Apex Prime Care Ltd

Apex Prime Care - Eastbourne

Inspection report

3a Courtlands Road
Eastbourne
East Sussex
BN22 8TR

Tel: 01323645592
Website: www.apexprimecare.org

Date of inspection visit:
20 March 2018
27 March 2018
04 April 2018

Date of publication:
18 July 2018

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

Summary of findings

Overall summary

This inspection took place between 20 March and 4 April 2018. The inspection involved visits to the agency's office, to people's own homes, conversations with people, their relatives, staff and professionals. The agency provided 132 people with a domiciliary service, for approximately 1,314 hours a week. Not everyone using the agency received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Many of the people supported by the agency were older persons, some people also lived with long-term medical conditions, some had substance abuse related conditions. People received a range of different support with their personal care in their own homes. Some people received occasional visits, for example weekly support to enable them to have a bath. Other people needed more frequent visits, including visits several times a day to support them. This could include two care workers and the use of equipment to support their mobility. Some people needed support with medicines and meals preparation. Services were provided to people who lived in Eastbourne and surrounding areas.

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

This was the service's first inspection. At this inspection, the service was rated as Inadequate over all. We found they were in breach of six of the 2015 Regulations of the Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's safety was not ensured across a range of areas. This included assessment of risk for people, including risk of falling, support with moving about in a safe way, preventing risk of infection and assessment of dietary risk. The provider was not auditing accidents and incidents to ensure lessons were learnt and risk factors reduced. The provider had also not ensured all medicines errors had been consistently reported to the Local Authority and had not ensured people were appropriately supported when taking their medicines.

The provider had not ensured all people had full assessments of their care needs. Some people's care plans did not outline their care needs, to ensure care workers had full information on how to meet their individual needs. When people's care plans were reviewed, the provider had not ensured all people's changed care needs were up-dated to reflect their current care needs.

Where people needed support in consenting to care, the provider had not ensured people had relevant mental capacity assessments completed or ensured that decisions made on behalf of people were made in

their best interests.

People told us they did not consistently receive continuity of care from care workers they knew. This was echoed by care workers we spoke with. People and care workers told us information systems, such as when care workers were running late, were not always effective. This meant people felt they were not always communicated with about relevant matters.

A range of people felt they had raised concerns. Systems for raising concerns were not robust and the registered manager therefore did not know about the types of matters which people felt they had raised about their care.

The provider did not have effective systems for the audit of care provision. This meant they were not aware of issues which affected people and staff, this included the on-call system and reports of some care workers not following care plans. Where audits had been completed, the information was not used to assess wider issues for people and drive forward improvement. The lack of effective audit also meant the provider had not identified a wide range of records relating to people's needs had not been made, were unclear or incomplete.

People and staff felt the provider had effective systems to ensure staff were supported by training and supervision. All of the staff we spoke with were aware of their responsibilities if they suspected a person was at risk of abuse.

The provider had safe systems for recruitment of staff and analysing if there were sufficient number of staff employed to support people.

People all confirmed how kindly and supportive staff were to them, saying how much they appreciated their visits from care workers and how much they felt respected and involved by the care workers who visited them. Care workers spoke warmly about the people they supported and clearly enjoyed supporting people to live in their own homes and fostering their independence.

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.

People's safety was not ensured across a range of areas, including supporting people with their medicines, risk assessments and systems for the prevention of infection.

People were not supported by prompt referrals to the Local Authority where they may have been at risk of abuse.

There were enough staff, who had been safely recruited, to support people.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not consistently supported to consent to care in accordance with the Mental Capacity Act (MCA) 2005.

Full assessments of people's individual needs were not completed appropriately.

Staff were supported through both training and supervision.

People were supported to eat and drink in the way they wanted and needed.

There were established links with external providers so people's health care and other needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people felt office staff did not show a caring approach to them.

Some information about people did not support their individuality.

People were supported by kindly, caring staff, their

independence was encouraged and their dignity ensured.

People's records, both paper and electronic, were stored confidentially.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have clear care plans which set out how their individual needs were to be met.

People did not feel they received continuity of care from staff and there were unclear systems for ensuring they received care visits when they wanted and expected.

People did not feel concerns and complaints were consistently responded to. Records of issues raised by people were not clearly maintained.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not perform regular audits of service provision to ensure people received a high quality service. Where issues were identified during audit, full action to address areas had not taken place.

A range of people's records were not made, were unclear or incomplete.

Some people and staff did not comment positively on the agency's culture.

Other people said they were pleased with the service and some staff said they felt fully supported by management.

Apex Prime Care - Eastbourne

Detailed findings

Background to this inspection

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

This comprehensive inspection took place between 20 March and 4 April 2018. It involved visits to the agency's office, visits to people in their own homes, telephone interviews with people and/or their relatives and conversations with staff. The service was given a couple of hours' notice of the inspection because it provides a domiciliary care service and we needed to ensure that staff were available in the office to be able to conduct the inspection. The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the agency. This enabled us to ensure we were addressing any potential areas of concern. The provider had sent us an information return (PIR) in which they outlined how they ensured they were meeting people's needs and their plans for the next 12 months. We also sent out questionnaires to people, their relatives, professionals and staff before the inspection. We received 22 replies to the questionnaires. As part of the inspection, we reviewed the PIR and responses to our questionnaires. We also reviewed other information about the service, including safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority before and after the inspection, to receive their comments.

We met with four people who received a service in their own homes. We received comments on the phone from 14 people, five people's relatives and two professionals. We spoke with 11 staff, four of the office staff and the registered manager. We reviewed 11 people's records, including the four people we met with.

During the inspection we reviewed other records. These included six staff recruitment records, training and supervision records, medicines records, the rota of visits to people, risk assessments, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

The service did not consistently ensure people's safety with medicines. We asked people about how they were supported with medicines. We received mixed replies. One person told us, "Some carers do not write down information [about medicines] properly," another, "If there's someone new, I have to tell them what to do" [about their medicines]. This was not echoed by other people. One person told us, "They're safe with medicines, they write it down" and another, "They do all that [about medicines], they put it in a book." This mixed response was echoed by care workers. One care worker told us a person's relative had told them about specific matters about their loved one's medicine, including how it worked and when they were to take it, to ensure the persons' needs were met. This had not been written in the person's care plan and they told us they had not been informed about the matter before they went to care for the person.

One of the people we visited needed support with taking a medicine. Their medicines administration record (MAR) had not been completed on two separate occasions before we visited the person. When the person's number of tablets was counted, they had two more tablets than they should have had. The two omissions in taking their prescribed medicines had not been reported to the office by other care workers who visited the person before we noted the matter. The registered manager said they were now investigating this matter.

The provider was not ensuring the safety of medicines for people in other areas, including by following current guidelines from the National Institute for Health and Care Excellence (NICE) relating to medicines in domiciliary care. One care worker told us there was, "No description what a person's medicines are for, no instructions," another, "It varies, some do, some don't." One of the people we met with was prescribed a tablet which was dispersible. There was no information on the person's MAR or care plan to document that water needed to be added to the medicine or how much water to dissolve the tablet in. This meant the provider could not ensure the person was being supported to take their medicine in a safe way because they had not ensured all care workers had been given the information they needed to safely support the person with this medicine. Most people's records only documented 'blister pack' on their MARs, and care plans about people's medicines did not outline any further information relating to their medicines. For example, one person was prescribed a high dose of a diuretic. This was not documented in any of their care plans, so care workers could ensure the person had additional supports with their continence care and observed for risk of dehydration.

Care workers told us information about prescribed skin creams was variable. One care worker told us, "Creams varies, sometimes body charts are completed, sometimes not," and another, "If the MAR's changed, were not always told and body maps not always completed." When we met with a person, we found this to be the case. They were prescribed a cream for a fungal infection. The directions on their care plan stated it was to be applied 'as required,' with no information about when the person would require it to be applied or how often this should take place. The person was also prescribed a skin cream for eczema. The body chart on their MAR had not been completed to show where it needed to be applied. The lack of consistent information in people's records about skin creams meant there was a risk they would not be supported with them in the way intended by the prescriber.

The provider had not ensured the safety of people in other areas. One person had a risk assessment dated in March 2017, a year ago. This risk assessment had not been reviewed or updated, although the person's ongoing records during 2017 to 2018 showed they had experienced several falls. Their records also indicated risks for the person associated with changes in their behaviour, including in relation to alcohol consumption and there was one occasion documented where the person could have put themselves at risk of a fire. Despite these matters being documented in the person's records which were held on the office's computer file, their risk assessment had not been reviewed and updated to ensure the person's safety, and the safety of care workers.

The provider had not ensured the safety or people and care workers in relation to supporting them with moving and handling. One person told us new care workers were, "Unclear" about using their hoist and said, "I have to keep telling them what to do." They told us they had been provided with new equipment four to five months ago but their care plan had not been revised to reflect this. We saw their care plan only documented they needed to be 'hoisted' with no information on the type of hoist used, including if it was a ceiling or mobile hoist. Their care plan also documented 'please insert sling following best practice and moving and handling polices' with no more information about the type of hoist sling used or areas to be considered when caring for this person, to ensure their individual needs were met. Another person had a detailed moving and handling care plan, however this care plan did not relate to how we saw the person being supported to move by a care worker, including no mention of the mobile hoist which was being used. Both people and care workers confirmed care workers did not always see the same people. Because of this, clear care plans, which were kept up to date about people's moving and handling needs were needed to ensure the safety of people and care workers.

The provider had not ensured the safety of people who may be at dietary risk. One of the people we met with was frail and looked thin. They had records completed about what they ate. We asked the care worker why this was. They said this was because care workers had been directed to complete these records because the person was at nutritional risk due to sometimes forgetting to eat. The person had no nutritional risk assessment and no care plan to support staff who were not familiar with the person in reducing their nutritional risk.

People who had catheters were at risk of not receiving the care they needed to ensure their risk of infection was reduced. NICE outlines that catheters can present a risk of infection, therefore there need to be effective systems to prevent infection risk where people have catheters. One of the people we met with had a catheter. Their notes did not document the type of catheter they used. There was also no information about how often their catheter drainage bag was to be changed. Manufacturer's guidelines state catheter drainage bags need to be changed every five to seven days to reduce risk of infection to people. Records in the person's home showed care workers were changing the person's urine drainage bag. This record showed care workers were not changing the person's catheter drainage bag in accordance with manufacturer's guidelines to reduce their risk of infection. This was because records showed the person's urine drainage bag had been changed after four days, followed by 14 days and on a recent occasion, 17 days. We looked at the records of another person who had a catheter. It only documented 'I have a catheter which needs to be emptied,' with no further information. The registered manager told us the person had a supra-pubic catheter and care workers were responsible for providing care to this person's catheter stoma site. There was no information in the person's care plan to ensure staff were aware of how to meet the person's hygiene needs in respect of cleaning the catheter stoma site or frequency of changes of their catheter drainage bag to reduce their risk of infection. The provider had not ensured staff had the information available to prevent risk of infection to people who had catheters.

The provider had also not ensured they had systems for reviewing accidents and incidents for people and

staff. Accident and incident records were kept but there had been no audit of them, to ensure lessons were learnt and to ensure the safety of people and care workers. This meant the registered manager had not analysed if some people fell, or otherwise injured themselves, more often than others and factors which might increase their risk. They had also not analysed if some staff injured themselves more often and if it related to specific people they cared for, or other factors. Staff told us they documented and reported to the office if they saw people had developed signs of pressure damage. Central records of pressure damage for people were not maintained to assess how the agency were supporting people who were at risk of pressure damage. This meant there was no analyses of whether the service was doing all relevant matters to reduce risk of pressure damage to people.

The provider had not ensured safe care was being provided in all relevant areas. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured people were safeguarded from risk of abuse. The registered manager confirmed the agency followed East Sussex County Council's (ESCC) safeguarding policies. This policy states, among other areas, that medicines errors need to be referred via safeguarding procedures, to ensure risk to people is assessed. This was confirmed to us by two professionals who worked for ESCC. One care worker told us about their concerns about people not receiving the medicines they needed, telling us "There's been missed medication out there and it's not been followed up." A record was maintained of medicines errors experienced by people. This showed six medicines errors had been recorded in the past nine months. None of the reports documented that the errors had been referred to ESCC as potential abuse, as part of the agency's safeguarding procedures.

The provider had not ensured all matters had been referred to appropriate authorities to ensure people were safeguarded from risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at eight staff files. All of them included records to show checks on prospective staff members had taken place, before their offer of employment, to ensure their suitability to work with vulnerable people. These included checks on prospective staff's past working history, at least two references, proof of identify and Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable adults. A new care worker told us about their, "Full interview," saying, "Everything was done and I couldn't start until was all done." The registered manager told us they interviewed all prospective staff personally to ensure their suitability for employment at the agency.

Both people and care workers said they felt there were enough staff employed to meet people's needs. We looked at records of missed calls. They did not relate to shortages of staff and had occurred due to administrative errors. There were enough staff employed for the office to organise an additional visit to people involved later in the day. Office staff told us if there were staff shortages, for example due to sickness, they would work as care workers to ensure people's needs were met.

The agency was ensuring people's safety in some areas. When we went out with a care worker, they checked both the person's smoke alarm and emergency call on their pendant while we were there, and recorded that both were working as anticipated. We could hear the care worker also checked the temperature of water before starting to support a person with their wash. One of the people we visited told the care worker that their leg, "Went" before they visited. The care worker carefully checked with the person that they had not fallen over or hurt themselves in anyway.

People told us staff always wore disposable gloves and aprons when they supported them with personal care. One person told us, "They do wear gloves," and another "Oh yes and they even change their gloves for different creams." One person told us their care worker, "Does dispose of it correctly," in relation to their continence aid. The care worker we went out with used gloves and aprons when they provided care, changing and disposing of them correctly when they needed, to reduce any risk of cross infection to people.

All of the staff who responded to our questionnaire confirmed they knew how to support people if they thought they might be at risk of abuse. One care worker told us, "I'd let the office, I know 100% they'd do something about it," another care worker told us, "I'd most definitely report it." Care workers also said they would take matters further if they felt the office staff did not report matters on. One care worker told us, "I'd be happy to go to social services," and another said they would feel, "Confident" in phoning up the Local Authority. Staff were also aware of the risks to people if they could not gain entry to a person's home when they visited. One care worker told us they would phone the office and stay until police or someone came to ensure the person was safe. Another care worker told us, "I have rung police before now, I wouldn't leave it alone." One of the office staff told us, "Of course I'd do something," if they received reports that a person was at risk of abuse and needed safeguarding. All four office staff we spoke with were aware of how to report safeguarding issues to the Local Authority.

Requires Improvement

Is the service effective?

Our findings

We looked at how the provider met the requirements of the Mental Capacity Act 2005 (MCA). The 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.

One care worker and a care coordinator told us about one person who had their medicines and alcohol locked away from them. We asked why the person's medicines and alcohol were locked away. We were told this decision had been made by the person's advocate to ensure the person did not put themselves at risk of drinking too much alcohol or making mistakes with their medicines. This person had a mental capacity assessment which stated they had full mental capacity to make decisions for themselves. There was no evidence decisions about locking these items away from the person had led to a review of their mental capacity assessment or if a best interests meeting had been held about this matter when restricting their access to their own property. We discussed a different person whose records indicated they were also drinking high amounts of alcohol and was considered to be at risk of not taking their medicines. We were told the agency was in the process of accessing a locked container for these items. The person had also been assessed as having full mental capacity. There had been no consideration of if this person's mental capacity had changed or if locking away their alcohol and medicines was in their best interests. We discussed with the manager that, in accordance with the MCA, decisions about restricting people should only be made with their consent and if they were not able to be involved in consenting to such matters, they must be made in their best interests. Such assessments and decisions need to be documented, to ensure all matters complied with the MCA.

The provider had not followed the principals of the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, we contacted the Local Authority to receive feedback about the agency. They told us they had been concerned recently, following a turnover in people supported, about the agency's ability to meet the needs of some people. They had, for a brief period, stopped contracting with them, to ensure the agency was able to meet new people's needs. The registered manager told us people's needs were assessed before offering them a service from the agency. The registered manager told us this included meeting people in hospital, to assess if the agency could meet their current needs. We saw this system was not always effective in practice.

We looked at the records of a person who had received a service from the agency until they had become unwell and were admitted to hospital. After more than six weeks in hospital, the person returned home, and the agency again provided their care. The person's current daily records indicated they were more frail than previously. They made reference to their suitability of their accommodation for their current needs and included references to the use of hoist slings to help the person move about. However their assessments and care plans had been drawn up six months before the inspection and had not been updated since their

return from hospital, to reflect their current needs. We looked at the records of two new people. These records showed incomplete assessments. One person, among other areas, had records which showed they were prescribed two different inhalers for a breathing condition. Their assessments and care plans did not include any information about if the person could manage these inhalers independently and if not, what supports care workers would need to give the person. There was also no information on if care workers had been trained in how to support people who used inhalers in the person's assessment. There was also no information on the side effects of the inhalers for care workers to observe for, although one of the inhalers could put the person at risk of a wide range of side effects. The other person was living with diabetes. They had no information about risk to them of high blood sugar levels or of actions to be taken by staff if they had high blood sugar levels. High blood sugar levels can present a risk to person's long term health and welfare, particularly in older people who may already be living with a range of other conditions which can be affected by raised blood sugar levels.

The provider had not ensured people had a full assessment of their needs to ensure they could receive appropriate care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager reported the provider had systems to ensure staff had the skills, knowledge and experience to deliver effective care and support. People told us they thought staff sent to them had been trained in their role. One person told us, "Staff obviously have the knowledge" and another, "Yes, they're trained."

All staff received an induction into their role. One new care worker told us their induction had been, "Very thorough, covered pretty much everything," they told us this compared favourably with other agencies they had worked for in the past. Another care worker described their induction as, "Well informed and thorough." One new care worker told us they had shadowed other care workers before they worked on their own. They told us their shadowing had been, "Very helpful, it showed how to do things practically." All of the newer care workers we spoke with told us they did not go out to work on their own until they felt ready to do so.

Staff commented positively on the training they received. One care worker told us, "Training's good and regular," another, "They give us relevant information" and another, "We do updates all the time." Most staff said they received regular supervision from their manager, both as one to one meetings and as 'spot checks.' One care worker told us, "My one to ones are helpful, more helpful than my previous job." One care worker described spot checks as, "Useful," they said their supervisor showed them what do if they were not doing it right. Another care worker told us about spot checks, saying, "If I get a bit slack, they pull you up a bit." We saw a care worker supporting a person using a hoist. They did this in a competent and safe way which showed the effectiveness of their moving and handling training.

The registered manager had a training and supervision plan. This enabled her to see at a glance which member of staff were due which training and if they were up to date with supervision and spot checks. She told us they also used ad hoc training, for example, a local solicitor had recently trained some staff in the MCA. She said she was next planning to support some care workers who had an interest in specific areas, such as Multiple Sclerosis, to undertake more advanced training in the area. That care worker would then work as a resource to other care workers and cascade information to them.

People who needed support with eating and drinking said they received the support they needed. One person told us, "They microwave my meals and they do it right. One person's relative told us, "Their brief is to make sure [my relative] eats, and they do do this." One person told us they appreciated the way their care workers always left them with water to drink, so they did not get thirsty between visits. Another person told

us they liked the way the care workers made them hot chocolate made with milk. When we went out with a care worker, the care worker always asked people if they wanted a drink before they left them. One of the people we met with had a detailed care plan which documented exactly how their liked their tea to be made.

People told us care workers supported them if they were unwell. One person told, "Once my carer came and I was very poorly, they called the ambulance and waited with me til it came, I'm very impressed by that." One care worker told us about two occasions when they had supported people who were really ill. They said on one occasion they had found the person on the floor and on another the person had breathing difficulties. They told us how they had called an ambulance, told the people's relatives, written down what had happened in the people's records and left a message with the manager on call to tell them what was happening.

There was evidence of close working relationships with other professionals. One person's records showed regular contact with an occupational therapist (OT) about their equipment. Several people's records showed regular contacts with the person's district nurse and social workers. The care worker we went out with said they appreciated the support they received from the local district nurses when they needed it.

Requires Improvement

Is the service caring?

Our findings

While we received positive comments about the caring nature of care workers from people, several people told us the office staff were not caring. One person told us, "Their work systems are done to suit themselves, not the client," another, "I'm happy with the staff, not the agency" and another, "I've no faith in them" about the office staff. Such comments were echoed by care workers about how office staff supported people. One care worker told us, "Some of the office staff are very nice, some are not helpful" and another, "Office staff can be lovely but….." then tailed off their comments and would not say any more. However such comments were not echoed by everyone. One person told us "The office are very helpful."

We looked at people's records, some did not indicate an individualised approach to caring for people. We met with four people. All of them were happy to describe their past lives to us and clearly enjoyed telling us about where they used to live and what their occupations had been. Only one of the people had any reference to their past employment in their records and this was very unspecific and did not include the areas they had enjoyed telling us about. The agency were not providing people with continuity of care from the same care workers, so such information is a key area to ensure all care workers who supported people could provide an individualised approach to providing care.

The caring approach by office staff and individualisation of people's records are both areas which required improvement.

All of the people we spoke with gave us very positive comments about the caring nature of the care workers who visited them. Comments included, "They're very kind to me," "They're very polite, they do what I want," and "All my girls are very good." One person told us, "I like a cup of tea and a chat, someone you can talk to, I love that." Another person told us, "My regular carer is "brilliant, [the care worker] does the extra for me." One person told us, "I had such a nice man to look after me this morning." One person's relative told us their relative's face, "Lights up," when they saw a particular care worker had come to support them.

When we visited people, we saw the care worker started by introducing themselves to the person to remind them of who they were. This was because they said they were aware they had not supported the person recently. They then went on to have a general chat to put the person at their ease. The care worker had a friendly approach to the people they visited and included lots of jokes and laughter with people if that was what they wanted. They were quieter and gentle in approach with other people, because that was what they preferred. One of the people we visited winked and smiled at us, saying, "They're pretty good aren't they?" The care worker we were with supported people with what wanted at the time of the visit. For example the answerphone of one of the people we visited was bleeping, they asked the care worker to check it for them, to stop the noise. The care worker was polite to the person when they were asked to do this, telling them why the answerphone was making the noise and stopping it from doing so, because it was disturbing the person.

People told us care workers supported their independence and respected their individual rights. . One person told us they appreciated the way, "They offer me choice," another said they liked the way, "They call

me by the name I prefer, not my name." When we went to visit people, we saw the care worker made sure they involved the person and encouraged their independence. The care worker chatted comfortably with each person, listening to what they said. They also asked for consent to the care they were providing care throughout all time they were in the person's home. One person told the care worker they wanted their socks to be put on before the care worker did anything else for them and the care worker ensured they followed what the person directed. The care worker supported one person in standing independently, giving them verbal advice, not rushing them in any way, while the person took their time to stand up. Once they had stood up independently, the care worker warmly praised them, which they clearly appreciated. The care worker supported another person with combing their hair, checking they were arranging the person's hair in the way they wanted. Before they left the people they visited, the care worker checked there was nothing else the person needed. One of the people's care plans documented the importance to them of maintaining their own independence as much as possible.

People said their dignity was respected. One person told us they had phoned up office when they were sent a male care worker for personal care and that this had not happened again. When we visited a person, the care worker observed the person's dressing gown was open at the front and checked with them if they wanted it to be done up to maintain their dignity. The care worker carefully checked the person's window curtains were drawn before they gave them personal care, to ensure their privacy.

Staff helped people with relationships with friends and family in the way they wanted. One of the people we visited was supported by a close relative. The care worker clearly had a good rapport with the person's relative, talking easily with them. With another person the care worker asked after about the person's main family supporter, finding out how they were that day, which the person they were visiting clearly liked. When they were with another person, they asked them to open and read out an Easter card sent to them by a relative, which the carer worker did. The person clearly enjoyed this support.

All of the staff we spoke with were aware of their personal responsibilities for ensuring people's confidentiality. People's records in their own homes were kept where people wanted. People's paper records in the office were kept securely. The app used by the provider was double-password protected to ensure people's privacy. The registered manager said it was regularly refreshed and could be promptly up-dated with changes, for example when a care worker left the agency's employment.

Inadequate

Is the service responsive?

Our findings

We asked people if the agency was responsive to their individual needs. We received mixed replies. One person told us care workers were, "Badly briefed." One person's relative told us, "Not all staff follow the care plan." Another person told us when we visited them that their morning care worker had not done what they wanted in a certain aspect of their care, and this had troubled them. This preference was documented in the person's care plan. Another person told us, "I dislike telling every care worker what needs doing, they should know." However this was not echoed by everyone. One person's relative told us, "All of them follow the same procedure."

Care workers also gave us mixed comments about if people's care plans informed them of how to meet people's needs. One care worker told us, "It would be nice if care plans were more up to date," another told us a couple of clients they had been to did not have information. This was, "Difficult when you don't know them." One care worker told us, "If I report changes in clients to the office, sometimes they do something, sometimes not, it varies." Other care workers told us care plans informed them of what people needed. One care worker told us, "It tells me everything I need to know."

We saw one of the people we met with used a specific aid to support their continence. Their care plan was dated 27 February 2017, over a year before we visited them. It had no reference to this aid to direct staff on how it was to be used for them. The person also told us how important it was for their independence to have their electric wheelchair charged overnight, so they could move about their home the next day. They also had no information about this care need in their care plan.
The person said their regular care worker knew about their continence aid and charging their wheelchair, but when they were not on duty, others did not.

Another person we met with had records which showed care workers documented when the person had opened their bowels. The person was also prescribed a laxative by their GP. The person's care plan had no information about if they had needs relating to their bowels and no information about what care workers should do if the person had not opened their bowels for a period of time. The person was living with dementia, looked frail and the care worker we visited them with told us they had dietary needs. Difficulties with bowel management, particularly constipation, can affect people's dementia, appetite and general well-being. The agency were not ensuring they were designing this person's care to ensure their needs were met.

One care worker told us some staff did not know about stoma care. We looked at the records of a person who had a stoma. Their care plan dated in January 2018 only documented 'I will need my stoma bag changed,' with no more relevant information, including the size and type of stoma bag the person used, how it was to be removed and replaced, how personal hygiene of the stoma site was to be managed, any signs such as sore skin to be observed for, and what to do if this happened. The agency had not ensured the person's care plans included relevant matters about meeting their individual stoma care needs.

We met with a person whose care plan documented they were partially blind. We saw they were sitting in a room which had its curtains drawn, thus giving a soft, gentle, dim light. There was no information in the

person's records about the extent of their visual disability, if how they had their room was their preference, or of areas where the person might need additional support. The care worker left the person with a bucket placed to one side and told them where it was, so the person could feel for it. We asked the care worker about this. They said this was what the person wanted. None of this information had been documented in their care plan to ensure all staff met this person's wishes. The person told us they were often cared for by different care workers; this was reflected in their daily records.

The provider was not ensuring they were designing people's care so their needs were met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Many of the people we spoke with raised issues about continuity of care from the same care workers who were familiar to them. One person told us, "I get a mixture, so I don't get to know them," another, "I get different ones every day, I once had a regular but they're messing me about – I'm not happy with that" and another, "It's not fair on staff, they keep changing and have to go somewhere different." Some people told us continuity of care was worse at certain times of day. One person told us, "Continuity goes in the evenings and at weekends." However some people told us they usually saw the same care workers. One person told us, "I now have regular carers, so much easier."

This lack on continuity was also reported by care workers. All of the 11 staff who responded to our questionnaire reported they were not generally introduced to a person before they worked unsupervised with them. One care worker told us, "I used to have regular clients but not any longer, keeps changing round," and another, "I've no regulars." However some of the care workers told us they nearly always visited the same group of people.

When we went out with a care worker, we visited four people. The care worker knew all four of the people but told us they had not visited them recently. One of these people told us they had the same regular care worker some days, but did not have a regular care worker when their regular care worker was not on duty. We looked at two of the people's records, they showed they did not receive visits on a regular basis from the same group of care workers.

People told us they were sent a rota, but this could not be relied on because it changed frequently. One person described the rotas as, "Chaotic," another told us, "I don't know who's coming," due to changes in the rota. One person's relative told us there was, "A lot of change in the rota. They do not let us know about changes," and another, "I don't know when the carers are coming or who because they change the rota so often." One care worker told us, "My rota often changes." When we went out with a care worker, they received a message on the agency's app on their phone relating to a change in visits for them that day. The office maintained records of missed call. We asked about one record of a missed call and were told it related to an information error between the care worker and the office.

People also gave us mixed responses about if care workers came on time. One person told us, "They can vary with the times," another, "They've been too late, mainly on a Saturday & Sunday" and another, "I'm not often told if they're going to be late." One person told us care workers were late because of timings between visits, telling us, "They're given five minutes to get from here to [a village several miles away]." This was not echoed by other people. One person told us, "They keep to their times."

Comments by people about late visits were echoed by a high majority of the care workers. One care worker told us about a recent incident when they had visited a person for their teatime call and had been unable to give them their painkiller when asked. This was because the lunch-time care worker had been running so late, therefore there had not been enough time between each dose of the painkiller. Comments from care

workers included, "I end up working late every day because not enough time between calls," "They only give five minutes between calls so constantly late," and, "Travelling times not good, I'm always running behind schedule." A few care workers did not echo this. One care worker told us, "I only occasionally run late."

We asked care workers what they did to inform people they were running late. We received a variety of replies. One care worker told us, "If I'm running late, there's no point phoning the office," they said they were not sure if there was a procedure about reporting running late. Another care worker told us, "If I'm late I phone the office, I'm not sure if they pass it on to client." Another "If I'm very late, I phone the office and they phone the client, sometimes they do and sometimes they don't, it varies."

We told the registered manager about the comments made by people and staff. They told us they had a sophisticated computerised planning system, which enabled them to track matters, including continuity of care for people and visit timings. They said the programme could also allow for variable timing between visits. They told us, due to a turnover in people during the winter, they were aware there had been some issues relating to continuity of care and the setting up of care packages. They said they hoped the situation would now improve as they now had a more stable client group. They were not aware of the extent of people and care workers' concerns when we fed back the wide range of comments to them. This means provider had not effectively assessed and analysed service provision to ensure they were consistently providing a responsive service to people. They had also not assessed the risk to people from not receiving continuity of care from care workers who knew people's individual needs.

The provider was not assessing, monitoring and improving the quality of care to people by seeking and acting on feedback from them. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they knew how to raise complaints and how they were responded to if they did so. Most people we asked about this responded unfavourably. One person told us, "We've put in lots of complaints, never get a letter back, we feel pushed under the carpet." Another person told us "My [family member's] contacted them several times," about complaints. One person's relative told us another family member had phoned up to complain, but no one come back to them. Another person's relative told us they had complained about the attitude of certain care workers; they did not know if anything happened about their complaint. Concerns about complaints management were also echoed by care workers. One care worker told us, "I'm concerned they did not follow their own complaints procedure," and another, "Complaints and concerns are not always followed through to a satisfactory resolution." These comments were not echoed by everyone. One person told us, "I put in a complaint about a carer I did not like, and office helped me."

We looked at complaints records. Only one of the issues a person told us about was documented in the agency's complaints records. One person told us a family member had called the week before our inspection to make a complaint. We looked on the person's computerised log in the office. It did not include any reference to the person's reported complaint. We discussed this with the registered manager. She said the office staff did not currently complete an 'issues of concern' log where matters were raised by people on the phone. She said this might mean people felt they had complained on the phone but it had not been regarded as a complaint by office staff or office staff had felt the matter had been dealt with at the time, so it did not need recording. This meant she was not aware of such matters being raised by people, so could not respond to them effectively or analyse issues to identify trends. She said she would look into this matter to ensure a responsive system was developed in relation to people's concerns and complaints.

The provider was not ensuring that any complaint received was investigated and action taken in response to any failure identified by the complaint or investigation. This is a breach of Regulation 16 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. We asked the registered manager about compliance with AIS. They told us they had recently been made aware of this standard and the provider had developed a clear procedure relating to it. They were planning to ensure that they reviewed information and people's care plans so they conformed to this standard. Current plans were that they would have addressed this matter within six months.

This agency did not currently care for people at the end of their lives. The registered manager told us if this should happen in the future, a key area would be working closely with the person's friends and family, district nurses, the local hospice, the person's GP and other supports in the community.

Inadequate

Is the service well-led?

Our findings

We received a wide range of comments about if the agency was well managed, from both people and staff. One person told us, "The manager does respond but the office staff don't," another, "There needs to be a much tighter control from the top" and another, "The company is a shambles." Such comments were also echoed by staff. One care worker told us, "The office is very disorganised and waste a lot of time," another, "It doesn't matter what you say, you're not listened to," and another, "The owners have no oversight." This was not echoed by everyone. One person told us, "The office are very good" and another, "The office? Oh yes they're helpful." One care worker told us, "I feel very comfortable to speak to anyone in the office" and another, "Staff in the office are very friendly and give you a lot of support."

Many of negative comments made by people and staff related to communication, particularly the on-call system. One person told us, "You never get phone calls back," and another, "The office are difficult, they don't ring back when promised." One person's relative told us, "I phone the office at the weekend and the on call does not answer." Such comments were echoed by staff. One care worker told us, "The on call phone is not answered, it's difficult if you're dealing with an emergency," another, "Sometimes I don't feel safe because on call does not answer" and another, "I've had problems with on call not picking up – it depends who's on call." Such comments were not echoed by all staff. One care worker told us, "You leave a message and they come back to you."

We discussed such comments with the registered manager. She said the agency did not currently audit how the office responded to phone calls, including when people and staff used the on-call system. She said, following such comments, she would fully review communication, particularly as regards the on-call phone.

We reviewed the provider's managerial systems for auditing the quality and safety of the service provided. The provider's only system for auditing quality of care was peer review visits by a manager from another agency; it had no other systems for overview by a senior manager from the organisation. We looked at the records of a peer review visit for October 2017. This was limited in scope as it had only reviewed the quality and safety of care for one person and their relative. Although this review did identify issues with timekeeping and the person not being informed of changes of care workers sent to them, the action plan only related to how this person's quality of care was to be improved. The review had not led to a general review of such matters across the agency to ensure all people received a quality and safe service, particularly in relation to timekeeping and information about care workers being sent to them as we identified at this inspection. The peer review also identified issues in relation to completion of one to one documentation for staff. This had not been addressed by this inspection because we found a variance in how such staff records were completed, with some supervision records being fully completed but others were not.

The registered manager's own internal audits were not effective in ensuring matters were identified and acted upon. For example, we looked at the records of a person whose care had been reviewed on 19 January 2018. The review had not identified the person's care plan did not reflect their current moving and handling needs, did not outline how their catheter care was to be managed in a safe way and that there was no information in the person's care plan to direct staff on how to support them with their stoma care.

Internal audits also did not include a review of key areas to ensure the safety of people and improve care provision. Although the office kept a record of medicines errors, these were not audited to identify if there were any trends, including people or staff involved. The records showed no action plans arising from the medicines errors. Due to the lack of auditing, it had not been identified that the information did not include key areas such as which medicine had been missed. The provider had also not identified that they had not made alerts to the Local Authority or CQC about these medicines errors, to ensure the safety of people.

The lack of audit also meant the agency had not identified and taken action on improving relevant documentation about people. One care worker told us, "Not everything about my clients gets documented when I'm not there," another, "I do report things to the office, but I don't know what happens next." Records which had not been completed included a person who we visited whose recent daily records documented about a red area on one of their limbs. The record was limited. A body chart had not been completed to show where the red area was on the person's limb and there was no indication of the size of the area to inform other care workers who supported the person. When we looked at the person's computerised log held in the office, it did not document that the red area had been reported to ensure management oversight. One person who we visited had a record of the food they ate. This record had not been completed every day, for example on 22 March, when their other records showed they had been visited. Their records were also not completed in enough detail to enable assessment of if the person what eating enough nutritious food. For example, one record only stated 'soup' and another 'cereal' with no indication of type or amount given to the person and whether they ate it all. One person's records showed they were supported by staff to continue drinking alcohol. The care coordinator told us this was because they were on a plan to regulate their alcohol intake. They had no care plan about this, their records did not indicate the type of alcohol they preferred, or how much they were to be supported with, to ensure consistency in approach and support the person with regulating their own alcohol intake. Matters like these had not been identified by the agency's internal audit systems to ensure a safe and consistent approach to meeting people's care needs.

Several staff old us about their dissatisfaction with the app used by the agency to monitor their visits to people. Several staff told us they were not logged as starting the call until they verified their visit on people's files and in their homes. When we visited one person with a care worker, we saw this was the case because it took the care worker some time to find a safe place to park and the person's access arrangements meant it took several minutes before they were able to access the person's folder. This was also the case when we left. Such timekeeping was not included or allowed for on the roster. Care workers we spoke with told us this affected timings between visits. It had also affected staff morale because some care workers felt the provider had not listened to them when they had raised issues about this matter. The registered manager told us the app system was fairly recently introduced and some staff still needed to become familiar with its use. They did not currently have any systems for monitoring the extent of time taken by care workers before and after logging on for a visit or if this affected timings between visits.

The provider was not ensuring they had systems which operated effectively to assess, monitor, mitigate and improve the quality and safety of services for people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The agency did have systems for involving and informing staff. Regular staff meetings were held, these were minuted and made available to staff. One member of staff made favourable comments about the meetings, telling us, "I constantly bring up issues at every meeting, I feel involved," another told us, "We do discuss problems," at staff meetings. During the inspection, we saw care workers coming in and out of the office, there was an easy, comfortable atmosphere between care workers and office staff. One care worker told us they appreciated this approach, telling us, "They've been very helpful to me personally." Another care worker summed up their opinion of the agency by saying, "They're lovely people to work for," another told

us, "It's a great place to work, colleagues are lovely, clients are lovely."

We saw the registered manager took their time to discuss matters when staff phoned them up, including supporting them with changes in their personal lives which would affect how they worked. The registered manager had clear systems for monitoring staff sickness. She took action were relevant within the provider's policies when staff went off sick or returned to work after periods of sick leave. The registered manger was familiar with the catchment area where the agency provided services. She was clearly used to working with range of professionals, including social workers and district nurses. The registered manager had an open approach to hearing issues raised with them during the inspection. Once matters had been identified to them she said she was keen to ensure improvements in service provision were developed promptly.

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 11 HSCA RA Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not protecting service users from risk of abuse and improper treatment. This was because their systems did not operate effectively to ensure potential abuse was managed in accordance with safeguarding procedures.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider's system for identifying, receiving, recording, handling and responding to complaints by people did not operate effectively. This was because the provider was not ensuring that any complaints received were investigated and necessary and proportionate action taken in response to any failure identified by the complaint or investigation.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care did not always meet their needs appropriately or reflect their preferences. This was because the provider was not carrying out an assessment people's needs and preferences for care or designing care with a view to achieving their preferences and ensuring their needs were met.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not always provided in safe way for people. This was because the provider was not assessing the risks to the health and safety of people and doing all that was practicable to mitigate such risks. The provider was also not ensuring the proper and safe management of medicines or preventing and controlling the risk of infections for people.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of people. The provider had not ensured they were assessing and monitoring the quality of care provided to people. The provider had not maintained an accurate, complete and contemporaneous record in respect of each

person, including a record of the care and provided to the person and of decisions taken in relation to the care provided.

The enforcement action we took:

Warning Notice