clearly, if they are not sure what to do they ask what do you mean Grandma. For her to allow two young ladies to call her grandma is high praise indeed" and "Excellent carers. They are very good; they go above and beyond what is required of them."

Most people and relatives confirmed that they generally received a regular set of care staff to support them and that any changes were normally at the weekend. One relative told us, "Yes I am very happy with the care we receive from the regular carers." Care staff also explained the relationships that they had built with people that they supported especially as they attended to those people on a regular basis. Staff told us that they usually had a consistent round so they were supporting the same people. One member of staff said, "This is really important for those clients who are living with dementia." A second care worker told us they made relationships with their clients very easily, "Caring is my calling" and "it is a privilege to be a care giver." A third care staff told us they try to make their input as meaningful and enjoyable as possible because, "I may be the only person they [people] see that day."

The service had recently received positive feedback from a health care professional who had worked very closely with a care staff in supporting a person with their care and health needs. The compliment described the relationship and understanding that the care staff had established with the person. The compliment stated, "An experienced carer had developed an excellent working relationship with the customer to the degree that she was usually able to anticipate her needs before being told. Although the customer was difficult to manage at times, [name of carer] was extremely patient, considerate and always willing to go the extra mile to ensure that her clients' needs were met in a way that did not undermine her independence and allowed her to continue exercising choice and control until the very end."

People's care plans were person centred and contained information about their religion, the languages they spoke, any relevant health details and the roles and responsibilities of others including family, friends or other agencies. Each care plan had a 'life history' section which gave information about the person's background, family and work history. This enabled staff to have some insight into the person they were supporting and their key life events so that any significant detail could be incorporated into their approach and the way in which they delivered care and support where appropriate. The care plan also outlined agreed outcomes and stated goals and how the person was to be supported in achieving the set goals. This included details of the tasks that were to be undertaken.

People and relatives confirmed that they had been involved with their care planning process and had also been involved in the reviewing of their care when necessary. One person when asked if the service had been

to review the care and support they received replied, "Yes, when they came to ask questions." One relative stated, "They come to review the care plan about twice year. I feel the issues are addressed. We both speak with them." Another relative told us, "We have meetings and review, we have agreed that they do more laundry for me."

Care plans detailed different methods of communication that care staff could use where people were identified as requiring a specific need or approach. The care plan for one person who had speech difficulties advised care staff to support the person by, "Listening carefully, being patient and looking at the person when they are speaking to her." Another care plan stated, "My care workers can communicate by speaking slowly and clearly. They can repeat when I fail to understand."

Staff were respectful of people's privacy and maintained their dignity. Staff told us they gave people privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain the person's safety, for example if they were at risk of falls. One staff member told us, "I respect them as an individual, I respect their life choices and what they would like to do and ensure that they live a dignified life." Another care staff said, "I respect their choices and wishes, encourage them, talk to them. When providing personal care I cover them with a towel."

We saw records confirming that staff received equal opportunities training as part of their induction. Care staff that we spoke with had an awareness of how people should be supported equally regardless of their gender, race, sexual orientation or religion. One care staff member when asked about equality and diversity told us, "Everyone is different, different cultures, religions. I support people as they want and I treat everyone as a human being regardless." Another care staff stated, "Everybody is an individual. They have their own opinion, own religion. It doesn't make a slightest bit of difference to me." People and relatives also confirmed that care staff treated them with respect and maintained their privacy and dignity. One person told us, "Yes, yes they do, like when they give me a towel and I wash that bit myself."

Requires Improvement

Is the service responsive?

Our findings

People and relatives that we spoke with told us that they knew who to speak with if they had a complaint to make about the service that they received. Most people and relatives did not have any complaints to make and were happy with the service they received. However, some people and relatives felt that although the service listened to their complaint they did not receive any feedback from the service about the actions that had been taken by the service to resolve the complaint. One person said, "Yes they do deal with complaints reasonably." Another person stated, "They have to do what I tell them to do, I can report it. I had a woman who only wanted watch television and write in her book. I reported it, phoned the office three weeks ago. They sent me a new carer they did sort it out for me." A third person told us, "Sometimes they feed back when I complain, sometimes they do not. It would be nice to let us know what the outcome was from our complaint."

Complaints records that we looked at and feedback from people and relatives identified a common theme around staff visits that were not usually reliable and punctual especially at the weekends. Some people and their relatives said they found communication from the service was poor and that they have had to contact the office when staff did not turn up rather than the office communicating with them. People and relatives also told us that when their regular carer was not available, they would not be told who the replacement carer was going to be.

Comments that relatives made included, "No problems at all, no reason to complain," "I have talked to person in charge. I don't know if these have been addressed, I get no feedback from the office, only know if they occur again if it has been resolved. Its left in the air," "Yes, but there's never any follow-up from the office; they don't return your calls" and "When we make a complaint they listen but we never get feedback it has been done. Sometimes it feels that we have to speak to one person, then another but still no feedback."

The service had a complaints policy in place which outlined how the service would deal with any complaints that were received and the timeframes that this would be done in. The policy also included contact details of the CQC and the local authority, to which a person may complain if required. Complaints that we looked included details of the complaint and the actions that the service had taken to resolve the complaint. Some records confirmed that the person or their relative had been spoken or written to and feedback had been provided but we could not see this for all complaints that had been received.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We highlighted the importance of effective communication to the registered manager and gave examples of the feedback that we had received during the inspection for their information. The registered manager confirmed that they would look at addressing these concerns with a view to making improvements.

We saw a number of very positive compliments that had been sent in to the agency about the care and support people received especially as part of nominations for the provider's annual dignity in care awards

nominations. One relative wrote, "We have nothing but admiration for the carers and the service that you all provide. Thank you all again from the family." One person wrote, "She [Carer] makes me feel like I really matter and I never feel she's doing it just for the income."

The service collated regular feedback from people and their relatives by conducting quarterly telephone surveys, quality assurance visits and annual surveys. People and relatives confirmed that they either received a telephone call or had completed a questionnaire about the quality of service that they received. One relative stated, "We have done a phone questionnaire. London Care have called me. We are happy with the care provided." Feedback from people was collated, analysed and a report was completed which outlined the findings and actions taken which included conducting additional reviews, increased spot-checks and liaising with people who provided negative feedback so that improvements could be made.

We asked the registered manager if a response was sent to people and relatives after the survey had been conducted which would outline they key concerns, issues or things they did well and the actions they planned to take. The registered manager was not sure about this and told us they would discuss this with the provider.

Care plans gave staff information about people's care needs and their preferences regarding how they wanted to be supported. For example, where a person was noted to have reduced communication skills, care workers were advised to speak slowly and ensure there was eye contact with the person. Initial assessments and care plans also identified when and for how long staff would visit people and also specified the care needs that staff would support people with and identified tasks and activities for each individual time slot. We observed that the care plans available at the home of the person we visited and the care plan in the office were the same, so staff had access to the most up to date care plan. Care plans that we looked at confirmed that regular reviews were taking place for people receiving care and support.

However, we looked at two care packages which gave 24 hour support. The care plans did not give much detail as to how these 24 hours were to be fulfilled. There was no specific schedule for the care workers to follow and no identified activities in which to engage the person who used the service. We spoke with the registered manager about this and were told that for one package in particular, each care worker brought their own individual style and skills to the package. For example, one care worker liked to do arts and crafts with the person whilst another focussed on outdoor activities. There was no formal activities timetable to reflect this as it depended on the person's choices on any particular day. The registered manager told us that they would review care plans where a high level of support was provided to ensure sufficient information and detail was included.

Care staff recorded their daily interactions with people in a home care report book which were held at the person's home. Notes included details of how the person was and the tasks that were completed. These also included the time the carer arrived and the time they left. We saw that not all entries completed were signed or dated and on occasions, times of the visit had not been completed. We saw this was identified in an audit and noted that the responsible workers were invited into the office for supervision and to attend 'impact training'.

Staff we spoke with told us that care plans were helpful and informative. One care worker told us there were occasions when the information did not reflect the current needs of the person they supported. They said they contacted the office and requested an amendment to the care plan and gave an example of where the mobility of a person who used the service changed and they required a different type of mobility support. However, one care plan identified that a person presented with behaviours which challenged. However, there was no guidance for staff as to how they would manage the person's or their own safety in those

specific circumstances. We did, however, see e-mail evidence that the registered manager had made frequent requests for funding of additional support hours from the local authority over a period of six months so that the person could be supported appropriately. This example of where further detail was required was brought to the attention of the registered manager for their attention.

People and relatives told us that the care staff and the service were responsive to their needs and wishes where required. This included having the choice of a male or female carer, accessing the community and social events and ensuring people were receiving appropriate care where significant changes had taken place. One relative told us, "My relative has come out of hospital and they are now bedbound. The company is working closely with me and the social services to ensure we get the right care package in place." Another relative stated, "They helped her to get ready for church." A third relative said, "We requested female carers and always get female ones."

The service had an out of hours on call system that care staff told us, "functioned well." A member of staff was always available on the phone at the office from 7am to 6pm, Monday to Friday and on weekends from 8am to 4.30pm. During all other times, a member of staff was on call to manage any emergency calls that were received. One staff member said, "The emergency on call is always available to help."

People and relatives told us they and their relative were offered choice in how they received their care. Staff demonstrated a good understanding of how to promote people's independence by involving them and giving them choice and control over the care that they received. Care staff gave us different examples of how they promoted independence and gave people choice. One care staff member told us, "Each person's needs are different. One client likes to go shopping and pick their own shopping. I only support them where needed." Another care staff member said, "I treat people with respect and dignity. Care needs depends on the person as an individual."

Requires Improvement

Is the service well-led?

Our findings

People and relatives were generally positive about the management team and the service that they received. However, out of the 20 people and 22 relatives that we spoke with nine people and 13 relatives gave us negative feedback which was generally focussed around lateness, missed and the poor communication that they experienced from the office. One person told us, "I am very happy with the company but it may change if they change my care workers." Another person explained, "They need to look at the rotas. Some care workers come by car, some by foot. They expect them to both come on time. How can a care worker come on time when they are on the bus, delays and have to walk to my house. The rotas are too close. They leave my house for 9.30am and get to the next visit at 9.30 am, does not make sense, the company needs to look at this." Comments from relatives included, "A great improvement from a couple of years ago but they should give feedback to us when we make a complaint. They should contact the relative if the staff are going to be late. These are my two concerns otherwise very good," "I have used other care agency for my relative these are good" and "At the moment they are good."

Staff told us and records seen confirmed that rota scheduling was not effective and appropriately managed as visits were arranged back to back with very little, or in most cases, no allocated travel time between shifts. This meant that people received late visits on a regular basis and, where back to back visits were organised, it was virtually guaranteed that staff would be late. We heard about instances where this had a negative impact on people. The way the rotas were organised also had a negative impact on staff, who felt stressed knowing that they were always going to be late to appointments. A commissioning authority had also raised concerns about back to back visits with no travel time.

Poor communication and lack of feedback to people or relatives who had complained was also a consistent and prevalent issue that had not been managed appropriately, Although it was positive to note that the service through an internal provider audit carried out in 2016 had recognised and highlighted similar issues to what we found during this inspection, the provider had failed to address the inherent fault in the management of staff rotas and lateness and where significant concerns and issues had been raised around lateness and missed visits, or ensuring people and relatives received appropriate feedback upon raising a complaint, this had not been addressed.

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

Following the inspection the provider was requested to provide information about the actions taken as a result of the issues and concerns that had been identified. The provider gave details of a number of actions that had been taken in order to make immediate remedial improvements and steps to reduce the risks identified which included a review of rota management systems, training and recruitment

Mostly all people and relatives that we spoke with knew who the registered manager was and felt able to contact them if there were any issues or concerns. However, there were some people who did not know who the registered manager was but did know that they could contact the office any time and speak with the

care manager, field care supervisors or care co-ordinator to discuss their concerns. One person told us, "Yes I know the manager, good from my perspective the carers turn up and they like my relative." Another person said, "The manager is alright with me." One relative commented, "No, I may have met them at the assessment." Other relatives named staff working within the office who they communicated with on a regular basis but none of them referred to the registered manager.

Most staff told us they found the office to be well-run and office staff to be supportive. One care staff told us, "I've really enjoyed working here. It's really good, really helpful and friendly. If I have a problem they [the office staff] help us. I feel very much supported." Another care staff stated, "They [the office staff] are a good bunch to deal with. [Registered Manager] is okay. I love her, she understands me."

Care staff told us that the office regularly communicated with them by telephone, text messages and emails about any day-to-day issues or updates around the provision of care. Monthly newsletters were produced and given to care staff which addressed issues locally as well as company-wide. Articles within the newsletter addressed issues around timesheets, training, lateness, communication as well as information on television programmes that highlighted unacceptable care.

The service also held care staff meetings every two to three months. Agenda items included CQC inspections, branch information, time critical calls, record keeping, medicine recording, lateness and no replies. Minutes of these meetings were produced and sent to any staff member that had been unable to attend. Care staff confirmed that staff meetings were scheduled and some they were able to attend, however, some care staff told us that they were unable to staff meetings because, "There is just no time to do this. I have too many calls to fit in." Where care staff were able to attend feedback about the meetings included, "Staff meetings are very helpful. As carers we don't get to see other carers and it's nice to see people. It feels like a family and we feel more united."

In addition to the care staff meetings, the provider, registered manager and senior managers also held management meetings on a regular basis which included branch manager meetings, operations meetings and care manager meetings. These meetings were recorded and agenda items included missed visits, time critical calls, internal audit reports and the steps to take if a person did not open the door at the time of their call.

The registered manager had systems and processes in place to check and monitor the provision and delivery of personal care and support. These included systems to monitor when a person's care and support package was due for review, a record and overview of late and missed visits, and unannounced spot check visits. The registered manager also carried out weekly random care plan checks and staff file checks. However, these checks were not recorded.

The provider had a branch reporting tool where each person receiving a support package was loaded onto the system. The service was then able to log onto the system any incidents or accidents, safeguarding concerns, complaints, lateness and missed for each person. This allowed the registered manager as well as the provider to access a dashboard where they were able to monitor any trends or patterns and then act accordingly to ensure improvements were made or any learning was acknowledged and implemented.

In addition to monitoring the delivery of personal care and support, the registered manager told us that the provider also carried out annual mock inspections which mirrored the way in which CQC inspected so that the service could be rated internally and improvements could be made where necessary. An action plan was in place to make improvements.

Management oversight of the service, through the branch reporting system, also included when care staff were due supervisions, appraisals, spot checks and refresher training. The service employed a quality manager who was responsible for ensuring that reviews, quality checks, supervisions and appraisals were scheduled in a timely manner. This included sending reminder emails on a monthly basis to all care managers informing them of all the reviews, supervisions and appraisals that were due. The quality manager was also responsible for auditing homecare report books and where issues with recording were identified these were addressed with the care staff through supervision. Where themes of concern were also identified refresher training sessions were delivered.

The service had a clear management structure in place with designated teams to support people and staff. Three teams covered one or two local authorities, dependent on size and were led by a care manager, care co-ordinator and allocated field supervisors. Attached to the team were electronic monitoring administrators who were responsible for overseeing the live call monitoring systems which ensured that people received their call in a timely manner where possible.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely and effectively.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always managed and responded to in a timely manner. People and relatives did not always receive feedback on the complaint that they had made and improvements were not always implemented.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not effectively manage and respond to complaints. Issues around lateness, missed visits and poor communication had not been addressed appropriately and immediate improvements had not been implemented.