First Choice Homecare & Employment Services Limited

First Choice Home Care & Employment Services Limited - Hackney

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 24 and 25 May 2016 and 1 and 3 June 2016 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 in. At our previous inspection on 9 January 2014 we found the provider was meeting the regulations we inspected.

First Choice Home Care and Employment Services Limited Hackney is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our visit the service was providing support to 429 people in the London Boroughs of Hackney and Camden. The majority of the people using the service were either funded by the local authority or the NHS.

There was a manager in post at the time of our inspection who had applied to be a registered manager. The previous registered manager had left recently and the current manager had been in post for two weeks. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service did not have appropriate systems in place to protect people from harm. People who lived with specific health conditions had not had the risks associated with these conditions assessed and care plans were not developed from these to ensure their safety and welfare. Risk assessments were not detailed, did not provide staff with guidance and had not been reviewed if people's needs changed.

The provider did not have a good understanding of the policies and procedures in place to safeguard people from abuse and avoidable harm. There system in place to report and follow up incidents was not followed and ineffective and disciplinary procedures were not followed to ensure people's safety.

There was not an effective system in place to monitor staffing levels and ensure that there was always enough staff in place to meet people's needs. Calls were not being monitored and there was no effective system to make sure people had their visits on time. The provider did not follow a robust recruitment process to ensure staff had the necessary checks and were suitable to work with people using the service.

Appropriate policies and procedures were not in place to ensure that people received their medicines safely and effectively.

Whilst a new trainer had been recruited and was starting to deliver their training programme, training records were inconsistent. Staff did not receive the required induction, training, supervision and support to undertake their role. There were staff working at the service without the knowledge and skills to provide people with safe care and treatment.

Requirements of the Mental Capacity Act 2005 (MCA) were not followed. The provider did not have a clear understanding that people should consent to their care and support to ensure that their rights were protected. There was limited evidence that the provider had sought people's consent such as signed consent forms and care plans, and there was no indication that people's capacity had been assessed and decisions made in their best interests where they were unable to make a specific decision for themselves.

People were supported to have sufficient food and drink however people's preferences were not recorded and care plans did not identify risks or nutritional needs. People with diabetes were not monitored or managed effectively to minimise the risk of their health being compromised.

People and their relatives told us that their regular care workers were kind and caring and knew how to support them. However, when replacement care workers were used people were not happy as late and missed visits became more of a problem and people received inconsistent levels of care.

Care plans lacked detailed information, were incomplete, not specific to people's needs and in some cases, not in place. We were not assured they reflected people's wishes and how they wanted to be cared for.

The investigation and review of complaints, incidents, accidents and serious events which occurred within the service was ineffective and did not support learning. Information was not identified and acted upon to ensure the safety and welfare of people.

The provider did not meet the CQC registration requirements regarding the submission of notifications about serious incidents, for which they have a legal obligation to do so.

There was no overall leadership of the service in place. Quality assurance and management systems were not in place to monitor the care provided to people who used the service.

We found a number of breaches of Regulations in relation to person centred care, safe care and treatment, safeguarding, consent, good governance, staffing, fit and proper persons employed and notifications. You can see what action we told the provider to take at the end of the full version of this report. We are considering what further action we are going to take. 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.

Risks to people's health and wellbeing had not been assessed and were not monitored to ensure people were safe.

People were not always protected from the risk of potential abuse because the provider did not always follow their disciplinary procedures or respond appropriately to safeguarding concerns.

There were inadequate systems in place to ensure there were always enough staff in place to meet people's needs. Robust recruitment procedures were not followed to minimise the risk of unsuitable people being employed.

Appropriate policies and procedures were not in place to ensure people received their medicines safely and effectively.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive the support and training they needed to carry out their role effectively.

Supervision and checks on staff were not in place to monitor their capability and understanding of the tasks they were required to undertake.

Staff did not have a clear understanding of the principles of the Mental Capacity Act 2005 and people had not consented to the care and support they received.

People's nutritional needs and preferences were not managed appropriately and did not take into account medical needs, such as diabetes.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in making decisions about their care and the support they received.

Staff did not always treat people with respect and were not always attentive to people's needs.

People commented positively about their regular care workers caring attitude however felt replacement care workers were less reliable and did not provide the same levels of care.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans for people lacked detail, were incomplete and were not person centred. We were not assured they reflected people's wishes and didn't meet people's needs.

There was not an effective system in place to deal with people's complaints and information was not used as an opportunity to learn and improve the service.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not meet the Care Quality Commission registration requirements regarding the submission of a number of safeguarding incidents and incidents involving the police, for which they have a legal obligation to do so.

Systems to monitor the quality of the service were limited and ineffective and there was a lack of an open and transparent culture.

There was a lack of leadership, direction and oversight of people's care which led to people experiencing inconsistent and unsafe care.

First Choice Home Care & Employment Services Limited - Hackney

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 the 24 and 25 May 2016 and 1 and 3 June 2016 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 in.

The inspection team consisted of three inspectors, with one present on all four days of the inspection, one on the 24 May and one on the 25 May. It also included two experts by experience who were responsible for contacting people during and after the inspection to find out about their experiences of using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC and the report for the last inspection that took place on 9 January 2014. We also contacted the local authority safeguarding adults team, the quality monitoring team and commissioning team and used their comments to support our planning of the inspection.

We called 78 people using the service and managed to speak with 25. We also spoke with 12 relatives and 32 staff members. This included the managing director, the business development manager, the branch

manager, three care coordinators, two field care supervisors, the HR officer, the trainer, an office assistant and 21 care workers. We looked at 16 people's care plans, 16 staff recruitment files, staff training files and records related to the management of the service.

Following the inspection we contacted seven health and social care professionals who had worked with people using the service for their views and heard back from four of them.

Inadequate

Is the service safe?

Our findings

Some people told us that they felt safe when they received their care and support. One person said, "They support me safely and look after me well." One relative said, "The current care worker has been coming for about two years and does a great job." However, we also received a number of negative comments where people did not feel safe. One person told us that they did not feel safe when they were being moved as the care workers did not know how to use the equipment properly. Another person said, "Lateness is always a problem and sometimes there are no visits at all. If they don't turn up I can't take my medicines." A relative told us there were problems with time keeping and missed visits and said it had an impact on them as they had to provide the support.

We were told that risk assessments were completed upon the commencement of care being authorised and that these were updated on an annual basis. We looked through people's risk assessments and noted that reviews of people's care and support were not taking place on a regular basis. One person had not had a review since October 2013 despite there being significant changes in their care needs. Individual care records did not identify risks in relation to people's individual needs such as medical conditions, mobility, personal care, their mental health and nutrition. In addition to this there were no records to indicate how risks should be managed by staff in any of the care records viewed which could put people at risk of unsafe care. Risk assessments were completed on a tick box format and did not advise staff about how to recognise the risk, what actions to take or how to mitigate the risk in the first instance.

One person had cognitive difficulties and a history of wandering. The risk assessment for this person stated that there were no risks to their safety. Their care package included a night time visit to check that they had not left the house but there was no management plan in place to advise staff about what to do in the event that the person was not at home to ensure that steps were taken to find them and ensure their safety. A door sensor was also in place but there was no record of this in their file. Another person was unable to get in or out of the bath, use stairs and needed support managing their continence. There was no information within the risk assessment about how to support them safely. There was no description of what the potential hazards might be and the action plan to minimise risks was blank. We saw risk assessments for two people who required the use of a hoist to carry out personal care. Both records contained no information or guidance for care workers about how to carry out these tasks safely or what level of support was needed. We carried out follow up calls to both people and their relatives who confirmed that their care workers were unable to move them safely and accidents had occurred.

The above demonstrates that the provider was not doing all that was possible to mitigate risks to people using the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider had ineffective systems in place to ensure that people were protected from abuse. People could not be assured that all incidents would be responded to appropriately and were not protected as staff did not understand their responsibilities in relation to reporting safeguarding concerns. The provider failed to report and follow up safeguarding concerns appropriately to ensure people's safety.

We saw records relating to five incidents involving eight care workers where disciplinary procedures were not being followed as care workers who had been suspended following safeguarding concerns were still actively working with other service users. Two care workers had been suspended pending an investigation into allegations of neglect. The provider told us that both care workers had been suspended and showed us a copy of their suspension letters. However, we saw evidence on the provider's electronic monitoring system that both care workers had worked the following day and throughout part of their suspension period. The business development manager was unable to explain why this was and said it was the responsibility of the registered manager, who was no longer working for the provider.

We saw information in the provider's out of hours report records that a relative had called to say they did not want a care worker to return because they had hit their family member. The provider was unable to provide another care worker to cover two further calls so the family member agreed to support the other care worker with the visits. The care worker was removed from that particular call, however continued to work with other people using the service until the following week. There was no evidence the incident had been recorded as a safeguarding alert or that the incident had been followed up. We made a follow up call to the relative who confirmed this and said that despite complaining a number of times nobody contacted them about it. They added that after they had made a complaint, when the care worker returned to their relative they poked them in the head and shouted at them for complaining.

During the inspection, one of our experts by experience spoke with a person who said that a care worker had stolen money from them but nothing had been done about it and the care worker was still working. We followed this up with the provider who told us that it was the first time they had heard of the allegation. The business development manager later told us that a field care supervisor had spoken with the person in January 2016 about the incident however there was no record of the allegation being logged, investigated, followed up or notified to the relevant organisations. We asked the provider to raise a safeguarding alert with the local authority during the inspection.

The provider did not always protect service users from abuse and improper treatment and did not have effective systems and processes in place to prevent abuse of service users. Safeguarding concerns had not been appropriately shared, investigated, recorded or recognised. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day one of the inspection we listened to part of a safeguarding training session that was being carried out for care workers. The managing director told us that they had just recruited a new trainer within the last four weeks after their previous trainer left in October 2015. The training was well presented in that accurate information was presented about safeguarding, scenarios were used and the session was interactive and thought provoking and time was given for staff to ask questions. Clear guidance was given to staff about reporting concerns immediately and there was an open discussion about what would be considered a safeguarding concern.

At the time of the inspection the branch manager told us that the office were short staffed and said the provider was in the process of recruiting three care coordinators. This left three care coordinators to cover all people's calls. One coordinator was responsible for covering the Camden area, two for the Hackney area. On the fourth day of the inspection one of the care coordinators was off work. We spoke with one of the other care coordinators about who was covering their area and they said at present they did not know. The office was a hectic environment throughout the inspection with care coordinators having to deal with calls, assign visits and deal with care workers coming in throughout the day to raise any issues they had and confirm time sheets. Two care workers had recently been asked to step up as field care supervisors to help out while positions were being recruited to. One care worker said, "There aren't enough care coordinators.

They say they are recruiting but nothing is happening."

We spoke with care workers about their schedules and if there was enough time to get between visits. One care worker explained to us that some calls finished when another one was due to start in another area of town so it was impossible to get to certain shifts on time. They told us that they were scheduled for a 7am-8am visit, then an 8am-9am visit, then a 9.30am-10am visit and then a 10am -11am visit, all in different locations and needed to use public transport to get between each call. They added, "I have to call the office if I'm running late but sometimes when they are busy they may not answer the phone."

We found that staff covering the 'night owl' shift (night time welfare checks) were also carrying out regular shifts in the day. Even though the business development manager said this was not the case we found evidence on the electronic monitoring system that these care workers were on the rota. One care worker had been carrying out the night shift for five consecutive nights whilst also covering up to four shifts during the day between 9am and 5pm. Another care worker was also carrying out shifts during the day as a field care supervisor. We spoke to the care worker about this who told us that they were helping the team out as they only had four drivers to cover the service and did not want to let them down.

People using the service and relatives that we spoke with told us about the impact that late and missed calls had on them. We looked through the out of hours report records for the four weekends prior to the inspection. We found 42 incidents of missed or late visits, including calls that had not been assigned as care workers were unaware of the shift. The out of hours staff were responsible for finding cover in these instances and we saw where they had contacted other care workers to cover the shift. However, we saw 12 incidents of missed or unassigned calls that had no further information about the visit. For example, one person called to say that their care worker had not arrived. The out of hours staff called the allocated care worker but was told they had not been allocated that call. As there was no further information we could not be assured that the call took place.

The above demonstrated that the provider did not ensure there were sufficient numbers of staff deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff recruitment records we looked at showed that there were processes in place to complete appropriate checks however some information was missing. Four care workers files only contained one reference and some references had not been verified to ensure that they were authentic. In addition references were not always obtained from people who were in a position to assess the staff member's suitability for their role. For example, one of the references we saw was from a landlord and not a previous employer so it would be difficult to confirm if that person was suitable from that reference alone. Although we saw some Disclosure and Barring Service (DBS) checks there was no robust system in place to monitor DBSs and there was no system in place to review each staff member's suitability at regular intervals. For example, in one file the last criminal records check was completed in 2011 and there was no evidence of any recent checks to ensure that the staff member remained suitable. One care worker, who had been involved in allegations of financial abuse, had a DBS which was three years old and there was no evidence that the provider had taken any action to ensure that they had current information about the staff member's criminal records to show that they were taking steps to protect people from unsuitable staff. When care workers had no DBS on file, electronic copies were printed and made available for us however one care worker had no DBS on file and staff were unable to locate it or show us an electronic version of it. We also found that one care worker was working without all the relevant checks being completed. The business development manager assured us that they were not working however we saw records on their electronic monitoring system that they had been scheduled onto the system to work with people.

The above demonstrated that the provider did not operate a robust and effective recruitment procedure to minimise the risk of unsuitable staff working with people who used the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the branch manager, a care coordinator and an office assistant about how they monitored people's calls, especially those who were classed as 'critical calls'. This could be somebody living on their own or with no family, people with specific medical conditions or those who were more vulnerable as a result of other factors. Staff showed us the electronic call monitoring system which showed care workers assigned to visits and when they arrived. This system allowed care workers to log in and out on people's landlines which showed they had attended the call. At the time of the inspection the provider was unable to tell us how many people had signed up to the monitoring system. We saw letters that the provider had sent people asking for permission for the care workers to log in upon arrival, which would not incur a phone charge. One care coordinator told us that a number of people had refused permission for this service to be used so they had to manually confirm calls by speaking with the person or the care worker. The risk alert notification system, which would notify office staff if a care worker was more than 15 minutes late, was not in place. For people who did not have a phone or refused permission for care workers to use their phone, there was a lack of effective systems in place to confirm if calls had been made.

We looked at one person's schedule on the monitoring system for the previous day. This person was classed as a 'critical call' who had five visits a day. All calls were unconfirmed so we could not be assured the calls had been made. We asked the care coordinator about this and they said they would be chasing this up today with the person or the care worker. They added, "They would call us if there was an issue." However if the person was unable to call the office staff would have been unaware if the person had not received their calls. We saw care coordinators confirming visits from the previous day. We spoke with an office assistant who was responsible for monitoring live calls. On the first day of the inspection they were carrying out payroll checks so we could not be assured that calls were being monitored. On the second day, the same office assistant showed us how they monitored calls, by going down a list and if they had not been confirmed they had to call the person or care worker. By 12pm we could see that they had only confirmed five calls. They were also unable to explain some features of the system as they had only been in post for one month.

We asked a care coordinator to show us when calls were being confirmed as we could not be sure that they were being confirmed on the day they were supposed to take place to ensure that people's needs were met. They tried to find this information for us, even calling the customer support number for advice but were unable to provide us with this information.

The electronic monitoring system was not being used effectively to monitor if people received their calls on time. The risk alert notification system was not being used, there were no systems in place to monitor critical calls and whether people's needs were being met on a day to day basis. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At time of inspection the registered provider did not know how many people needed prompting or assisting with their medicines. Their medicines policy stated that if people were prompted, this needed to be recorded so the support people required with their medicines could be monitored and reviewed if their needs changed. However, we found that this was not always the case.

There were no assurances that people received their medicines safely. We were only able to look through three people's daily log records and we saw no evidence of medicine administration record (MAR) sheets being filled in. The branch manager told us that if people just needed prompting then care workers did not

need to record what medicines were taken on a MAR sheet and could record it within the daily log records. However, three care workers we spoke with told us that they had been told to fill in the MAR sheet even if medicines were prompted. In one person's records we saw the care worker had recorded in the daily contact sheets when the person was prompted with medicines but there was no record of the type or dose of medicine taken. As there were no auditing records of medicines we could not clarify if the person's needs had been reassessed in line with the medicines policy.

Medicines risk assessments did not state how people's medicines were to be taken and at what time. Information for one person had been completed incorrectly. The assessment asked what assistance was required and it was recorded as prompting however at the end of the assessment the care coordinator had documented the persons medicines were to be administered but with no further information. There was a risk that staff may not administer the person's medicines properly.
One person's initial local authority assessment stated that the person needed support with their medicines however there was no mention of this, or any information relating to medicines in their care plan. Another person had the wrong medicines information in their file. Therefore there was a risk that the person may not have been receiving their medicines as prescribed.

Medicines were not managed in a way which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

When people started their employment with the service they had an induction and we saw some induction checklists in staff files. It covered a wide range of topics and policies and procedures, including a 'Getting Started' workbook, safeguarding, medicines, home visits and lone working.
However, there was not a lot of detail within the files and there was no clear indication of the induction process followed. Shadowing checklists were seen in four of the files viewed to show that staff had the opportunity to shadow senior staff before starting work on their own. Care workers we spoke with confirmed this. However, one file showed two days of shadowing while the others only had one in each file, indicating that new staff only shadowed other staff for one day before commencing work, and some cases this was just for two calls which wasn't sufficient to prepare staff to work independently.

At the time of the inspection the provider had a newly appointed trainer who had been in the post for four weeks. During the inspection we observed parts of mandatory training courses that were being carried out for staff. Ten training topics were delivered to staff as part of the mandatory induction which included safeguarding adults and children, moving and handling, health and safety, medicines and infection control. We saw that these training programmes would be carried out over four days.

Training records in staff files were not clear or up to date so it was hard to tell what training had been completed. There was evidence of mandatory training being completed in 2015 in four of the files. However, in one staff file there was no record of training since 2014, in another file six training certificates were out of date and in another there was no record of training at all. We asked to see the training matrix and the managing director told us that after the previous trainer had left it had taken time to find a replacement. She told us that there were gaps in staff training but said they were now working towards updating mandatory training for all staff. We found that even where training had been completed, training records were incomplete in staff files. At the time of the inspection 54 staff had moving and handling training that had expired, some had not had training since 2014 despite the provider's policy stating that all staff were to have annual moving and handling training. We saw that training was being carried out during our visit but we saw no practical training when it came to moving and handling. Care workers were only able to see videos of safe moving and handling practice before going to work with people and had not been able to take part in practical training so that they knew how to use equipment to move people safely. One care worker said, "The DVD showed us how to do it, but there was no equipment to practice it out on, no proper hoisting facilities available."

We had been told before the inspection that four care workers who had been involved in a safeguarding incident would have training in safeguarding and record keeping as part of the action plan following the investigation. However, the provider was unable to show us any evidence to demonstrate that this training had taken place. One relative had made a number of complaints about unsafe moving and handling techniques for their family member and we saw one such incident recorded in the out of hours report. We asked the business development manager for a copy of the care workers moving and handling training certificate however it could not be located. One care worker told us that they did not have any training before they started working with people. They said, "I had training with my previous company so I didn't do

any with First Choice. I've worked with some care workers and they have not had any training before starting but they should."

The managing director told us that supervision was carried out every three months. After requesting specific care workers supervision records we saw no evidence for supervisions for 14 care workers. Four of these had been involved in a safeguarding incident and we had been told they would receive monthly supervision for six months but this had not taken place. Other supervision records we saw were incomplete in files and there was limited evidence that development needs were discussed. One file had no supervision recorded since 2013 and two files had no recorded supervision from 2014. One care worker told us that they were not sure when they last had a supervision but it might have been at the beginning of the year. Another care worker told us that it had not been done for a long time because there is not enough staff. We spoke to one care coordinator about carrying out supervisions and they told us that they had not been able to carry out any supervisions since September 2015 as they had been short staffed. The managing director admitted this had been an oversight and stated that they did not have access to a previous system to get records. However this system was accessible as a care coordinator gave us access to check previous care worker schedules.

Not all files seen had appraisals in place. One appraisal was seen for January 2015 and one seen for February 2016. Four of the files we looked at had no appraisals in place. The appraisals seen did not explore performance and development needs in sufficient detail to show that any issues or concerns were followed up and staff offered the opportunity to develop. For example, one appraisal we saw for a care worker that had been carried out recently had very limited information in it. All performance areas had just been ticked, there were no comments from the care worker or the manager, no objectives had been highlighted and there was no evidence of discussion about future training.

The issues above highlight the lack of appropriate training and support for staff to allow them to carry out their roles effectively. This was a breach of Regulation 18 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 decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff who were responsible for carrying out assessments on people using the service had not undertaken training in understanding the MCA so that they understood their responsibilities in relation to adhering to the requirements of the Act and protecting people's rights. There were no consent forms on file and no evidence of best interests decisions or mental capacity assessments highlighting that people did not have capacity to sign agreement to their care plan. Some care plans were signed by the person, some were signed by relatives with no authority to sign on behalf of their family member. One person who was living with dementia, had not had their care plan signed and there was no evidence of a capacity assessment or best interests meeting. We saw three care files that had been signed by a relative but there was no evidence that the relatives had Lasting Power of Attorney and therefore the authority to do this. Two care files recorded that the family managed their finances but there was no information to ascertain if a best interests meeting was held regarding the person's capacity to manage their own finances. Therefore there was not always evidence in the care records that people had consented to their agreed care and support.

The provider did not have a clear understanding that they were required to demonstrate that people had

consented to their care and support and that where they were unable to do so that there was a process in place to ensure that any decisions were made lawfully and in the person's best interests.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day one of the inspection we observed part of a training session which covered food hygiene. It was divided into five sections and covered areas including bacteria, high risk foods, personal hygiene and temperature control. One care worker we spoke with told us they found it really useful and it was really important to understand the risks associated with it.

People told us that where they required assistance with food and drink, snacks and meals of their choice they were usually prepared as they wanted them. One person said, "They help me in the mornings. They put my porridge in the microwave and make me a cup of tea." Another person who was not so happy said, "They [staff] never check, they have left me meals that have been cold." A relative told us that there had been times when the care worker had not given their family member food, so they had gone without.

There was very little to no information about people's nutritional and dietary needs in any of the care plans we saw. People who required support with meals did not have their preferences highlighted, whether they had any medical conditions or whether they had any allergies. For people with diabetes, there were no risk assessments in place highlighting the risks and how these should be managed. There was no mention of the importance of visits taking place on time to ensure people received food at regular intervals and maintained safe blood sugar levels. For example, in one person's care plan it only stated 'support needed' and therefore this person was at risk of their needs not being met. In another person's care records, under diet in the nutrition section, it said 'none'. One other person was a diabetic but again there was no information within the care plan. Under diet it said 'can eat anything'. In a quality monitoring form, this person brought up a concern of a care worker falsifying a care log to say they arrived at 9.30am but had arrived at 10.30am so they had a late breakfast. There was no follow up of this concern in relation to their nutritional needs being monitored. Missed and late visits in addition to a lack of information and guidance for care workers put people at risk of avoidable harm in relation to their diet.

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

People told us that they were supported to maintain good health. One person said, "They always ask how I am and call the doctor if I'm not well." Another person told us that their care workers had contacted the GP when they had not been feeling well. One relative told us that their care worker had helped with getting their family member to hospital appointments. One person who was less positive told us that even though they told the care workers they were not feeling well, they did not tell the office or contact their GP.

As we were unable to see a large sample of people's daily records it was difficult to determine whether people were supported to maintain their health and access healthcare services. We saw some evidence in the out of hours records where care workers called ambulances or liaised with GPs and other healthcare professionals, such as district nurses. However, none of this information was held within people's care plans. Care plans also did not include people's GP contact details or information for when staff might need to make referrals to other health and social care professionals if their needs changed.

Requires Improvement

Is the service caring?

Our findings

The people using the service and their relatives had mixed views about the service. Some people were positive about the caring attitude of the staff and said that they were thoughtful and kind. One person said, "They always turn up and they are usually on time. I must admit they are both excellent. They are friendly and look after me well." One relative told us that the care worker was "very caring, capable and conscientious". However, some people made less positive comments. One person said, "Some of them are terrible. They try to finish as quickly as possible and give excuses that they need to go. Even if they aren't my regular carers they still need to look after me." One relative told us that there were lots of inconsistencies which had an impact on their family member and commented, "Sometimes they just come in without knocking, they rarely stay the full length of time but write down in the book they do."

People were generally assigned a regular care worker and people told us that they had their regular care workers other than when they were away or off sick which meant that people were supported by care workers who got to know them. A care coordinator told us that they looked at care workers geographical location when assigning them to people so it minimised the risk of care workers running late. People commented positively about care workers that they had had for a prolonged period of time however care was not consistent when other care workers had to cover. One relative said, "My [family member's] carer is on holiday this week and no one turned up today. I rang the office to inform them as I need to make sure that someone comes tomorrow. It really can be hit and miss."

Some people told us that their care workers stayed for the full visit and would sit and chat with them. However, the majority of feedback we received highlighted that care workers had a task led approach as they did not have the time to talk with people in a meaningful way. One relative said, "They don't always stay for the full time. They go early if they have finished their tasks. They have started logging in when they turn up but not when they leave." Another relative commented that if tasks were completed before the visit, care workers would leave rather than spending time sitting and chatting for the full visit. They added, "Those few minutes could be really important to find out how they are doing." One care worker told us that they sometimes did not stay for the full visit if they had finished what needed to be done. "If they don't need the full hour, I sometimes leave early." When we asked them about what was recorded in the log book, they added, "I'll be honest, it isn't always accurate what we write down."

Staff generally listened to people and acted on their views. Some care workers we spoke with told us they were flexible in their approach but sometimes they were running late so the time they spent with people was compromised. One care worker said, "I speak with my clients and try and find out what time is best for them." Another care worker told us that they did not think they were given enough time to get to visits. "I have one visit finishing at 9am and another starting at the same time. I have spoken to the office about it though." Some people said that whilst late calls could not be avoided it would be courteous for staff to call and let them know. One care worker said, "I used to call the office if I was running late but sometimes they wouldn't inform the client so I call them directly now."

People using the service and their relatives told us that their service had started usually after a stay in

hospital or a period of ill health. Some people using the service had been involved in the planning of their care. The approach for some people had been a visit from a care coordinator to complete an assessment of their needs before care and support was arranged. One relative told us that somebody had visited their home to carry out an assessment and felt they listened to their family member.

However, other people were not involved in planning their care. Some people were unaware if they had a care plan or not and whether any reviews had taken place. We saw care plans that had not been signed by people or their representatives with little or no information gathered about how they wanted their care to be carried out. Some care plans we asked for were not available. Therefore we could not be assured that people were involved in planning and making decisions about their care.

Most people told us they were treated with dignity and respect at home. One person said, "They respect my privacy and dignity. They know what I am capable of. They will wash my back in the shower and they will leave me alone and make my bed whilst I wash the rest of myself." One relative said, "They always get my [family member] involved. It is all part of routine. They get him/her in the shower and know how to give him/her time on his own." However, some people told us that staff were not always considerate about them or showed respect for their home. We were told of three incidents by people using the service and their relatives where care workers had been aggressive and shouted at people when they had complained about not being treated in a caring or respectful manner.

One person told us that care workers did not clean their flat after they had visited despite reporting it to the office. One relative told us that a care worker had left the front door open after finishing a shift. Another relative told us that some care workers took advantage of people's homes. They added, "I've seen them charge their phones, play on their phones and have drinks from the fridge without asking. I've had to install cameras around the house."

One person's records stated that they were receiving end of life care. When we asked one of the care coordinators about this they were aware of this however there was no information within the person's care records which gave any medical information or guidance for care workers to support the person while they were receiving care to ensure that their needs and preferences were met.

Inadequate

Is the service responsive?

Our findings

People were at risk of not receiving the care they required as their needs had not been fully assessed and identified. Each person had an individual care folder which included an initial assessment from the local authority with an overview of people's care and support needs. However, this did not translate into the needs assessments and care plans produced by the provider. Their assessment covered a wide range of needs, including mobility, personal care, communication, nutrition, community access and inclusion, medicines and health and wellbeing. However, in all of the files we reviewed, we found care documents which lacked detailed information, were inaccurate or did not contain important medical information about the person. Two of these care files had no care plan in place. For one person, there was no information within their assessment form and a blank copy of a care plan with a note that said 'please fill in if applicable'. The other person had no care plan in place and the assessment form just said 'support needed' throughout so there was no guidance for staff about how to meet the person's individual needs. There were also three specific people's files that we requested during the inspection that could not be located so we could not be assured these people had a care plan in place.

One person had a history of aggressive behaviour however there was no information recorded within their care plan about how to manage this risk. A recent continuing care review had taken place and the person's care package had increased from two to four visits a day, with two care workers attending each time. This review by a health care professional highlighted that care workers were responsible for managing the behaviour that challenged and checking for pressure sores but there was no record of this in the care plan. Call times had also not been included in the care plan and there was no information about how care workers were to support this person with their care needs.

Another person who had diabetes and was incontinent had no information within their care plan. There was no record of the time critical nature of calls to ensure their diabetes was managed and no information about any preferences. Under the continence assessment it just said 'N/A'. There was no information for staff to understand how this person would like to be supported. The rest of the assessment either said 'support needed' or 'N/A' and gave no further detail to guide staff about how to meet the person's needs.

The care plans that had been completed were inadequate. They did not contain guidance for staff on how to meet people's needs but just listed tasks to be completed. They were not personalised and did not contain any information about people's preferences, including food likes and dislikes or their preferred gender of care worker. One relative said, "I saw they sent a male to my [family member], which I wasn't happy about." Care plans were not reviewed on a regular basis or when people's needs changed. Even where care plans had been reviewed the records were incomplete in that they did not provide any detail about what was discussed in relation to people's needs, any changes or any areas of concern to be addressed.

The lack of detailed and effective person centred plans in place to meet the individual needs of people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that they found it very difficult to get in touch with the office when they

wanted to raise concerns or complaints and didn't feel listened to when they did. One person said, "I have told the office about the issues but they don't take much notice." Another person said, "I told them about a problem however they have done nothing about it." One relative told us that there had been ongoing issues for a number of months where care workers did not turn up for calls. On one occasion they did not come for two days running. "I ring up the office to complain but nobody calls me back. I ring again and I'm just repeating myself. It is unacceptable and it upsets my [family member] when they don't turn up."

The business development manager talked us through their complaints procedure. They told us that complaints were logged by whoever takes the call, action was taken to follow them up and then the conclusion of the complaint was recorded. However, we found that there was not an effective system in place to record and respond to complaints.

We saw records that showed that people had contacted the provider as they were unhappy about the level of care they received. One relative told us that when they made a complaint about a care worker, they did not send them again. However, we saw records and spoke with people who told us that this was not always the case. When one person asked to change the care worker because they did not like their attitude, they were told there was nobody else. Three relatives told us that the provider kept sending care workers to them despite asking for them not to return.

One person had to ask for advocacy support in making a complaint as they had not heard back from the provider about concerns raised. The advocate contacted us when they were told by the provider there was not a complaints procedure. We asked to see the details of this complaint and saw it had been logged but there was no evidence of the outcome so we could not be sure it had been investigated or resolved. A relative raised concerns with the provider about the care their family member received and highlighted that management do not deal with complaints. They contacted us about it prior to the inspection and the business development manager told us that the complaints procedure had been followed. When we asked to see a record of this there was no record of the complaint or any follow up by the provider. We found that the person had moved to another care provider after complaining to the local authority.

We saw records in the out of hours report where people had made contact to raise concerns. One relative called to say that they were not happy with the care worker. Another relative called to say that the care worker had not arrived and that it happened every Sunday. There were no records of these complaints being recorded or followed up. A care worker told us that when they reported issues to the office they were not followed up. They said, "They should look into more complaints that I tell them about and follow it up, letting others know about it too."

We spoke with the business development manager and managing director about people not being listened to and complaints not being dealt with. The business development manager told us that dealing with complaints had been overlooked as they were short staffed and only one person at the time of the inspection was trying to deal with all complaints. The managing director acknowledged that this was not acceptable as it was within their policy to respond to people within five days, which they were not doing.

The lack of systems in place to monitor and effectively manage complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection there was a newly appointed branch manager who had been in place for two weeks and had applied to the Care Quality Commission (CQC) to become a registered manager.

The registered provider is required by law to notify the Care Quality Commission (CQC) of important events which occur within the service. We saw records and received information during our inspection about 14 incidents which should have been reported to us which had not been. They included safeguarding incidents involving the police, allegations of financial abuse, physical abuse, neglect and death notifications.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered provider did not have an internal auditing and monitoring process in place to assess and monitor the quality of service provided. At the time of the inspection we found a number of records were not being checked on daily, weekly, monthly, quarterly or yearly cycles. There was no system in place for people's daily log books to be checked or collected to see if people were receiving the right level of care. We were unable to see a number of daily record books as they were kept in people's homes or archived at the provider's head office. One care coordinator told us that if a book was completed then pages could be added to it and that it could take up to six months for the book to be returned. Medicine administration record (MAR) sheets and financial transaction forms were also kept in people's daily logs so these records were not being checked either. In one person's daily log book that we were able to see the information provided for care workers was from an out of date local authority assessment involving a previous care agency. We could not be sure if the person's needs had been reviewed or whether staff were working from the most up to date assessment. Another person's daily logs had contradictory information in about the level of support required compared to their care plan. We spoke with the business development manager about this who confirmed there was not an effective monitoring system in place. He said that the provider would look to implement a quarterly audit going forward. We could see that the new branch manager had started to address some of the issues, specifically the auditing of people's care files. However some files that had been checked still lacked sufficient detailed information about people and how their risks would be managed.

We saw that some quality monitoring visits were taking place to check that people were satisfied with the service. However, the records we saw relating to these visits did not include any actions or follow ups information so we could not be assured that any issues had been addressed. Some quality monitoring spot checks were seen in staff and people's care files along with telephone questionnaire forms but these were sporadic and there was no evidence to demonstrate that these checks took place on a regular basis or that there was a system in place to ensure that adequate quality monitoring took place. Some people had not received a visit in over a year. One care worker told us that they had not had a spot check for over six months. Another care worker said, "The person who is supposed to be doing it isn't at the moment because they have to work in the office." In addition, where there was information or feedback from people there was no indication that this had been followed up by staff. In one person's file, during a spot check the care coordinator had assessed the home as 'cluttered and hard to complete work in this condition and the

furniture needs to be moved for safe moving and handling'. However there were no further actions or follow up recorded. We could not check what actions had been carried out as there was no information made available to us. There were some notes in staff files to show that where complaints were made a supervision session was held to discuss this but again this was not consistent. For example, there was no information to evidence that a complaint about late calls had been addressed that had potential to impact on a person's wellbeing as they had diabetes and regular meal times were important.

We found inaccuracies within four sets of time sheets where calls had overlapped that had been completed and signed off. For one care worker, we saw five overlapped calls for two people within a 90 minute window. They had two 5pm – 5.30pm calls, one 5.50pm – 6.20pm call and two 6pm – 6.30pm calls on the same day which had not been picked up when they were signed off. We could not be assured which calls had taken place at what time.

Staff within the service did not understand their responsibilities in reporting, investigating and recording of incidents, accidents, complaints or concerns which occurred within the service. There was no system in place to monitor records of incidents and accidents, no investigations had been completed into incidents such as falls, hospital admissions, missed visits and allegations of care workers falsifying daily logs. One person called to complain that a care worker had completed the log book for two days even though no care had been provided. We were able to see these incidents had occurred by looking through the out of hours reports but there was no evidence these had been investigated and any learning from these incidents shared across the service. There was no information to support the monitoring of these incidents for trends and recurrent themes which required further investigation.

The lack of effective governance and quality assurance systems was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns raised with us both prior to and during the inspection showed there was a lack of openness and transparency in the service. Throughout the course of the inspection we were told information that we found was not true. At the end of day one of the inspection, we gave feedback to the branch manager and managing director that the care plans were inadequate and lacked detail about people and guidance for care workers. On the morning of day two we were told by the branch manager that the reason for this was because the local authority had told them to use their initial assessments in people's care plans. However, the local authority did not confirm this and on day three the business development manager confirmed that this was not the case. On day two, a member of the office staff showed us how they monitored calls. We asked for records of previous days call confirmations as we were told they had to be emailed over to the branch manager. When we requested to see copies of the emails or drafts we were told there were none. On day four we spoke with the business development manager about their moving and handling training. He told us that they had ordered a hoist to support the training sessions. When we asked to see an invoice they were unable to provide us with one and later told us that a hoist had not been ordered. We raised these issues of honesty and openness with the managing director during our final feedback session on the last day of the inspection and they apologised.

Some people we spoke with told us they were satisfied with the service they received however the majority of people we spoke with told us of their frustration when they tried to get through to the office and complained about the lack of communication. One person said, "I'm not happy with the service, things never improve." One relative said, "They need to be more in tune with how it's working and what the problems are. Another relative told us that they felt the service was chaotic and not well organised, which is why there were gaps in the care their family member received.

Care workers we spoke with commented how they felt supported by their care coordinators but that they were always so busy dealing with everything else some issues were never followed up. Staff told us how there had been a high turnover of managers and this had led to problems. Due to this, staff felt it had an impact on communication and sharing information. A member of staff said, "If you don't ask, you won't know what is going on." One care worker said, "There are always different managers, I don't know who is who and it is always difficult to speak to anybody." Another care worker said, "I don't feel looked after as a care worker here but I stay because of my clients." One member of staff told us that the past few months had been challenging. "We haven't had field care supervisors or a trainer. There have been issues with teamwork and it has created a lot of pressure." Another member of staff said, "They don't listen to us and many of us get fed up. They need to support us, not push us away."

We saw evidence to show that the provider had put some staff wages on hold because their staff files were found to be not up to date during the inspection. Staff were contacted and told that due to missing or incorrect information held about them on file, they had to contact the HR team with the information for their payment to be released. One member of staff told us that they had already given this information when they started working for the provider. They felt threatened by the provider and were worried that if they did not comply they were going to lose their job. They added, "What have they done with my information? They shouldn't be stopping our money." Other care workers told us the same and said it was impacting on them wanting to work for the organisation. We spoke with the provider about this who told us that in some isolated cases they were unable to process payroll due to three specific factors. These were that payroll noticed errors with personal information, care workers did not log in to register their visits/submit verified timesheets or staff whose records did not contain up to date information.