London Care Limited

London Care (Poole)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12, 13 and 17 July 2017 and was unannounced. London Care (Poole) provides personal care and support to people living in three extra care housing schemes. These consist of private flats within staffed buildings with some communal areas. At the time of our inspection there were 71 people who were receiving personal care.

There were many other people who received welfare calls from London Care staff but this part of the service is not regulated and inspected by CQC.

There was 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.

The service was registered in March 2017 and this was therefore the first inspection of London Care (Poole). London Care had been providing care at the two of the three schemes since July 2016 and at the third scheme from November 2016. When London Care started to provide care and support, they were not registered to provide this service in Poole and it was managed from another of their registered locations in London. Therefore people in some of the extra care schemes in Poole had received care and support from London Care for almost one year. Newly registered services must be inspected by CQC within 12 months of the anniversary of registration. This inspection was brought forward because we were aware that people had been receiving services for nearly a year and because we had received concerns about how the service was run.

At this inspection we found nine breaches of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

People's medicines were not managed safely. People's needs had not been properly assessed and planned for regarding the help they needed to take their medicines or apply prescribed creams. This meant that people were at risk of not receiving the correct medicine, in the correct quantity, at the correct time.

Systems to manage risk and ensure people were cared for in a safe way were ineffective. Risk assessments were not always fully completed or regularly reviewed. Some risks had not been identified as such and therefore no action had been taken to reduce or manage the risk. For example, some people had items of equipment such as hoists, bed rails and oxygen condensers. The service had not carried out risk assessments to ensure that the equipment was fitted correctly and worked safely. This meant that people's safety and well-being was not always protected.

People told us staff were kind but there were many examples of poor practice and lack of understanding

with regard to ensuring people's rights to privacy and dignity were recognised and respected. For example, male staff had been sent to females who had specified that they did not wish to receive personal care from males. Some people lacked mental capacity to make important decisions but staff had not ensured that the decisions that were made on people's behalf were in their best interests and were likely to have been what the person would have chosen for themselves.

Staff had completed training in essential areas such as moving and handling and health and safety. However, they did not always have the right skills and knowledge to meet people's specific needs. For example, they were caring for people with complex health conditions or learning disabilities but had not completed training in these areas.

There were not enough staff employed to meet people's needs. People did not receive calls at the times they needed and visits were often cut short. Where people needed two staff to support them, they were not always both available at the correct time or sometimes only one member of staff completed the visit. Steps had not been taken to ensure that staff were suitably supervised. This meant that people were not always cared for by staff who had been supported to deliver care and treatment safely and to an appropriate standard. Appropriate checks and references had not always been completed before new staff were allowed to work with people. This meant that the provider had not taken all possible steps to ensure that staff were suitable to work with vulnerable people.

People did not always receive the care they required. Care planning systems were not robust. Some assessments had not recognised specific care needs and no care plans had been created for these. For example, where people lived with diabetes, there was no care plan outlining what the condition meant to the person, how it affected them, how it may progress and any risks such as high or low blood sugars, or other possible complications. Some people's needs had changed and care plans had not been reviewed and amended. For example, a person returned from a stay in hospital and required two staff to support them when before they had only needed one staff member. The service were not aware of this and had not planned for the changes in the person's needs. This meant that staff were providing care and meeting needs that had not been fully assessed and planned for.

Management arrangements and systems did not ensure that the service was well-led. Recruitment systems were not always fully implemented to ensure that staff were suitable to work with vulnerable people. Quality monitoring systems were not used effectively, surveys were not responded to and people were not listened to when they made complaints. Record keeping was poor; records were out of date and contained errors and omissions.

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.

You can see what action we asked the provider to take at the back of the full version of this report. 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 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.

People were not always protected against the risks associated with the unsafe management and use of medicines.

The risks to people's health and safety whilst receiving care had not been properly assessed, and in some instances, action had not been taken to mitigate any such risks.

There were not enough staff employed to meet people's needs. Some calls were missed and other people did not receive calls at the times they needed and visits were often cut short.

Staff had not always been recruited safely.

Possible incidents of abuse had not always been recognised and reported.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive the supervision and support they needed and there were no systems in place to ensure that follow up actions were completed when issues with staff performance were identified.

Staff had undertaken training in essential areas such as moving and handling and health and safety. However, they did not always have the right skills and knowledge to meet people's specific needs.

People's rights were not always protected because the service was not acting in accordance with the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that staff were kind but there were many examples of poor practice and a lack of understanding of people's needs, which meant care was not always provided in a way which respected people's privacy and dignity.

Staff did not always respect people's rights to privacy and confidentiality.

Is the service responsive?

Requires Improvement

The service was not responsive.

Some people had not had their needs met and other people were at risk of their needs remaining unmet because assessments were not robust.

Care plans lacked information and changes in need were not always reassessed and planned for.

The service had a complaints policy but had not established an effective system for identifying, receiving, recording, handling and responding to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider was not meeting their responsibilities to manage the service under the Health and Social Care Act 2008. There were breaches of ten regulations.

Quality monitoring systems were ineffective and record keeping required improvement.

Care Quality Commission

London Care (Poole)

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 12, 13 and 17 July 2017 and was unannounced. One inspector carried out the inspection.

Before the inspection, we reviewed the information we held about the service; this included notifications, questionnaires and information we had received from third parties including a local authority contract monitoring team and safeguarding team. We did not request a Provider Information Return (PIR) because this inspection was brought forward due to concerns. The PIR 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.

We visited seven people in their homes. We also talked with five relatives, six visitors, nine care staff, three office-based staff, the registered manager and the nominated individual. We reviewed seven people's care and medicine records in the office and the records in their homes, with their permission. We also reviewed another three people's care and medicine records in the office. We checked records about how the service was managed. These included five staff recruitment and monitoring records, staff rotas, complaints, safeguarding and training records, audits and quality assurance records as well as a range of the provider's policies and procedures. The registered manager emailed us various policies and training information, as we requested following the inspection.

Inadequate

Is the service safe?

Our findings

One person told us, "I sometimes don't feel safe because some of the carers are not always aware how to support my legs properly when I am using the hoist". A relative said, "They are always short staffed. There are not enough staff for the general (planned) calls. What would happen in an emergency?"

Discussions with people, relatives and visitors revealed consistent themes of lack of staff, high staff turnover, poor communication and lack of management. People also said that they rarely received rotas and never knew when to expect staff to arrive even though their care plans stipulated times that calls should be made.

One person said, "I would like to know who is coming. They haven't been to me yet". They made this comment at 6.20pm. Their care plan stated that their evening call should be made at 6.00pm. Analysis of the previous seven days evening call start times showed that they varied from 4.50pm to 6.45pm. This person's calls were to provide meals to support their diabetes, which meant they needed their calls at specific times.

People were placed at risk because staff did not handle medicines safely and people did not always receive them as prescribed.

The assessment and care plan for one person stated that they were independent with all prescribed medicines and creams. However, a summary of tasks to be completed at each visit included an instruction to staff to administer medicines.

Another person told us that their relative required creams to be applied at each of the four calls made each day. This was especially important to help prevent pressure sores because the person was cared for in bed. However, they had noticed that the staff did not always remember to do this.

Blank Medicines Administration Records (MAR) charts were included in the record books that were placed in each person's home at the beginning of each month. Staff hand wrote the items that each person was prescribed into the record at the beginning of the month and also added in any other items that were prescribed during that month. We found that the names of the medicines, strength of the medicines or the times they should be administered had not always been properly recorded. Most entries had been signed by the person creating the record but entries had not always been checked and signed by a second member of staff to confirm that the correct instructions had been recorded. The name of one medicine had been spelled incorrectly. The dose for this medicine was the same five days of the week and was to be given at a higher level two days of the week. There was no care plan for this medicine or for the health condition this was prescribed for. The MAR showed that the increased doses had not been given to the person. Nobody had recognised this and therefore the person had not received the dose that had been prescribed for them. Records had not always been completed and there were gaps in the record meaning it was not possible to be certain that the person had been offered their medicines or that they had been administered.

Eight of the people whose care records we examined had skin conditions and had been prescribed topical creams to treat this. The directions on the MARs for two creams stated, "use as directed" but there was no other information about this. There were no assessments or care plans for any of the topical creams that we checked. The MAR for each person stated the name of each cream but not always where it should be applied. There was no guidance in place to ensure staff applied the correct amount or followed other requirements, such as leaving on the skin or rubbing into the skin. This meant people may not have received some of their medicines as prescribed.

There were occasions where staff took medicines out of the original container and left them out for the person to take at a time when staff were not there. This had not been risk assessed.

Another person was prescribed time sensitive medicines that the pharmacy label stated must be given 12 hours apart. There was no information in care plans or other documentation about this requirement or the effects of not following the instruction. We checked 14 days of administration times and found this instruction was rarely followed: there was only one occasion where the item was administered within a 15 minute period of before or after the time due. There was one occasion where it was given 2 hours early, one that was 1.75 hours early, five occasions that were 1.5 hours early, one occasion that was an hour early and two occasions that were 30 minutes early. There was also one occasion of 30 minutes late, one of 45 minutes late and one of an hour late.

Staff had been trained in the administration of medicines and their training was updated annually. Their competence in administering medicines was tested at the end of their initial training. The London Care policy also stated that staff competency should be assessed during unannounced spot check observations by more senior staff whilst providing care. This would help ensure they were following the correct instructions for medicines and keeping suitable records. However, the registered manager confirmed that these checks had not all been completed and that a plan to address this was being developed. None of the concerns we found regarding medicine management had been recognised by any of the staff who administered medicines.

Some medicines were prescribed in variable quantities or on an 'as required' basis (also known as PRN). There was no assessment or care plan to guide staff on when to administer the medicine, the reasons for the variable doses, how much to give or the maximum amount to be given within a fixed period.

Some people were prescribed a blood thinning medicine. They had to have regular blood tests and information was sent to them following each test, to confirm the dose they should take. Two people were taking this type of medicine. There was no evidence on the MAR that staff had checked with the person or seen the most recent blood test results and could therefore be certain that they were giving the correct dose of the medicine. For one person, staff were unable to locate the most recent result and therefore could not be certain that they were administering the correct amount. The test result for the other person was available and staff confirmed the correct dose was being given.

These shortfalls were breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe management and use of medicines.

There were systems in place to manage risk but these did not operate effectively. Risk assessments lacked detail and were not always person specific. The service used a standard pre-printed form which covered some common risks but this did not include prompts or space to include additional risks that were specific to individual people. The standard risk assessments included people's home environments, as well as risk

to people from falls, developing pressure sores, malnutrition, and the use of some items of equipment. The completion of the forms lacked consistency; some risk assessment forms had been placed in people's files but not fully completed. It was therefore not always clear whether control measures were in place or had been effective in reducing risks. One person had an assessment that indicated they should be assisted to reposition in bed to try to prevent pressure ulcers. There was no evidence that this was taking place. This meant that people were at risk of not receiving the care and support they required.

Some people had items of equipment such as mobile hoists, ceiling track hoists, bed rails and oxygen condensers to support their needs. The service had not carried out risk assessments to ensure the equipment was fitted and worked safely and that any risks either to the person or staff were identified and managed correctly. There was also no information about action to take if any of the equipment failed. This meant that there was no system in place to protect either the person or the staff.

Where people had specific medical conditions, risk assessments had also not been put in place. For example, some people used urinary catheters or stoma bags. There were no risk assessments or care plans about what staff should do if the item became blocked or was not functioning properly. There was also no information about infection prevention and control when supporting people with these items. This meant that there was a risk that staff may not recognise when complications were occurring that could be harmful to people.

Some people lived with diabetes or other conditions such as epilepsy or multiple sclerosis. There were no risk assessments or care plans in place to ensure that people's needs were supported safely. In the cases of people with diabetes, the possible complications, signs that staff should be observing if people's blood sugar became too high or too low and the action to take in these circumstances had not been assessed. This meant that there was a risk that staff may not recognise when a person was showing signs of becoming unwell and that they may not seek suitable support from relevant professionals such as paramedics.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Care and treatment was not provided in a safe way because the risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks.

The service had satisfactory policies and procedures in place to protect people from abuse. Staff received regular training in safeguarding and whistleblowing and information about this was included in the staff handbook, which was given to all staff. Staff told us they knew the different signs and symptoms of abuse and said they were confident about how to report any concerns they might have. However, the local authority had investigated safeguarding concerns reported to them by people using the service, relatives and friends and visiting professionals. The registered manager had not notified CQC about these concerns. In addition, people told us about incidents and concerns during our inspection that they had reported to London Care. These issues could have constituted abuse and should have been reported to the local authority to investigate but staff had failed to do so. These incidents included the possible theft of cash and jewellery and missed visits. Missed visits are of concern because it means that people did not receive the care and support required which may have been a form of neglect.

Some people required support with shopping. We found records that cash had been handed to staff, the item purchased and the change that was returned to the person. These records were not signed by either person and there were no receipts. We also found a record that cash had been handed to a member of staff but there was no further information about what this had been for, any change or any receipts. The registered manager told us that financial transaction forms were kept in every file, that these should be

completed each time a financial transaction took place and were then audited at which point any discrepancies were addressed. The records we saw were incomplete and there was no evidence that the records had been audited or any action had been taken to address the issues we found. This meant that there was no system in place to protect either the person or the staff.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not safeguarded from abuse and improper treatment.

From the start of the service provided by London Care (Poole) in July 2016, until June 2017, the employment of staff had not always been undertaken in a way that meant people were protected against the risks associated with the unsafe recruitment of staff. In June 2017 London Care internal auditors had noted that appropriate references, checks on previous employment, proof of identity and checks of possible criminal records had not always been completed. For example, from the records we checked, suitable references had not been obtained and verified for two members of staff and evidence of previous qualifications was not provided for another two staff. A DBS (Disclosure and Barring Service) check had shown a previous criminal conviction which the person had also declared. They had been employed without following good practice and company policy of completing a risk assessment. A process had been put in place following the internal audit to obtain outstanding information and checks and a risk assessment had been completed. Information was still outstanding at the time of the inspection. This meant that the provider had not taken suitable steps to ensure that there were effective recruitment procedures in place. The provider had not used information gathered from recruitment checks to determine whether staff members were suitable to work with vulnerable people.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because recruitment procedures were not operated effectively to ensure that all staff recruited were suitable to work with vulnerable adults.

People did not consistently receive care treatment and support that met their needs and protected their rights. This was because care workers were arriving either too early or too late and not staying for the full time. Analysis of daily visit records showed that staff often did not stay for the planned length of the call. The total minutes planned for one service user over 20 calls was 600 minutes. The actual time spent with the person was 476 minutes. This happened on occasions to all of the service users whose records we examined.

The rotas also showed that some staff worked long hours with few breaks. The majority of the calls did not have any time between them. For example, one call was at 8.00-8.30 am, the next 8.30-9.00am, and the next 9.00-9.45am. Some staff worked 7.15am to 3.00pm with calls back to back and no breaks. Two staff told us that they had been working very long shifts with little time off in between. They said that they had asked to reduce their hours but this had not yet happened.

The rotas also had times where calls to different people overlapped, such as call to Person A was 12.00pm to 12.30pm whereas the same member of staff should have been with Person B from 12.15pm to 1.00pm. Sometimes there was a complete duplication with staff supposed to be with two different people at exactly the same time.

In the case of visits where two staff were needed to support people safely, the rota did not always have them arriving and leaving at the same time. Service users, relatives and staff all confirmed that there were often occasions when time was wasted because they were waiting for a second member of staff. The call then had to be completed in less time and the person felt they had been rushed. Relatives also said they often

stood in as the second person and staff told us that they had completed calls on their own rather than make people wait. This had put both themselves and the people they were supporting at risk.

People told us that they had repeatedly asked to be given rotas so that they knew when to expect their calls and who was coming to their homes. Most people told us that they had never received a rota since their package of care had been provided by London Care (Poole). Two people said they had occasionally received a rota but that the staff had arrived at different times to those on the rota and had also not been the staff that were named on the rota. They confirmed that when this had occurred there had been no communication from London Care (Poole) to advise them of any changes.

People and staff told is that they did not believe that London Care (Poole) had enough staff to carry out all of the calls they were contracted to provide and were relying on existing staff working additional hours.

People told us that they found it very hard to have strangers arriving at their home. They also said that most of these staff had not read the care plans and had little or no idea about the care they must provide. In most cases care plans were out of date so would not have given staff correct information if they had read them.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed to meet all regulatory requirements.

Requires Improvement

Is the service effective?

Our findings

A relative told us how their father had not had a shower for nine weeks. This was because the person lived with dementia and although family members had explained to staff the approach that they should take to ensure the person accepted help and support, staff had not followed this. We checked the care plans for this person and the guidance from the family was not included.

Another relative told us how the person they lived with experienced almost continuous pain due to their condition. They said that the person had occasionally experienced more pain as a result of being cared for by staff who had little or no understanding of how their illness affected them.

Training records showed that staff had completed comprehensive induction training based on the Care Certificate. This included the essential topics such health and safety, infection prevention and control, fire safety, safeguarding vulnerable adults, medicines administration and moving and assisting people.

However, training to meet people's specific needs had not been provided. People receiving care from the service were living with conditions such as dementia, multiple sclerosis, Parkinson's disease and diabetes. Other people were living with brain injuries, were recovering from strokes or had learning disabilities. People told us that a number of staff who visited them did not have an understanding of their condition and how it affected them. The registered manager told us that training in learning disability was being developed and staff would be given the opportunity to study this in the future.

Staff had not received adequate supervision and support. A system to ensure supervision happened had not been established when the service first started and very few supervision sessions, spot checks or appraisals had been completed during 2016. During 2017, out of 40 staff employed at the time of the inspection, 21 had received one supervision session and 12 had received a spot check. Five of the staff who had a received spot check had also had supervision session on the same day. London Care internal auditors had noted in June 2017 that supervision and spot checks were not being completed. The registered manager stated that a plan was in place to address this.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not supported with regular supervision and appraisal and their practice was not monitored. They were also not supported with training to ensure that people's specific needs could be fully met.

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 make decisions for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when required. 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.

The service did not always follow the required processes when caring for people who may lack capacity to

consent to receiving care. Staff had completed training in the principles of the MCA. However, examination of records and discussions with staff highlighted that there was not always a sufficient understanding of the processes to assess capacity, when assessments should be completed, make decisions in people's best interests where necessary and to accept that people have the right to make unwise decisions. At this inspection, from the records we looked at, we identified that there were two people who lacked capacity receiving care from the service. Decisions such as to provide personal care and administer medicines had been made by the service; there were no assessments of their capacity, whether they could make simple decisions for themselves such as what to eat or wear or be supported to make more complex decisions. There was no evidence that, where decisions had been made for them, the best interest's decision making process had been followed and care plans had not been completed to ensure people were protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service was not acting in accordance with the Mental Capacity Act 2005.

People and relatives confirmed that staff always checked with the person before providing care and gained their consent to provide the care needed. Care plans contained consent forms and these had been signed by the people receiving care where they had capacity to consent to care.

People were mostly supported to maintain good health. People gave us examples of health professionals such as GPs and district nurses being contacted by staff on their behalf when they requested it. However, amongst the concerns highlighted to us from the local authority safeguarding team, were issues that involved staff failing to recognise that a pressure sore was developing and they had therefore not sought professional help. This was an area for improvement.

People told us that they were supported to have enough to eat and drink. They said that, where preparing food and drinks was part of their care package, staff would offer them choices and ensure that they had any necessary support to eat their meals. We observed one member of staff patiently offering one person four different meals, discussing the ingredients of each meal and helping the person decide which meal they would like to eat. However, two people told us that they were losing weight and found that staff were lacking in basic cooking skills; one person told us they only asked staff to make them toast and jam. This was because, previously, they had asked for other meals including a boiled egg and staff had been unable to make these. The registered manager told us they were unaware of these issues and would investigate people's concerns. This was an area for improvement.

Requires Improvement

Is the service caring?

Our findings

One person told us, "They are very very good. They really care for me and make me feel good. I know all their names and feel like part of the family."

Two people told us they were treated with respect, and that their privacy and dignity were preserved during their care. The staff we spoke with recognised the importance of this and gave examples such as keeping people covered with towels or ensuring curtains were drawn and doors were closed before commencing personal care.

However, a relative of a person who received care told us, "They have used the key safe and started to let themselves in before they even knock on the door. This is my home too but they don't even give me a chance to open my front door. Then they rush in and say hello to [the person] without gauging how well [the person] is and how they are feeling. They also call [the person] by a shortened form of their name but it is not a name that [the person] has ever used and we don't like it. [the person] is very able to make all their own decisions and communicate them but the staff often ask me, in front of [the person], what I want them to wear! I have to remind them that [the person] is able to decide for themselves."

Two people told us they had requested that only female staff provide them with personal care and that male staff were often sent to them. One person said they refused to allow the member of staff to support them which meant they had to go without the support they needed. The other person said that they did allow the male staff to provide some personal care but not all and that they were very uncomfortable about this.

The staff we spoke with knew about requirements to keep people's personal information confidential. However, some people told us that there had been instances where staff had talked about other people that they cared for. The registered manager told us that they had become aware of this and it had been addressed.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had failed to ensure that people were treated with dignity and respect. People's privacy had not always been maintained and their preferences for the gender of staff providing them with personal care had not always been respected.

Some of the staff we spoke with were aware of people's preferences, likes and dislikes, although assessments and care plans did not always reflect this. This meant not all staff would be able to provide the same level of care because they did not have sufficient information in the care plans. This was an area for improvement.

Requires Improvement

Is the service responsive?

Our findings

A relative told us, "Because [the person] doesn't eat well, we have asked that the staff prepare his meal at the beginning of the call and then they can complete other non-care tasks while he is eating. This way we have asked them to encourage him to eat. We have asked this many times but it never seems to happen."

Another relative told us, "Some of the staff write in the book before they complete the care they are here to give. How can they record what they have done before they do it?"

One of the people we met lived with diabetes. A district nurse visited twice a day to support the person to test their blood sugars and administer insulin. Relatives and staff told us that the person should then eat within 45 minutes of the visit. They said that they had reported this to London Care (Poole) on more than one occasion but the service had not responded to this information. It was not included in the care plan and it was evident from examination of rotas and times of arrival records in the daily records books that this was not planned for or often happening.

A relative told us about the care one person required. They said that the person was cared for in bed and had very little mobility. Therefore, one of the most important things was that staff left everything within easy reach, such as bed and television controls, telephone and drinks, at the end of each visit. They told us that they were always reminding staff and had even written notices but staff still did not always do this. They said this was especially worrying if they were not at home as it could be up to four hours between the calls and their relative could be left worried and distressed.

People's care needs were not always fully assessed and planned for. For example, people with conditions such as diabetes, dementia, Parkinson's disease and multiple sclerosis did not have care plans outlining what the condition meant to the person, how it affected them, how it may progress and any risks or possible complications that may occur.

All of the care plans we looked at contained omissions or inaccuracies, either because initial assessments had lacked detail or because people's care needs had changed.

During our visits, we saw that some people used oxygen concentrators to support their breathing. There was no reference to this or the reasons for this in either the assessments or care plans for these people.

Two people lived with diabetes. There was no care plan outlining what the condition meant to the person, how it affected them, how it may progress and any risks such as high or low blood sugars, or other possible complications. There was also no information about the medicines people took to manage their condition or whether the timing of their visits and meals was important in managing the condition.

During our inspection, one person was discharged back to their home following an eight day stay in hospital. The staff at the location were expecting the person and helped the ambulance crew to settle them back into their flat. After the person had been settled, staff returned to the office to advise that the person's

needs had changed and they would now require two staff at all calls instead of the one member of staff that had been required before their stay in hospital. No reassessment of the person had been carried out prior to their arrival to ensure the service had a plan in place to meet their needs.

Staff told us about two people who had recently become unwell and their needs had increased. They said it was likely that the people were at the end stage of their life. Daily records showed that one person was being cared for in bed all of the time and the other person may sometimes get up and that both people needed more support with personal care, eating and drinking. Care plans and assessments had not been reviewed and updated to reflect that their needs had changed. There was no information about their wishes for where or how they received their care or any other things regarding the end of their lives that was important to them.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

People, relatives and visitors told us that they had raised concerns about the support people received. None of them had felt they had received a full response or that a satisfactory outcome had been achieved.

The registered manager told us that a copy of the complaints policy and procedure was given to people when they began receiving care from the service. Some of the people we spoke with said they were unsure of how to make a complaint, others felt that there would be no response from the service if they did make a complaint.

We were told about three complaints that had been made to the service. There were no complaints recorded in the complaints files at the office and the registered manager stated that they had not been made aware of any complaints.

This breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not always know how to complain and the service did not properly investigate and act on any complaints that were received.

Inadequate

Is the service well-led?

Our findings

A visitor told us, "I think my nine year old could run the place better than this. There is a huge lack of common sense here." Another person said of the staff and the management, "They don't know us and they're not in touch with the place". A relative who lived with their partner at one of the schemes told us they had never met the registered manager and would not know how to contact them.

Another person told us about when the extra care scheme was created last year and the contract was won by London Care. They said, "We were promised so much at the beginning and now it has all gone to pot. We have asked to meet with people from London Care but no one comes. We have been told that if we need support from the staff outside of our normal package, we will be charged for this and we can't afford it. We are scared to ask for help now."

All of the feedback we received from people, relatives and staff was very poor with regard to the management of the service. People told us that they never knew who was in charge or who to go to if they had a problem or concern. People also expressed frustration that, if they did approach staff with concerns or requests for help and support, staff were unable to help them or said they would pass the issue on to a manager. People said they never received responses if they were told their issues had been passed to a manager.

The management structure of the services was not clear to people. Four people told us they did not know who the registered manager was. Those people who did know the registered manager were not aware of the registered manager's role within the service.

The registered manager had more than one role within London Care; they were a regional manager for the national company as well as the registered manager for London Care (Poole). People, relatives and staff felt that the registered manager's presence at the service was limited. The registered manager confirmed they attended the Poole location every week and were available by telephone at all other times.

There were other staff with management roles employed at the service, but their roles and responsibilities were not clear. When we raised issues during the inspection with the registered manager they often stated that they had not been made aware of the matter. For example, they were not aware of the complaints that people had made about the service. People and relatives told us that communication amongst the staff in the service was poor.

Each of the extra care schemes was led by a team leader during the day. The registered manager stated that the team leaders were supernumerary. The team leader job description stated that the role was responsible for completing a range of functions. These included the assessment and review of people and their needs and the practical supervision, instruction and support of staff. They were expected to carry out spot checks on staff, implement quality assurance processes, assess health and safety risks and take appropriate action, and be alert to possible abuse or neglect. Team leaders told us that their roles also included creating and managing staff rotas, addressing payroll issues and interviewing applicants for work at the schemes. There

were two team leaders in post at the time of the inspection. Analysis of the rotas showed that in addition to the team leader role, they were also providing care to people. Over a 16 day period, one team leader was shown on the rota providing 153 hours of care and the other, over the same period, was shown providing 74 hours of care. People and staff at the scheme with no team leader all said that, when a team leader had been in post, they had also completed a high number of hours of care.

The provider had a quality assurance policy and systems in place to assess and monitor the quality of its service. However, London Care quality assurance processes were not implemented effectively and were not used to drive a process of improvement.

Staff completed regular quality assurance checks with people who used the service. Two recent checks showed that people had requested changes to their rota or hours or said they were unhappy with aspects of their service. There was no evidence that this had been fed back by the member of staff to a manager and people said that nothing had changed following the quality assurance check.

One person told us they had recently completed a survey with a member of staff but because the staff member also provided their care, they told us they did not feel able to raise the issues that were concerning them. The person told us they needed two staff to support them at all calls. They raised concerns about the timings of calls, two staff not arriving on time or together and not staying the required length of time. They felt they had been rushed and not had all of their needs met when staff were late. They also said that it could often be difficult if the staff did not like each other or had fallen out with each other as they did not try to remain professional whilst working. The form completed by staff therefore showed that the person was satisfied when they were not but had not felt empowered to speak up. The registered manager stated that they would remind people that there are managers available to listen to any concerns and about the London Care complaints process included in the guide.

The London Care Quality Assurance policy stated that a customer satisfaction survey, which was confidential, would be completed annually. The registered manager confirmed, following the inspection, that these were being sent to people. They also confirmed that confidential telephone calls were made by members of the audit team and that any issues or concerns would be highlighted in this way.

The policy also stated that internal quality audits would be completed twice a year. Audits of the three extra care schemes were completed in June 2017. Some of the issues highlighted at this inspection had also been highlighted by the London Care auditors. Action plans had been drawn up but it was not clear if items were prioritised and there were no timescales for addressing the issues. For example, many of the issues highlighted in this report regarding medication had been identified. However, during the inspection, there was no evidence that any action had been taken to address the concerns and ensure people were receiving their medicines safely.

Other quality assurance processes, including staff supervision and spot checks, had not been completed.

During the inspection a number of different records were examined. These included care plans, daily records, medicines records and staff records. A number of these records were not dated, timed or signed. Some records were illegible. This meant that staff may not be able to read important information or know who to ask if they had queries about the entries that had been made.

Other records contained inaccuracies and inconsistencies or lacked detail. They had not been updated to include current information. For example, two people had become unwell and were cared for in bed. Information about them referred to them being supported each day to get up, washed and dressed in the

morning and prepared for bed in the evening.

Many of the records that we looked at had been audited by a member of the management team and no comment or action had been made about them. This meant the registered manager was not aware of the issues that we highlighted during our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

We had not received any notifications from the service. Prior to the inspection we were aware of a number of safeguarding concerns that were being investigated by the local authority and should have been notified to CQC by the provider. During the inspection we found incidents such as injuries to people and events where the police were called that had also not been notified.

This was breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because reports of notifiable incidents had not been made.

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 18 Registration Regulations 2009 Notifications of other incidents Notifications of reportable incidents had not been made.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service had failed to ensure that people were treated with dignity and respect. People's privacy had not always been maintained and their preferences for the gender of staff providing them with personal care had not always been respected.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People did not always know how to complain. The service did not properly investigate and act on any complaints that were received.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure that all staff recruited were suitable to work with vulnerable adults.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe management and use of medicines. The risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks.

The enforcement action we took:

issue a warning notice

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abuse and improper treatment.

The enforcement action we took:

issue a warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

The enforcement action we took:

issue a warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed to meet all regulatory requirements.

Staff were not supported with regular supervision and appraisal and their practice was not regularly monitored. They were also not supported with training to ensure that people's specific needs could be fully met.

The enforcement action we took:

issue a warning notice