Aquaflo Care Ltd

AQUAFLO CARE LIMITED

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 January and 1 and 2 February 2017 and was unannounced.

At the last inspection on 27 and 29 September 2016 we found breaches in relation to safe care and treatment, complaints, staffing, the employment of fit and proper persons and notification of incidents. The service was rated Requires Improvement overall and Inadequate in Safe. The provider sent in an action plan to tell us what they were going to do to make improvements. We found that not all improvements had been made.

AQUAFLO CARE LIMITED is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our previous inspection the service was providing support to 118 people in the London Boroughs of Hackney, Tower Hamlets, Islington and Newham. The majority of the people using the service were either funded by the local authority or the NHS. At this inspection they were supporting 132 people, but were no longer supporting people in the London Borough of Newham. These people were being supported by another branch of the provider.

There was not a registered manager in post at the time of our inspection. We were told that two senior members of staff were in the process of applying for the registered manager's post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived with specific health conditions did not always have the risks associated with these conditions assessed and care plans were not always developed from these to ensure their safety and welfare. Risk assessments lacked detail and did not always provide staff with guidance on how to minimise risk. Risk assessments had not been updated in line with the provider's action plan.

Appropriate policies and procedures were not in place to ensure that people received their medicines safely and effectively. People's records were not clear as to what support they received with their medicines and were not being checked to ensure they received them safely.

People were not always protected from the risk of potential abuse because the provider did not always act appropriately to safeguarding concerns or follow them up to ensure people's safety.

The provider had improved their staff recruitment process and initial interview assessment process to ensure staff were suitable to work with people using the service.

Staff did not have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA). Where family members had signed to consent to the care and support of their family member, the provider was

unable to demonstrate that the relative had the legal authority to do so and was therefore not working in line with the MCA.

New staff received an induction training programme with regular staff having an annual refresher. The provider was aware of some of the issues raised regarding the amount of training that was covered in the induction programme and they were in the process of reviewing this.

We saw that more regular supervisions were being carried out by suitably qualified staff. A supervision and appraisal matrix had been developed and information was seen to highlight when staff were due to receive one.

People were supported to have sufficient food and drink. Information had been recorded in people's files however still lacked detailed information of people's preferences and nutritional needs.

People and their relatives told us that their regular care workers were kind and caring and knew how to support them. Staff understood the importance of respecting people's privacy and treating people with dignity and respect.

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

Care records had been improved since the previous inspection as more person centred information had been included. However some people did not have a care plan in place so we could not be assured their needs had been identified and met.

There had been some improvements in how complaints were being managed, however we found some had not been dealt with in line with their own policies and procedures.

People and their relatives gave us mixed views about how well they thought the service was managed. Staff felt supported by management to carry out their roles. Health and social care professionals commented on the lack of communication from the office and management when following up concerns.

We could see that there had been an improved approach to quality assurance since the previous inspection and audits were in place to monitor the quality of the service, but were not always consistent to monitor the care provided to people. A number of audits to improve the service were in the process of being implemented at the time of the inspection.

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

Not all parts of the action plan that was submitted to us by the provider had been followed through effectively to improve the service.

We found three continuing breaches of regulations relating to safety, complaints and notifiable incidents. 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. Two new breaches of the regulations relating to consent and safeguarding people from abuse were also found. You can see what action we told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were in place but lacked detail and action needed to reduce the likelihood of people coming to harm. They had not been updated in line with the provider's action plan.

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

People were not always protected from the risk of potential abuse because the provider did not always recognise, respond and investigate safeguarding concerns.

Staff recruitment procedures had been improved to minimise the risk of unsuitable staff being employed. Initial interview assessments were more robust to ensure competency and understanding.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have a clear understanding of the principles of the Mental Capacity Act 2005 and people's consent to care and support was not always recorded accurately.

Records showed training was in place with new staff receiving an induction and current staff having an annual refresher. The provider told us they were in the process of extending their induction training programme for new starters.

Improvements in staff supervision were seen and were carried out by a suitably qualified member of staff. A supervision matrix was now in place and care workers spoke positively about their involvement in them.

Information about people's health and dietary support needs had been recorded in their files however still lacked detailed information.

We could not improve the rating for Effective from "Requires

Improvement" because to do so requires us to see sustained improvements over time. We will check this during our next planned inspection.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

The majority of people spoke positively about their regular care workers and felt they were kind and respectful.

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

Care workers respected people's dignity and maintained their privacy.

We could not improve the rating for Caring from "Requires Improvement" because to do so requires us to see sustained improvements over time. We will check this during our next planned inspection.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records had been improved as more person centred information had been included. However some people did not have a care plan in place so we could not be assured their needs had been identified.

There was evidence that people's cultural and religious needs were being supported.

There had been some improvements in how complaints were being managed, however we found some had not been dealt with in line with their own policies and procedures.

We could not improve the rating for Responsive from "Requires Improvement" because to do so requires us to see sustained improvements over time. We will check this during our next planned inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider continued to not meet their legal obligations to inform the Care Quality Commission of notifiable incidents.

We could see that there was an improved approach to quality assurance and audits were in place to monitor the quality of the service. A number of audits to improve the service were in the process of being implemented so we could not comment on their effectiveness at this inspection.

Staff felt supported by management however there were mixed views with people and their relatives about how well the service was managed.

We could not improve the rating for Well led from "Requires Improvement" because to do so requires us to see sustained improvements over time. We will check this during our next planned inspection.

AQUAFLO CARE LIMITED

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to check that improvements to meet legal requirements planned by the provider after our inspection on 27 and 29 September 2016 had been made. We looked at the overall quality of the service to provide a new rating for the service under the Care Act 2014; prior to this inspection, the rating for the service was Requires Improvement.

The inspection took place on 31 January and 1 and 2 February 2017 and was unannounced on the first day. The provider knew we would be returning on the following days.

The inspection team consisted of three inspectors, with one present on all three days of the inspection, one on the first day and one on the second day. It also included two experts by experience who were responsible for contacting people during and after the inspection to find out about their experiences of using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report. We considered information of concern which local authorities had shared with us after the previous inspection. In addition to this we reviewed the provider's action plans that had been submitted to CQC since the last inspection.

We called 43 people using the service and managed to speak with 14 of them. We also spoke with seven relatives and 18 staff members. This included the director, two operations managers, a branch manager, three care coordinators, three human resources officers, an assessor and seven care workers. We looked at 11 people's care plans, nine staff recruitment files, staff training files, staff supervision records and audits and records related to the management of the service.

Before, during and after the inspection we spoke with nine health and social care professionals who worked with people using the service for their views and feedback.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection of the service we found that people's safety was at risk. During this inspection we found that the provider had not taken sufficient action to address the concerns and had not made sufficient improvements to ensure people's safety.

Our previous inspection identified that the provider had failed to manage risks to people's health and wellbeing as risk assessments did not adequately identify assessed risks or guide staff about how to mitigate these. The provider submitted an action plan stating that all risk assessments had been updated and actions for each risk identified had been added. At this inspection we found that improvements had not been made.

An assessor would visit people and carry out a risk assessment on the safety of the person's home environment as well as other areas of support, including the person's medical conditions and nutritional needs. This information was then incorporated into a care plan which would inform the care worker of the tasks that needed to be completed in their care of the person. Risk assessments were divided into different sections including mental capacity, physical and psychological health, environment, medicines, equipment checked and supplied, with an action plan to detail what further actions needed to be taken by the service. We found shortfalls in all risk assessments that we looked at. All the risk assessments were checklists where risks were identified, but not explored, with no further guidance or advice for care workers.

One person was at risk of falls and needed full assistance with all transfers, from getting in and out of bed, sitting to standing and when they needed to be repositioned. The action plan was blank with no further guidance or information for care workers on how to carry out these tasks safely. We showed this to a care coordinator who acknowledged that it lacked detail and had no control measures in place.

Another person needed support with getting out of bed due to a spinal condition. The care plan stated it needed to be done using a safe method but there was no information about how this was to be done. The care tasks also said the person needed support with chest physio suction, correct positioning and had to be transferred into a wheelchair using a hoist. This information was not recorded in the risk assessment, which had not been updated since 13 March 2015. The risk assessment recorded that the person could be difficult to hold, with a comment saying 'Yes, can be dead weight', with no further information for care workers on how to support the person. Even though the person needed a hoist and wheelchair for transfers, the equipment checked and supplied section said 'Non applicable'.

Another person was supported with a percutaneous endoscopic gastrostomy (PEG) feed. This is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.
There were some instructions for care workers in how to manage this PEG feed including that it must be rinsed out daily with water, however, it did not include an updated feeding regime, with specific information about nutrition and time. The only indication of the correct food was within an 'Enteral Feeding Regimen' which was dated July 2014. We contacted a healthcare professional during the inspection who supported

this person as we had concerns from a recent serious safeguarding incident about how people with PEG feeds were supported. They told us that a care plan had been sent to the provider on 20 October 2016 with an updated version but this was not in the person's records, and their risk assessment was dated 14 September 2015. They also confirmed that another care agency was supporting this person and was providing support together with the provider, but this was not recorded in the care plan. Before contacting the healthcare professional, the care coordinator was unable to explain the care and support the person received.

There were two people with no risk assessments in place in their care records. For one new referral the local authority assessment was unclear about what kind of care and support was to be carried out. The care coordinator told us that a care worker had informed them the person was a heavy smoker. We saw that they had made contact with the social worker for further information but confirmed care had been carried out without the relevant risks assessed. The care coordinator added, "We do need to push to get that assessment done." This meant that staff did not have the information they required to ensure that people received safe care and support.

The above information demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we could not be assured that people received their medicines safely. The provider's medicines policy stated that a risk assessment must be carried out for people who required support with their medicines. However we found that one person who had been receiving care since 6 December 2016 did not have a risk assessment in place, even though their local authority assessment and daily records confirmed that they would need support with their medicines.

For one person, their care plan said care workers were to prompt medicines, but there was no further information. Information in their daily logs recorded that insulin was given by the care worker, then medicines, but it could not be confirmed how they were supported with this. The medicines risk assessment said it was dispensed by a care worker but there was no further information so we could not be assured what support the person received. We asked a care coordinator and an assessor about this but they were also unsure and had to call the person to confirm how they received their insulin. For another person, their risk assessment said a relative supported them with their medicines, however the outcomes in their care plan was for care workers to prompt their medicines from a blister pack. It was unclear from their records how they were being supported.

Where people's care records stated that they needed assistance with their medicines, there were no medicines administration records (MAR) available for all the files we viewed so we could not be assured that people had received their correct medicines, at the correct time. A care coordinator confirmed that there were no MAR records available at the time of inspection but told us they were in the process of being returned on a monthly basis.

We saw records in two people's daily logs that they were being supported with creams but we found no records in people's care plans that this had been recorded. One person was being supported with three different creams but the name of the creams, the reason for their use and what areas they were for were not recorded as there were no care records in place. Another person's care plan stated that care workers needed to apply cream but there was no further information available.

The above information demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we found that the provider was not always following up on the actions identified as a result of safeguarding meetings that had taken place. At this inspection we found similar concerns. After a serious safeguarding incident involving a person who was being supported with a PEG feed in November 2016, the provider told us, the local authority and safeguarding team that they had a lead nurse who would carry out reviews for all people being supported with this to check they were receiving safe care. However, we found for one person that this had not been done. We received information during the inspection from a health and social care professional that they were in the process of finding a new care provider for this person due to the concerns raised. We were also told different information about the lead nurse at meetings on 16 January and 18 January 2017 which did not assure us that actions had been carried out. At the safeguarding meeting on the 18 January, the provider told us that some of the failings had been the responsibility of the registered manager, and were in the process of deregistering them. They had not been suspended during the investigation and we were told they had been working under supervision.

We found that safeguarding concerns were not always appropriately recognised, responded to, investigated or recorded. For the serious safeguarding incident that occurred in November 2016, it had not been recorded in their safeguarding file, despite it still being open and waiting on further investigation from the local authority. For two further safeguarding incidents, they had not been recorded in their safeguarding file. One of them had not been investigated, despite a relative sending the provider an email on 21 January 2017 with a record of all the concerns they had. The relative told us on the second day of the inspection they had still not received a reply. The local authority were aware of the concerns and when we spoke to a care coordinator about this, they were unable to provide us with any information to show that the concerns had been followed up.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we found that staff recruitment checks were not thorough and staff files were incomplete and did not always contain appropriate references. At this inspection we found that the provider had made improvements.

We saw that all staff who had started since the last inspection had appropriate references in place with valid identification and proof of address documents, including documents which evidenced people's right to work. A system for Disclosure and Barring Service (DBS) checks was now in place and all were up to date. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. A human resources officer showed us a new audit form and that they were about to implement an audit on all staff files, but had not started at the time of inspection.

We also saw improvements in how applicants' assessment tests during interviews were marked. Previously, we saw examples of assessment forms being incomplete with no further follow up. We looked through a sample of recent assessment forms which showed applicants' had been unsuccessful if there was a lack of understanding or questions were not answered. For the recruitment of a care worker in December 2016, the assessment showed an understanding in medicines, dementia, no response policies and infection control, which had been marked and signed by the interviewer.

We received both positive and negative comments from people and their relatives regarding the time keeping of care workers. Positive comments included, "We did have problems but it has improved now, the carer does turn up on time" and "The carers come on time and it is very rare that they don't turn up." However one person said, "I've just spoken to the manager about the weekend carer, they are so unreliable, they haven't turned up for two weeks." A relative said, "Once a week a second carer is late, sometimes they

can be as late as thirty minutes, sometimes they may not turn up. This has happened recently and a family member or friend has to step in."

We spoke with a care coordinator about the monitoring of calls. The provider was in the process of moving to a new monitoring system and it was being set up during the inspection, but not in use to monitor calls. There was no monitoring information available at the time of the inspection and we were told that they checked timesheets to ensure visits were carried out as planned. We reviewed timesheets for care workers supporting four people which showed some discrepancies. For example, one care worker obtained a signature for a person's visits from 6 December to 11 December 2016, but another care worker had recorded 'unable to sign' for the same person from 19 December to 24 December 2016. Another person had also signed some timesheets with others recorded 'unable to sign'. This had not been followed up so it was difficult to confirm if the timesheets documented the actual visit times.

We did see that the provider had just implemented recording missed visits on care workers electronic profiles, and a care coordinator told us that they were in the process of implementing a missed visits log which would highlight the action taken and outcome from the incident.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At the last inspection we found that the provider did not always accurately record that people had consented to their care plans as not all care plans and assessments had people's signatures. During this inspection we checked whether the service was working within the principles of the MCA and saw inconsistencies with people signing care plans. Where people lacked capacity, others had signed on their behalf without the legal authority to do so. For one person, their risk assessment stated that they were not able to make their own decisions and a family member was responsible for this, but there was no evidence of lasting power of attorney (LPA) in place, which was acknowledged by a care coordinator. We also saw that it was another family member present at the assessment who had signed the documents, and not the one who was recorded to have the authority to do so.

For another person, their care plan had been signed by a family member with no evidence they had the legal authority to do so. Under the mental capacity section of the risk assessment, it recorded that a different relative was applying for the LPA. Furthermore this person had signed their own risk assessment and it was not clear why they were able to sign this document and not their care plan.

For another person, their care plan stated they were unable to make decisions, but an assessment of needs showed the person had signed the document, with the risk assessment signed by a relative, highlighting they could not make decisions.

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

At the last inspection we found that staff did not receive appropriate supervision or appraisal and that they were not carried out by an appropriately trained member of staff. At this inspection we found that some improvements had been made.

A human resources officer showed us that they had created a supervision and appraisal matrix and we saw correspondence which showed when care workers were due for their next supervision, and how many staff required one. Supervisions were carried out under a procedure which required discussion of work related issues, review of current performance, training and development, new developments and information sharing. For one member of staff who had started in October 2016, we saw that they had received monthly supervision up to December. One care worker told us that they had a supervision at the beginning of January 2017, while another care worker said, "I had one in November and found it useful, I was offered further training." However we did see that at the end of supervisions staff were required to sign to indicate

they had read and understood the following policies, with a list of 22 policies, including safeguarding and medicines. In most cases this had not been completed. We were also told that a care worker had been brought in for a supervision to discuss issues regarding the recording in a person's daily logs, however there was no record that the specific issues had been discussed.

We saw that training was being carried out over the three days of the inspection. One of the operations managers told us that it was a mix of regular staff having refresher training and new staff going through their induction. Their current induction consisted of a two day training programme which covered 25 topics, including moving and handling, safeguarding, medicines, fluid and nutrition, infection control, mental health awareness, fire safety, basic life support and communication. Staff were given a Care Certificate training booklet relating to this two day course, which contained basic information on these areas. In some cases staff had signed each section to indicate their understanding, however this was not consistent in all the files we reviewed. One staff member had only written on the section referring to whistleblowing. One staff member had also completed an online induction which covered fire, health and safety, abuse and neglect, infection control, medicines, care planning, promoting independence, record keeping and personal care. They scored 85% on these, indicating an assessment was carried out but this was not evident in all staff files. One care worker said, "The trainer was good. If we didn't understand anything she'd explain it." Another care worker said, "It's adequate if English is your first language, but I know a lot of people struggled to understand it."

We saw that specific training had been booked for staff in response to a serious safeguarding incident. The safeguarding meeting confirmed that a member of staff involved had not received the relevant training to support someone with a PEG feed. We saw email correspondence between the provider and training company regarding the training, with the training company confirming to us that it had been booked.

We saw that shadowing records of new staff were not in place. For one member of staff who started work at the beginning of January, there was no evidence that they had any shadowing opportunities before starting work on their own. For two members of staff who had no previous experience in health and social care, there were also no records available. We received differing feedback from care workers we spoke with. One care worker told us that as they had previous experience, they did not have any shadowing opportunities before starting work. Another care worker told us they only had two opportunities and it was not well organised while one care worker told us they were paired with an experienced care worker, which improved their confidence. One person told us that when they received a new care worker, they had not shadowed the regular one beforehand. A human resources officer acknowledged the issues with shadowing records and showed us the new form for staff files, which would record shadowing visits new staff carried out before working independently.

We received both positive and negative comments from people and their relatives about the skills and knowledge of staff and their ability to meet people's needs. Positive comments included, "I feel they have the right skills and experiences, I don't have any problems" and "Mostly they are well trained." However we received a number of negative comments relating to the training of staff. One relative said, "Once two carers attended and they didn't have any expertise in the hoist. My [family member] has other risks and the carers need to be skilled, patient and focused, and the less experienced ones don't have this. It is evident that the people who have just started have not had training." Another person said, "They were nice, but they just didn't know what to do." We spoke to an operations manager who told us that they were looking at extending the induction training so specific topics, such as medicines and moving and handling, could be covered in more detail. They were also looking at how they could improve their competency assessments for staff to get a better idea of their understanding. They showed us a draft copy of a refresher assessment test which had 25 questions, but it was still in the development stage.

Care workers we spoke with had an understanding of people's health conditions and how they had to support them, and knew to call the office if they had any concerns. One care worker, who had worked for the provider for just under a year, was able to give us a detailed overview of one person's needs and what they would do if they had concerns. Another care worker said, "They text us information to remind us about reporting concerns." There was also a message in people's care plans that stated health conditions were to be reported to the office in a timely manner. However information from a relative and the local authority for one person highlighted that care workers had not been aware of a health condition and had not been recording it in the daily logs, which resulted in the condition going unnoticed. In another person's care records, it stated they had 'swollen fixed limbs' on the left side of their body, but there was no further exploration of this or advice for care workers from healthcare professionals or otherwise.

Some people were supported with their nutritional needs and we could see that it had been recorded in people's files what support they needed, however it was not consistent throughout all the care records we reviewed. For one person, it highlighted that they were diabetic and mealtimes were an important part of maintaining their health. We also saw that preferred foods were recorded within their daily records. However for another person with diabetes, as there were no care records in place, we could not confirm how they were being supported. Their daily logs did not specify what food had been given and a relative had complained that snacks were not being offered and they were not offered a choice.

For two people, we saw their care records stated that they would like their diet/nutrition to be monitored, but there was no evidence or records to show how this was being done. For one of these people, we saw that a recent review had been carried out in November 2016 and highlighted that their food should be soft or pureed, but it had not been updated in the care plan and information in their daily logs did not record this.

Although we found that some concerns had been addressed in relation to the support that staff received, we found that people's consent to care and treatment was not always sought in line with current legislation and guidance. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.

Requires Improvement

Is the service caring?

Our findings

The majority of people we spoke with told us they felt well cared for and thought their care workers were kind and respectful. Comments from people included, "The best thing is the individual commitment and care that some of the carers have shown. It is growing", "They are very kind. One would call in to see me to check I was alright. I call that above and beyond" and "As we become more like friends we will be able to converse and have the odd joke." One relative said, "When the carers come in, you can tell they are genuine. They are jolly and you can tell they are caring in their tone and the way they speak." Comments we received that were of a negative tone generally related to care workers who covered shifts and did not know the people as well as their regular care worker. One person said, "Sometimes some people can be bossy, but I go along with it. They say 'you've got to do this' or 'why haven't you done this'. I would like to be treated by someone with a little more respect." Another person said, "I had a strange carer last night, I had never seen her in my life and I had to tell her everything. It is confusing to me."

People were assigned regular care workers depending on their needs and then had cover care workers when their regular staff took planned or unplanned leave. A care coordinator told us that they looked at care workers geographical location, skills and experiences when matching them to people. Care workers we spoke with told us they generally worked in their local area which minimised the risk of them running late. One care worker said, "I work in the same area and am able to turn down packages if they are not in a reasonable distance." People and their relatives commented positively on their regular care workers and they felt it was very important to have regularity with their care. One relative said, "The best thing is the carers reliability and they all seem concerned. These are tremendous features of the care." Care workers we spoke with knew the people they were caring for and understood the importance of their work and caring for people in the right way. One care worker said, "I have a good relationship with him/her. I always encourage them to talk and we always have a chat." We did receive comments from a relative who had concerns regarding the language barrier, which caused communication difficulties when carrying out care. However, another relative said this issue had improved. They added, "I have to tell them about everything they are doing, I have drawn a diagram of the catheter and showed them what to do. They have got better as they have gone along. English is not their first language but that is not a problem as they understand my [family member] and are always happy to oblige."

We received mixed comments from people and their relatives regarding how involved they had been in the planning of their care. A care coordinator told us that people received a visit from a manager, care coordinator or assessor to complete an assessment of their needs or to carry out a review. One person said, "I'm aware of the care plan and involved in the reviews." One relative told us how a member of staff had visited recently to update the care plan. They added, They sent me a copy to read through and I made a few amendments." However two relatives told us how care was being carried out but nobody had visited to carry out an assessment. One person said, "They haven't come out to check from the office." Another person said, "They came out when it first started but there is no care plan that I know of." We also saw records in one person's care plan that highlighted the person wanted their family member present as they were responsible for helping with decisions, but the assessment was carried out without that family member present.

People and their relatives told us staff respected their privacy and dignity. The majority of comments received were positive about how respectful care workers were when they worked with people. One relative said, "When the carers are washing my [family member], they put a towel over their private area and tell them what they are doing, such as turning them." Another relative said, "They talk to him/her and persuade them to do things. They make allowances and are very accommodating of him/her, and give them time to explain."

Care workers had a good understanding of the need to ensure they respected people's privacy and dignity. One care worker told us how they supported a person when they carried out personal care. They said, "I talk to them throughout. I close the curtains and the door, and always when family or visitors are home. I always make sure they are covered up." We saw information in the care plans we reviewed which reminded care workers to ensure that dignified care was given.

Although we found that some concerns had been addressed, people and their relatives were not always actively involved in making decisions about their care. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found that the provider did not always ensure proportionate action was taken in response to complaints. Whilst we found some improvements in this area during this inspection, we still found some complaints had not been dealt with in line with the provider's own policies and procedures.

We looked through the complaints received by the provider, which were arranged in folders according to the local authority they covered. We saw that complaints had been logged and they recorded what follow up action had occurred. For example, we saw statements had been taken from members of staff involved, along with email correspondence to the local authority confirming what action had been taken. Some people and their relatives told us that they did not have any issues and had not had to make a complaint. One relative said, "It's very good at the moment and I have no complaints. But I'm here all the time to keep an eye on things."

However we found inconsistencies throughout the complaints we looked at. For one complaint, the action was 'frequent and better communication will be kept with the service user, care worker, care coordinator and social services updated.' But there was no further information as to how this would be carried out or what the outcome was. A care coordinator told us that they would carry out a spot check on the person to see if the situation had improved.

The provider sent us in an action plan after the previous inspection which stated all complaints would be promptly logged in the complaint folder and responded to by way of acknowledgement immediately. The provider's complaints policy confirmed that verbal and written complaints would be acknowledged within one working day when received and a record would be kept of it.

One relative told us how they had spoken with the provider and sent a confirmation email on 21 January 2017 that detailed the concerns they had but had still not received a response from them by the time of the inspection. We discussed this with a care coordinator as there was no record that this had been logged or any action had been taken. They told us that they would follow this up.

Another relative told us about problems they had with the out of hours service. They said, "Sometimes people don't pick up. If the first person doesn't answer it, it goes to a second person. If they don't pick up it cuts out. I expect somebody to get back to me, but on occasions they haven't. It has been formally raised with them." However we did not see any record of this complaint in the files or if any action had been taken. Another relative told us that they had to get the social worker to speak to the office when they had problems, as nothing happened when they brought it to the attention of the provider.

An operations manager attended a safeguarding meeting on the first day of the inspection, where we saw a lack of response from the provider relating to the safeguarding concern. We saw a health and social care professional had emailed the provider on 5 and 6 January 2017, with no response. They then followed up on 10 January as they had still not received a reply. There was no record of this investigation.

The above information demonstrates a continuing breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the previous inspection, we gave the provider a recommendation to seek advice from a reputable source regarding care planning to ensure that records contained sufficient information to enable staff to meet people's needs. At this inspection we could see that more person centred information had been added to people's care plans. For one person, we saw a very detailed 'This is me' section, which had a lot of information about the person's upbringing, their family and what things were important to them. It also included information about their health conditions and what support was needed to meet their needs. People's outcomes were recorded and included what care workers needed to do to ensure these outcomes were met. One care worker commented on one person's care records. They said, "It has been updated recently and we are able to see what needs to be done." One relative said, "I believe the support my [family member] receives is personalised."

We saw information that showed the provider listened to people and tried to support their cultural and religious needs. We saw records for two people that highlighted that a Bengali female care worker was needed and from records we saw we could see that this had been accommodated. We saw that a care coordinator was able to communicate with people and their relatives in their own language to discuss the care package and whether they had any concerns. One care worker told us that they only supported one person and they were from the same cultural background and could communicate with them in the same language, as they were unable to speak English. We saw information detailed in another person's care plan that going to church was important to them and care workers should engage in conversation about this and encourage them to attend church.

However for two people's care records we requested we found they did not have a care plan in place. For one person, there was no care plan in place despite the person having received care since 6 December 2016. There was a note in the file saying that the next of kin had refused to sign a care plan, so there was no record of what care needed to be carried out. The local authority assessment highlighted they needed to be supported with washing, dressing, toileting meal preparation and medicines, but as there was no care plan in place the person's preferences had not been recorded. We looked through a sample of the daily logs and saw that a care worker had written the same sentence for a number of the morning and evening visits, without recording the name of the food that was given to the person. From the information in the daily logs we could not be assured that the person was receiving the care they required as their needs had not been identified.

We saw daily logs for one person which showed limited information about their visits from July to December 2016, with the same sentence being recorded at each visit. For example, the morning visit stated 'I gave him/her insulin shot, then breakfast, then medicines.' The person's care plan recorded that they should be assisted with dressing and personal care, supported with creams and served breakfast of choice. However there was no record of these activities being carried out. One care worker told us that the daily logs could be a problem because not everything was always recorded at the previous visit. They added, "It needs to be a bit more detailed. Sometimes I have no idea what has happened by looking in the logs."

We received some comments from people and their relatives who confirmed that they had a care plan in place, however for the majority of comments we received, people said they were either unsure if they had a care plan, or did not have one in place. One person said, "I don't have a care plan but they do sign the book." A relative said, "I don't know anything about a care plan and I haven't seen one."

Although there had been some slight improvements, we found the provider was still in breach of the

regulations in relation to dealing with complaints. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was not a registered manager in place. The previous registered manager sent in their deregistration application during the inspection and we were told they were no longer working for the provider. Two operations managers and the staff team were present and assisted us throughout each day of the inspection. The provider was in the process of recruiting a new registered manager, and both operations managers were supporting the service at this time.

The registered provider is required by law to notify the Care Quality Commission (CQC) of important events which occur within the service. At the last inspection the provider had not submitted statutory notifications to the CQC relating to safeguarding concerns. At this inspection we found that significant improvements had not been made. We were notified of one serious safeguarding incident which we attended strategy meetings for. However we found one safeguarding incident which was being investigated at the time of the inspection that had not been notified to us. We also found two separate allegations of neglect in records that had not been notified to us. We spoke to a care coordinator about this who acknowledged they were aware of the incidents and would send in the notifications after the inspection. However these had still not been received by the time the draft report had been sent to the provider.

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

The majority of staff we spoke with commented on how supported they felt in their work and were happy working for the provider. One member of staff said, "I do feel 100% supported in my role by the operations managers." Another member of staff commented that there had been some improvements. They added, "They do listen somewhat and have been better recently. If I call with an issue about a person they do get back to me immediately." One care worker said, "I feel they are organised and all round it isn't a bad place to work. I'm happy working with them and would not have any problem bringing up any issues." I've never felt let down and am supported well." We only received one negative comment which related to communication with the office.

We received a mixture of positive and negative comments from people and their relatives about how well managed they thought the service was. One relative told us how they had made great improvements. They said, "Last year I was pulling my hair out, but now they are excellent. They are a breath of fresh air and everything you would want in a carer." Another relative said, "I can only comment on the care manager I've talked with and she was very experienced, very committed and caring." Negative comments we received related to communication issues. One relative told us that they were not always fully updated. They said, "I want them to be transparent because if they know there is an emergency and they don't have the right combination of care workers, they should tell me and I'd be happier. It is a definite weakness in terms of management." One person commented that they thought it was OK but when they spoke to the office, they would say what they would do but actions would not always be carried out.

Health and social care professionals we spoke with also highlighted their concerns regarding

communication and that there had been occasions when information requested was not made available and that it took a long time to get a response from the provider when following up concerns. We also found similar concerns when we requested documentation regarding a serious safeguarding incident. We had requested specific information relating to the incident on 15 December 2016 and had to follow up with numerous emails. Some of the information requested was not received until the 17 January 2017. One health and social care professional told us that they had made three attempts to get information but continued to not hear back from the provider during this time. We saw an email from a health and social care professional in one person's care records that highlighted concerns in the service delivery and the issues that had been discussed had not been addressed, so a one week notice period to cancel the service was given.

We saw the agenda for the most recent care worker meeting which was held on 17 January 2017, which showed that 20 care workers had attended. Topics such as safeguarding, complaints, training, concerns and communication were discussed. A care coordinator showed us a good example of recording in the daily logs that was discussed with care workers to remind them of the importance of completing detailed information in the log books. We saw the agenda for the most recent monthly managers meeting which was held on the 24 January 2017 and the minutes were still being drafted. We saw topics discussed which included branch responsibilities, recruitment, monthly audits, spot checks, monitoring, training and information about CQC inspections throughout the branches. One operations manager told us that they also tried to have fortnightly staff meetings for the office staff.

We saw 26 people had responded to their annual survey from December 2016. The results were still in the process of being analysed so we were unable to see the full results. Whilst we saw some positive comments in sample of forms reviewed, we saw comments from five people that highlighted communication with the office was an issue and were not satisfied. There was no record on the form whether this feedback had been followed up.

At the time of the inspection the registered provider was in the process of implementing a number of audits to monitor the quality of the service. People's daily logs and medicine administration records (MARs) were in the process of being returned monthly for auditing but it had not been fully implemented yet. We saw that some logs had been checked once they were returned but this was not the case for all the logs we reviewed. We spoke with a care coordinator about this who explained the reason for auditing these records and they were able to give us a detailed overview of what they would be checking when they were returned. They added that where issues were found, care workers would be invited in for a supervision session. They confirmed that as this audit process had just started, no supervisions had been carried out from the findings yet. A member of staff told us that monthly spot checks were being implemented to check on care workers and monitor the service people received. One care worker said, "In the last two months, they have been out three or four times to check on us."

We spoke with a care coordinator who showed us an operational audit spreadsheet for the service, which indicated when an assessment had been carried out and whether there was a review and spot check, and when this review was to be carried out. This record showed that all people had had an assessment, except in some cases where the reason was recorded as a hospital admission or they had refused a review. We saw that about half the people who used the service had had a recent spot check. They showed us a sample of a weekly report, which had scheduled reviews and care plan meetings, including if staff required a spot check. This report showed that the member of staff was scheduled to carry out eight assessments or reviews and seven spot checks on staff.

We looked at a sample of out of hours records, which was covered by the staff team on a weekly basis. We

saw that two care coordinators had a different system in place to record incidents and share with the rest of the team. Where some visits had been cancelled, we saw records showing there had been correspondence with the local authority. Where an issue of missed visits had occurred, we were told that a meeting had been arranged with the relative to discuss the issue. A branch manager, who was responsible for people within the local authority of Hackney, told us that they had an on call diary in the office which was emailed to the team and filed in the office as the on call report.

A care coordinator told us that since December 2016 they had set up a communication group with care workers to be able to communicate with a large group of people in a quick and effective way. We saw that messages included cover calls, new packages of care, no response policy, communication, and if care workers had any issues at all, to remind them to get in touch with the office.

Although we found that some concerns had been addressed, systems of quality assurance were in the development stages and sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.

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 The provider did not always ensure that care and treatment was provided with consent for the person using the service. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to operate effective systems to prevent abuse and investigate allegations or evidence of abuse Regulation 13 (2), (3)

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18 (1), (2) (a) (ii) (iii) (b) (e)

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that risks to the health and safety of service users were regularly assessed and did not do all that was practicable to mitigate any such risks. Regulation 12(1)(2)(a),(b) The provider did not ensure that care and treatment was provided in a safe way as systems for the proper and safe management of medicines were not operated effectively. Regulation 12(1),(2)(g)

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not ensure proportionate action was taken in response to any failure Identified by the complaint or investigation. Regulation 16 (1).

The enforcement action we took:

We issued a warning notice.