Lifecare Qualifications Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

The inspection took place on 6 and 7 September 2017 and was unannounced. This was the first inspection since the provider registered with us in December 2015. The provider had recently completed an office move and this location registered with us on 7 August 2017.

Lifecare Qualifications Limited is a domiciliary care service providing personal care to people living in their own homes. At the time of our inspection they were providing care to approximately 240 people across four local authority areas.

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

People were not consistently protected from avoidable harm and abuse. Although care workers escalated concerns about people's circumstances to the office, office based staff failed to identify these concerns as possible abuse and did not report them on as safeguarding concerns. The provider had failed to identify issues with care worker attendance at care visits could constitute neglect.

Plans in place to mitigate the risks people faced while receiving care were insufficient and did not include enough information to address the risks. Not all risks faced by people had been properly assessed and instructions for care workers to mitigate these lacked detail. Records did not show medicines were managed in a safe way.

People told us their care workers were rushed and often late. Records showed care workers were often late or early and did not stay the full allotted time. There were not enough staff deployed to ensure that people's needs were met. Recruitment files did not demonstrate staff were recruited in a safe way.

People did not feel confident that all staff had received the training they needed to perform their roles. Training records were incomplete and showed not all staff had received the training required to perform their roles. Records did not show staff received supervision in line with the provider's policy.

Consent was not always sought in line with the requirements of the Mental Capacity Act 2005 and related guidance. Care workers told us they offered people choices.

People told us care workers were meant to support them with meal preparation and eating and drinking. People's experiences varied and some people told us this support was not good enough. Staff maintained records of what people had eaten and drunk.

Records showed care workers escalated concerns about people's health and supported them to access

healthcare professionals when required. Information about people's healthcare needs and usual presentation was limited which meant there was a reliance on individual care worker knowledge to ensure people's healthcare needs were met.

People told us their relationships with regular care workers were positive and caring. However, they also told us the strength of relationships was affected by changing rotas. Some staff did not demonstrate they understood the importance of kindness and compassion in care relationships.

Care plans did not include information about people's sexuality and there was no consideration of the impact this may have on their care preferences. Relatives told us their cultural background was not always taken into consideration by the service.

People gave us mixed feedback about the level of involvement they had in writing and reviewing care plans. Care plans lacked detail, were not personalised and did not contain enough information to inform staff how people liked to receive their care.

People and relatives told us it was not always easy to make complaints about the service. Records of complaints showed the provider investigated and responded to complaints but there was no record that lessons were learned and some agreed actions were not clearly completed.

The registered manager and nominated individual told us they were aware of the issues with the quality and safety of the service, and had been working to address them since June 2017. The efforts made to address the concerns had not been effective as issues remained widespread at the point of inspection in September 2017.

Records showed audits did not consider the quality of records. There were plans in place to seek feedback on the quality of the service from staff and people but these had not been completed.

Records showed the culture of the management team was not one that valued staff. Care workers felt under pressure to take on more work than they were able to manage.

We found breaches of eight regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The 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.

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. The service did not identify or escalate concerns or incidents as safeguarding concerns.

There were insufficient measures in place to mitigate risks people faced during care.

Medicines were not managed in a safe way.

Staff were not deployed in a way that ensured people's needs were met. Records did not demonstrate staff were recruited in a safe way.

Is the service effective?

Inadequate

The service was not effective. Staff had not received the training or support they needed to perform their roles.

The service was not seeking consent in line with legislation and guidance.

People told us not all staff supported them with meals in an appropriate way.

Care workers escalated concerns about people's health but office staff failed to recognise where these could constitute possible abuse.

Care files did not contain clear information about people's healthcare needs.

Is the service caring?

Requires Improvement

The service was not always caring. Some people told us they had developed good relationships with their regular care workers. However, other people told us care workers did not show a caring attitude.

Some staff described how they build relationships with people. However, some staff did not demonstrate an understanding of compassionate care.

Care plans did not include information about people's sexual orientation and the impact it may have on their care preferences. Some staff demonstrated a limited understanding of the impact of sexual orientation on care preferences.

People and relatives told us the service did not always understand or reflect their cultural background.

Is the service responsive?

Requires Improvement

The service was not always responsive. People and relatives told us they were not always involved in writing and reviewing their care plans.

Care plans lacked detail and did not contained personalised information about people's care preferences.

People were not confident in the complaints process. Records showed the provider investigated and responded to complaints, but it was not always clear that lessons had been learnt.

Is the service well-led?

Inadequate

The service was not well led. Actions taken to address issues with the quality and safety of the service had not been effective.

Audits did not consider the quality of records.

The management team did not present a culture that valued the contributions of all staff.

Lifecare Qualifications Limited

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.

The inspection took place on 6 and 7 September 2017. The first day of the inspection was unannounced. The inspection was completed by three inspectors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts had experience of caring for someone who received personal care in their own home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we sought feedback from the local authorities who funded packages of care with the provider.

During the inspection we spoke with 17 people who received a service and six relatives of people who received a service. We spoke with 13 members of staff including the nominated individual, registered manager, deputy manager, one care coordinator, a human resources advisor and eight care workers. We reviewed 18 people's care files included their needs and risk assessments, care plans, reviews and records of care received. We reviewed 18 staff records including recruitment, supervision and training records. We also reviewed various documents including meeting minutes, emails, call monitoring information, surveys, feedback and audits relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

People and their relatives were confident they were safe with their regular care workers. One person said, "I do feel safe with [regular care worker]." Another person said, "She [regular care worker] tried to protect me." A relative told us, "I feel confident about the carers." However, people and relatives also told us they did not always feel safe when their regular care worker was unavailable and cover care workers provided support. One person said, "I feel safe with the regulars, but with some of the other fellows I'm not so sure."

Staff told us, and records confirmed, they reported concerns if people were unsafe or being abused to the office. However, office staff were not identifying concerns as possible allegations of abuse or neglect by their staff. Although records showed office based staff escalated concerns to social services, they did not raise concerns as safeguarding alerts. For example, the complaints record submitted by the provider included allegations of missed and late visits, and of staff not preparing meals as directed by the care plan. Although the service had responded they had not identified this as an allegation of neglect and raised the appropriate safeguarding alert. Other records showed care workers had reported concerns regarding possible financial abuse which had not been raised as safeguarding concerns.

The minutes of a staff meeting held in April 2017 were reviewed. These contained the note, "Missed visits are unacceptable and can lead to Safeguarding; this is something that must be avoided at all times. Safeguarding can cause a lot of problems and lead to even closing the business." There was a risk this could be interpreted as instructing care workers that safeguarding was unacceptable. The provider told us the emphasis was on missed visits being unacceptable but this was not clear from the record. Despite the provider agreeing that missed visits were unacceptable and should be reported as safeguarding, there were still many missed visits and they still did not report these as safeguarding.

Call monitoring information was reviewed by the inspection team and showed calls recorded did not match those scheduled. Calls were frequently late, missed, or cut short, and where two carers were required, their visits did not always overlap. The provider had not identified care delivered in this way may constitute neglect and should be raised as a safeguarding concern. We raised safeguarding alerts regarding the call monitoring data.

The above issues are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who received a service presented with a range of risks that required mitigation. For example, people needed support with moving and handling, or had health conditions which required support to manage, including diabetes, epilepsy and pressure ulcers. Although the service completed environmental risk assessments, the other risk assessments in place contained insufficient information to mitigate risks or had not identified risks at all.

For example, in two care files the referral information included the need for care for existing pressure ulcers but the care assessments had recorded that people's skin was "clear" and there was no information for care

staff about how to mitigate the risks of pressure damage to people's skin. After the inspection the provider submitted a risk assessment in relation to another person's risk of developing pressure ulcers. The information remained insufficient to mitigate risks. The risk assessment stated, "Although the risk of pressure sore is small, it does remain a prevalent and consistent risk. If it is not a matter dealt with in a timely matter. Consistent tilting and repositioning for the carers do well to build up the consistency." This is not information that informs staff how to mitigate the risk of developing pressure ulcers.

Risk assessments in place around people's moving and handling needs lacked detailed instructions for care workers to follow in order to mitigate risks. The provider used a template which included space to specify the support needed and equipment used for different types of manoeuvre, such as standing up, transferring from one seat to another or getting into or out of bed. The risk assessments stated only the number of carers required and not what actions they had to perform.

Where people required hoists to transfer there was no information about the type of sling or person's position within the sling during transfer. One care worker told us, "I support people who use the hoist. The occupational therapist explains to us or the senior carers explain to us. Most of the hoists are for two people so we learn from the other carer." A relative told us they were not confident staff were trained to use moving and handling equipment in a safe way. They said, "Lifestyle just come to help [live in care workers from another agency] with the manual handling twice a day, they are not really of a standard that could do anything else."

Referral information and feedback completed by care workers showed that some people behaved in a way that challenged care staff, or behaved in a way that put themselves or others at risk. One person's care file noted they were often verbally abusive to care workers, and behaved in a way that risked harm to themselves. Although this was noted in the care file, there was no information for care workers on how to respond to these behaviours or manage these risks. This meant people and staff were at risk of harm as there was insufficient information for staff about how to mitigate risks.

People were supported to take medicines by staff. The provider had been in the process of introducing electronic medicines administration records (EMAR) since January 2017. However, this system was not yet operational. Care plans did not contain information about people's medicines and there was no information available to care staff about the purpose of medicines or any potential risks or side effects of medicines. Although the provider told us care workers could access this information from their phones through their online care records system, only one of the eight care workers we spoke with told us they did this. All the other care workers told us they found medicines information by checking medicines containers in people's homes. This information relates to prescribing instructions only and does not include information about side effects or the purpose of medicines that is required by care workers to ensure they are administering medicines in a safe way.

While the EMAR system was being introduced the provider instructed care workers to continue to complete paper medicine administration records (MAR). MARs checked by the inspection team did not demonstrate people had received their medicines as prescribed. Staff were signing to say that the "contents of blister pack" had been administered. This is not sufficient as staff are required to record which specific medicines have been administered. The registered manager and nominated individual told us that spot checks completed by care coordinators included checks on medicines administration and records. However, in the 18 care files checked there were only five spot checks completed since January 2017. This meant issues with the safety of medicines administration and record keeping had not been identified and people remained at risk of unsafe medicines administration.

The above issues with risk assessments and medicines management are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff told us they did not think the service had enough staff to meet people's needs. People and relatives told us this affected the punctuality of care workers. One person said, "My regular tries to be on time but they overwork him, always another visit to do poor fellow." Another person said, "I'm losing my times, the lady from the office stood in today. Instead of 7am they can come up to 9am. I'm up early waiting for a shower and breakfast. They are short with staff on holidays." A relative said, "It's just the times. I can best describe how the times work as being up the creek. They should be here at 7, but not always. I understand if they get a bit delayed but it can get difficult. We needed them to be here early so I could go for an appointment but the girl didn't get here till 9.30. They had put her on three visits between 7 and 9 and that makes it impossible to get here on time. That is not unusual." One care worker told us, "They need more carers. We need them to make the work flow better." A second care worker said, "They always seem to be short staffed. Don't get me wrong, I love the work, but it can feel like I'm being forced to take on extras."

The registered manager told us care visits were scheduled to include travel time for care workers. Electronic call monitoring information reviewed showed that while care workers were sometimes given gaps between visits on their schedules, this was not always the case. In addition, records showed that even where schedules included gaps care workers punctuality was poor. Analysis of the call monitoring data for 16 care workers showed that out of 951 calls logged just 39% were within 15 minutes of the scheduled time. 20% of calls were between 15 and 30 minutes outside of the schedule, 22% of calls were between 30 minutes and one hour outside of the schedule and 19% were over an hour outside the schedule. This meant staff were not deployed in a way that ensured people's needs were met as care was not being delivered on time.

In addition, the call monitoring data showed that care workers were not always spending the allotted time with people. One person said, "They all seem to want to do and go. They are supposed to stay an hour but only one or two do." A relative told us they thought care workers rushed their family member. They said, "I feel he was rushed, and was not given the full hour." Analysis of 16 people's call data showed that only 59% of the scheduled hours had been delivered. 154 visits were logged as being less than half the length of time scheduled. One person received five calls that were under five minutes in length including two that were only three minutes long. This meant staff were not deployed in a way that met people's needs.

The above issues with staff deployment are a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment files did not show safe recruitment practice had been followed. Records showed application forms and first interview screening forms had been completed but there was no recorded assessment of the information in the application form or responses in interview. Application forms viewed lacked details and some did not contain any information about previous employment or qualifications obtained. There was no record these issues had been explored prior to appointing staff. References were dated after people had started working, in some cases there was more than six months between the recorded start date and the date of the references. This meant staff had been working with people in their own homes before the provider had sought assurances they were suitable for this type of work.

In addition, eight of the 15 staff files checked did not contain a photograph of the staff member. This meant the service could not be assured that the person whose identity and character had been checked was the person working for them. The provider told us they had identified the gaps in references when they changed record keeping systems and they were working to address them. However, none of the 18 staff files was fully

complete so the actions taken by the provider had not been effective in addressing the issues identified.

The provider told us their policy was that staff could start working with a criminal records check (DBS) from a previous organisation and then the provider would complete their own check. Records showed the provider was relying on previous employer DBS checks for two members of staff. There was no record to indicate these staff members had signed up for the DBS update service or that the provider had run an update check. There was no risk assessment within these staff files to show the risks of them working prior to a criminal records check being completed had been considered or mitigated against. This meant the service could not be assured these staff were suitable to work in a care setting as they may have committed an offence since their last checks had been completed.

The above issues with recruitment are a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People and their relatives told us they thought their regular care workers had received sufficient training to perform their roles. One person said, "My regular care worker is very well trained." However, several people told us they were not confident in the skills of all the care workers who visited them. One person said, "My regular is very well trained but at the weekends some that come are hopeless. They have no common sense and don't listen to me when I tell them anything." Another person told us, "They do seem well trained but some are better than others." Staff told us they completed both online training and face to face training in a classroom.

Records of training completed were unclear. A complete training matrix was requested but the information supplied related only to the care certificate. The care certificate is a recognised qualification that provides staff with the fundamental knowledge and skills required to work in a care setting. The provider told us staff completed additional training and refreshed the care certificate standards annually. The information submitted showed that 10% of staff training on dementia and cognitive issues had expired. In addition 14% of staff training on basic life support, 13% of fluid and nutrition and 10% of health and safety had also expired.

The provider's policy stated staff should receive supervision a minimum of quarterly. Staff files did not show this was taking place. In seven of the 18 staff files viewed there had been no supervision for over six months. The provider told us this was a filing issue and submitted a supervision matrix. This showed 18% of staff had no supervisions recorded, 2% had not received supervision in over a year and 15% had not received supervision for between six and 12 months. It was noted that dates in the matrix did not match dates of supervision records viewed in files. One staff member told us they were offered supervision, but it was not at a time that was possible for them. They told us, "I work weekends, but they don't do supervision on the weekend. So I have to go in during the week. If I need to do training I have to take leave from my other job to do it." This meant staff were not receiving the support they needed to perform their roles.

The above issues are a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest and as least restrictive as possible. Any restrictions for people who lack capacity and are living in the community must be authorised by the Court of Protection. We checked whether the service was working within the principles of the MCA.

Care files contained a tick box where staff completing assessments indicated whether people required the support of an advocate to make decisions relating to their care and treatment. In two care files this had been completed indicating these people lacked capacity to consent to their care. One person's file contained the name and contact details of a relative. The file noted, "[Relative] makes the decision on behalf

of [person]." The second person's file contained no contact details but a relative had signed the care plan. It was not clear whether this signature was indicating consent on behalf of the person or that the relative had been involved in a best interests decision making process. Relatives or other named individuals may only consent to care on someone's behalf if they are authorised to do so, either by being appointed as attorney by the person, or by being appointed by the Court of Protection. The provider had no record to show these relatives were legally appointed decision makers and the records were unclear as to whether the provider was following a best interests decision making process. Therefore they were not able to demonstrate they were seeking consent in line with legislation and guidance.

The above issues regarding consent are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information for care workers lacked detail about the type of decisions people were able to make, or how they expressed their choices. However, staff told us they continued to offer people choices while providing care. One care worker said, "I allow them to make choices. There are a few who can't communicate but we still ask them. We ask about their clothes, meals, shopping etc."

People and relatives told us care workers were meant to support them to eat and drink during their visits. Care plans included information that care workers should support people with meal preparation. However, there was no information about people's dietary needs or preferences to ensure care workers were preparing meals in line with people's preferences.

People told us they were not satisfied with how they were supported with eating and drinking. One person said, "My regular care worker does my meals. I have two boiled eggs, toast and a banana for breakfast, most acceptable. But at the weekends they don't know how to cook an egg." Another person told us the timing of their visits meant they did not always receive the support they needed to prepare and eat their meals. They said, "I put my evening meal in the oven so if they don't turn up on time it gets ruined. It's not the girls fault but I can't time it you see."

Records of care delivered showed that where care workers supported people with eating and drinking they recorded how much of what food people ate. Care workers told us they asked people or checked what was available to find out what people wanted to eat. The lack of information meant there was a risk people were not supported to eat and drink enough to maintain a balanced diet. After the inspection, the provider told us they would increase the level of detail in care plans in response to our feedback.

People and relatives told us their care workers would contact the office or healthcare professional if this was needed. Care workers told us, and records of their communication with the office confirmed, they would contact the office if they were concerned about people's health and would support people to see relevant healthcare professionals. Care files showed people who received a service were living with a range of long term physical and mental health conditions. Care files did not contain information on what the usual presentation of people was, and there was a reliance on the knowledge of regular care staff who knew people recognising when there had been a change in people's condition that might indicate the need for further healthcare support. This meant there was a risk that unfamiliar care workers might not identify when people became unwell and not request support appropriately.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us where regular care workers were provided they had built up and established positive relationships. However, the quality of relationships was affected by changing care workers. One person said, "He is a champion my regular carer, most kind and respectful. Most of the girls are too, but they are rushed." Two people told us they preferred to go without a service when their regular care worker was not available. People told us they felt their regular care workers treated them with respect and upheld their dignity.

However, other people told us the attitude of care workers meant they did not wish to develop relationships with them. One relative explained, "I had to speak to the office about some carers and ask for them not to come back. They worked like robots." A person told us, "Staff are pleasant enough but there's not much time. It's crash bang wallop." A second person described the attitude of carers as, "Indifferent" and "Very grudging."

Care workers were asked how they developed relationships with the people they supported and found out about their lives prior to receiving care. Some staff described how they would ask questions while they supported people, or chat with them and their relatives. One care worker said, "As you get to know them they tell you about their pasts, and they'll show you. They'll explain who is in the photo on the shelf once you've been a few times. It needs a relationship before they will tell you." Another care worker told us, "I have a chat with them. For example, [person] used to work in a factory. I know that because we have a chat."

Care workers confirmed that information about people's past was not included in the information they received about them. Some care workers told us it was not appropriate for them to know about people's pasts, or develop relationships with the people they cared for. One care worker said, "We don't build up relationships. When you come to them you remember they are not your family or friends. They will say things behind your back. After the shift we have left. I don't ask about people's lives. That doesn't matter we give them a shower just the same. I will support them with their care, and then I'll wait in the corridor to give them space until the time is finished." This showed a lack of understanding of the difference between professional boundaries and compassionate care.

Care files did not contain information about people's significant relationships and assessments did not contain questions regarding people's sexuality. In their PIR the provider had stated they had supported one person who had identified as lesbian, gay bisexual or transgender (LGBT) and they understood that it was important for people to feel safe to disclose their sexuality and the affect it may have on their support preferences. However, assessment records did not show staff were exploring issues of sexuality and preferences for care.

All the care workers we spoke with told us information about people's sexuality was not included in the information they received. Most of the care workers told us that identifying as LGBT would not affect the support people received. However, one care worker said they did not know what the terms lesbian and gay meant. As information about sexuality was not included in care plans, care workers were asked how they

would know if someone identified as LGBT. Several support workers told us they knew that no one they supported was LGBT because they had opposite sex spouses. This demonstrated a limited understanding of sexuality and the impact it may have on people's support preferences.

Care files contained information about people's religious beliefs. For example, it was noted in one person's file that practicing their faith could help make them feel better. However, in most files the impact of religious faith or cultural background on people's care preferences was not explored. As one relative explained, "We wanted care workers to wear shoe covers, we don't wear shoes in the house. The agency said we had to provide these ourselves." After the inspection the provider sent us records demonstrating they purchased overshoes for staff to wear in people's homes. Another relative told us they had transferred to a different provider because the service could not provide care workers who spoke the same language as their relative. They explained they had always been clear about the need for care workers to be able to communicate with their relative in this language. The provider had accepted the package of care but was unable to meet this need. This meant the service was not consistently providing care in a way that reflected and respected people's religious and cultural backgrounds.

The above issues are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives gave us mixed feedback about their level of involvement in writing and reviewing their care plans. One person said, "A person came from Lifecare and did a health and safety check. She explained what the carer would do when she came." Another person said, "Someone did come from the office a little while ago and there is a folder."

Three people we spoke with did not know what a care plan was. Other people told us the service was using the information that had been supplied by the hospital before the service started. One relative told us, "The care plan really baffled me. This man came out to do an assessment and statement of needs. He talked to me and my relative and then went away. A little later a carer brought a form for us to sign. It was a complete mess. It didn't relate to my relative at all and some sections were just repeated with a variety of incorrect answers. We should have had a revised plan but I haven't had one yet."

Care plans reviewed lacked detail and did not contain sufficient information for care workers to ensure they knew people's care preferences. For example, one person's care plan stated, "The service user is happy to have their personal care done, clean and tidy [their flat] and preparing meals." There was no information for care workers to know what their personal care consisted of, and what their preferences were for care tasks. Other care plans contained reference to people requiring specialist skills to support them. For example, one person's care plan stated their continence needs, "Require skilled input to manage." However, the care plan did not explain to care workers how to support this person with their continence needs.

The assessments completed by office based staff included a section where staff could record details about people's personality type. This was a tick box section where people could be categorised as "Passive." "Communicative." "Aggressive" or "Other." None of the care files contained further information to inform care workers how to respond to people's personality types. A number of people were described as "aggressive" with no other aspect of their personality or preferences explored. This was not a person-centred approach to developing care plans.

Some staff told us the high level summary provided in care files was sufficient for them to be able to provide care. One care worker said, "I know what personal care means." However, other care workers said it would be helpful to them to have more information about people's specific needs and preferences. One care worker said, "The care plans are kind of generic. It will say the same thing for each visit. I can work it out, for example they won't be having a bath four times a day, or lunch at breakfast time. We have to ask people for the detail. It can wind up the clients when we have to ask lots of questions."

Records did not show people's care plans had been reviewed in response to changes in their circumstances. For example, one person had recently been admitted to hospital and their discharge summary detailed significant changes in their needs and package of care. The documents in the file had not been updated to reflect this change. The provider told us care workers were able to access a greater level of detail through their online care records system. However, records viewed on this system contained no additional detail about people's needs or preferences. In addition, staff told us they got the information they needed from the

paper files in people's homes. Only one care worker told us they regularly got information about people's needs and preferences from the online system. This meant there was a risk that people did not receive care appropriate to meet their needs as care workers did not have up to date information about what people's needs were.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives gave us mixed feedback about the ease of the complaints process. While some people and relatives told us they had raised concerns and these had been addressed, other people told us they found it difficult to raise concerns. For example, one person said, "I haven't complained, what would be the point?" A relative said, "If you ring the office half the time they don't ring you back, or if I leave a message I am never sure where it goes, or if it goes at all."

Records of complaints showed most complaints considered were raised with the provider by the local authority as quality alerts rather than being received directly from people or their relatives. Records showed the provider took appropriate action to investigate and respond to these concerns. Ten complaints had been investigated during 2017. Six of these had been upheld, however, there was no record of any lessons learned from these complaints. Each complaint response included increased monitoring of the care packages to reduce the risk of future problems. However, there were limited records to show monitoring of care packages was taking place. This meant the provider had not ensured that lessons were learnt following complaints. After the inspection the provider told us they were introducing a system to ensure quality monitoring of packages was scheduled and completed regularly.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us they did not think the office was well organised or was effectively managed. One relative said, "They [management] change the girls schedule all the time. Two girls turned up one morning as they had changed the girls' calls on their phones last minute. I ask you, is that organisation?" A second relative said, "The carers are OK but the management is something else." A person who used the service told us, "I've spoken to the managers a few times. They were calm not aggressive. They were not knowledgeable about procedures." Although most staff told us they felt supported by the office and that management provided support to them, two care workers had never heard of the registered manager.

The registered manager and nominated individual told us they were aware of the concerns about the quality and safety of the service identified during the inspection. They told us they had identified issues with the completeness of recruitment files when updating their online systems in January 2017. They told us they had identified issues with the quality and completeness of people's care files and risk assessments in June 2017. The inspection took place in September 2017 and found these issues had not been effectively addressed.

The provider submitted copies of audits and correspondence between the registered manager, nominated individual and office based staff regarding improvements and actions required for people's files. These showed there had been a review of the content of files, but not the quality. Staff were instructed there was a need for a risk assessment, review or updated care plan but were provided with no feedback about the quality of the documentation.

People told us they were not offered the opportunity to provide feedback. Only one person told us they had been asked to complete a survey. This was despite the provider's business plan stating quarterly feedback surveys should be completed with a target of 50% completion. The provider told us, and the complaints analysis showed spot checks should be completed at least quarterly. However, only two of the care files reviewed contained a spot check that was less than 3 months old.

The provider submitted correspondence showing they had appointed a member of staff to monitor the quality of the call monitoring data. However, this correspondence, and related meeting minutes and supervision records showed the focus was on ensuring that the system was used, not ensuring that calls were completed on time and for the full duration. This meant the provider was not using the systems available to them to identify or address issues with the quality and safety with the service.

The service was managed by the nominated individual, registered manager and a deputy manager. In addition, each geographic area had allocated coordinators and supervising care workers. The management team told us they held weekly office based meetings to discuss quality issues and to communicate key messages. However, only one meeting record was made available to us and this dated from July 2017. The management team also told us they held regular staff meetings. They sent us a copy of records of one meeting from April 2017. After the inspection the provider told us dates when other meetings had been held. The provider sent out quarterly newsletters to their staff. These methods of communication had not been

effective as staff were not working in line with the provider's policies.

The management team told us they had attempted various initiatives to increase staff capacity, particularly on weekends. These included recruitment drives and offering permanent contracts to staff. Supervision records showed staff were asked to work in addition to their stated availability. Email correspondence showed staff who could not work weekends would not be offered fixed contracts, which were hoped to incentivise staff. An email between the management team showed they had moved a care worker from their preferred place of work, but were now refusing to offer them a fixed contract. The email stated, "We have agreed that people who cannot work on Sundays cannot be offered the contract. [Staff member] refuses to work Sundays." The email continued, "[Staff member] did not want to go to [different area for work] but we made him go." A care worker told us, "They don't recognise I have other commitments. You get forced into working more hours." This showed the management team did not promote a culture that valued staff contributions to the organisation.The provider sent us copies of the feedback surveys completed by staff. They had not raised the issues found on inspection through these surveys.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect and did not feel their cultural needs were met. Regulation 10(1)(2)(c)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Records did not show the provider had sought consent in line with the MCA. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Records did not demonstrate staff had been recruited in a safe way. Regulation 19(2)(a)(3)(a)(b)

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 9 HSCA RA Regulations 2014 Person-centred care Needs assessments and care plans lacked detail and did not contain sufficient information to ensure that people's needs were met. Regulation 9(1)(a)(b)(c)

The enforcement action we took:

We issued a warning notice for the provider and registered manager to comply with this regulation by 30 November 2017.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been appropriately identified or mitigated against. Medicines were not managed in a safe way. Regulation 12(1)(2)(a)(b)(g)

The enforcement action we took:

We issued a warning notice for the provider and registered manager to be compliant with the regulation by 30 November 2017

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service had failed to appropriately identify and escalate safeguarding concerns. Regulation 13(1)(3)

The enforcement action we took:

We issued a warning notice for the provider and registered manager to comply with the regulation by 30 November 2017

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	Systems and processes were not operating effectively to monitor and improve the quality of the service. Regulation 17(1)(2)(a)(b)(d)(i)

The enforcement action we took:

We issued a warning notice for the provider and registered manager to comply with this regulation by 30 November 2017

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed in a way that ensured that people's needs were met. Staff did not receive sufficient support and training to perform their roles. Regulation 18(1)(2)(a)

The enforcement action we took:

We issued a warning notice for the provider and registered manager to comply with this regulation by 30 November 2017.