Allcare Agency Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an announced inspection of Allcare Agency Limited on 23 October 2018. Allcare Agency Limited is registered to provide personal care to people in their own homes. The 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 consider any wider social care provided. At the time of our inspection, the service provided personal care to 19 people in their homes.

At our last inspection on 15 September 2017 the service was rated 'Requires Improvement' overall. We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not ensure staff received regular training, supervision and an appraisal to enable them to carry out their role in an effective manner. The service did not have adequate governance systems in place to ensure people were receiving a service that safe, effective or responsive to their needs.

At this inspection we found that these previous breaches had not been addressed and we found further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service had a registered manager. 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 legal requirements in the Health and Social Care Act 2008 and the associated regulations on how the service is run.

People's risk assessments had failed to identify or address their support needs, which meant staff were not aware of how to keep people safe. Staff were not always recruited in a safe manner and line with the provider's recruitment policy, which meant we could not be assured that they were suitable to carry out their role. People were not supported to receive medicines in line with best practice and the provider had failed to provide medicines training for all staff who required it. The service did not have systems in place to oversee safeguarding which placed people at risk of potential abuse. Staff did not always arrive on time to see people and there was no system in place to monitor time keeping. The service did not record accidents or incidents or evidence how they learnt lessons which placed people at risk of repeated incidents. People and staff were protected from the risk of cross-infection.

Staff did not receive an induction into the service. Training was not well managed and systems were not in place to ensure all staff received regular support through supervisions and appraisals. This meant staff were not equipped with the necessary skills and tools to practice in a safe and effective way. The service did not complete pre-admission assessments or review people's needs and preferences prior to support starting which meant staff were not aware of people's specific needs and wishes. The service worked in line with the principles of the Mental Capacity Act 2005 and staff ensured they gained consent from people before providing care or support. People were protected from discrimination.

The service had not involved people in reviewing their care plans, which meant care may not be delivered in line with their wishes. People told us staff were kind, caring and friendly. Staff understood how to support people in a manner that ensured people were protected from discrimination. People told us their privacy and dignity was maintained throughout their care and staff promoted a sense of independence for all people.

The service did not always work in a person-centred way. People had their own care plans but we found these were not detailed and they were not regularly reviewed with people and their relatives. People knew how to make complaints; however, these were not documented or monitored which meant we could not be assured of the action taken to resolve concerns or complaints. People were supported at the end of their life; however, staff did not receive up to date training in this area and care plans did not reflect this.

The governance systems at the service were ineffective and failed to identify areas of concern or drive improvements. Previous breaches of regulations had not been addressed and the quality assurance systems in place had not identified the additional concerns we found during our inspection. People, relatives and staff were mixed in their feedback about the management team. People and staff completed feedback surveys for the provider; however, this information was not used to make improvements. Statutory notifications, required by law, were not always sent to the CQC.

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.

Risk assessments were not always in place to guide staff on how to keep people safe.

The service was not safe.

Risk assessments were not sufficient to guide staff on how to keep people safe.

Medicines were not administered safely.

Staff were not always recruited in a safe manner.

Staff understood how to keep people safe from abuse, however not all staff had completed training in safeguarding.

There was not a system in place to oversee staff attending appointments on time.

The service did not record or evaluate accidents and incidents.

People and staff were protected from cross infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive consistent and up to date regular training, supervisions or appraisals so they did not have the up to date skills and knowledge to provide effective care.

The service did not complete pre-admission assessments to ensure they could meet people's needs.

People did not always have access to health and social care professionals.

The service was working in line with the legal requirements of the Mental Capacity Act 2005 and staff gained consent before providing care and support.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in reviewing their care plan or package of support.

Staff ensured equality and diversity was respected.

We found that people's independence was promoted and their privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People knew how to make a complaint; however, there was no system in place to monitor complaints.

People were supported by staff who demonstrated an understanding of end of life care; however, staff training was not up to date and care plans did not evidence this.

People's care plans were not detailed or up to date.

Is the service well-led?

Inadequate

The service was not well-led.

The service had failed to improve since our previous inspection. Robust quality assurance systems were not in place to regularly assess and monitor the service.

The registered manager did not understand their legal obligations to submit specific notifications and documents relating to the service to the CQC.

Systems were in place to gather feedback from people and staff but there was no evidence of how this feedback was used to develop the service.

The service did not always work in partnership with other health and social care professionals.

Allcare Agency 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 23 October 2018 and was announced. We announced our inspection because we wanted to be certain that someone would be available to support us. The inspection was undertaken by one inspector.

Before the inspection visit, we spoke with three people who used the service and three of their relatives. We also spoke with five care staff. We also reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events which the provider is required to tell us about by law. We sought feedback from health and social care professionals.

The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

During the inspection we reviewed documents and records that related to people's care and the management of the service. We reviewed four people's care plans and three staff files. We looked at other documents such as medicine, training and supervision records. We also spoke with the registered manager and one care staff.

Inadequate

Is the service safe?

Our findings

Individual risk assessments were not detailed and did not adequately assess the level of risk in particular areas. There was insufficient guidance for staff about how to mitigate risks. One person's records said the person's vision was, 'Problematic.' Another person's records said they were supported to be fed through a peg. A third person's records said the person had, 'Dementia'. These care and support needs would require a risk assessment to ensure staff understood how people were affected by their conditions and how they could be supported in a safe manner, however; these were not in place.

Risk assessments were not regularly reviewed by care staff or management. We looked at people's 'moving and handling' risk assessments and did not see any evidence of people's mobility being sufficiently reviewed, there were no assessments from relevant health and social care professionals and details of who to contact in an emergency were blank. We found that one risk assessment had not been updated since 2014. A second person's risk assessment in 2017 said their, 'Physical risk factors' were, 'Using cooker, transferring' and no further details were provided. We found that in 2018 their 'moving and handling' risk assessment said their, 'Physical risk factors' were, 'Using cooker and kettle.' It was not clear what had changed for this person over a 12-month period or how staff should support this person to keep them safe.

We also found that risk assessments identified people were at risk of falls but no further information was provided. One person's risk assessment said, 'Yes, frequently. [Person] has fallen over a few times due to [person's] condition.' It was not clear what condition this person had, and there was no risk assessment in place. This showed that risks were not assessed or mitigated, which placed people at risk of potential harm.

The registered manager told us they did not record accidents or incidents that had occurred while people were receiving care and support. There was no evidence of any potential incidents being recorded or discussed during team meetings or in supervisions. This demonstrated that the service did not effectively monitor the care and support provided to ensure lessons could be learnt and there was not a culture of continuous improvement that ensure people received safe care and treatment.

The service did not manage people's medicines in a safe way. Records, including Medicines Administration Records (MAR) failed to provide details of the specific medicines which staff gave to people and lacked important information, such as people's allergies. We spoke with the registered manager about this, however; they were unaware of one person's allergies. This meant that the provider was unable to assure us that staff were aware of the correct medicines to give people, or if they could take them safely.

The provider had failed to provide staff with the training they needed to administer people's medicines. Their medicines policy stated that staff should be 'Trained to a competent level to deliver medication safely.' We reviewed 10 staff training records and found that six had completed medicines training. The four remaining staff members were administering medicines as part of their role, which placed people at risk. The registered manager advised us they did not complete audits on MAR and did not complete competency assessments for staff following their medicine training.

This meant the service did not have sufficient systems in place to ensure people were supported with their medicines in a safe way.

The provider had failed to ensure the proper and safe management of medicines and had failed to do all that was reasonably practical to assess and manage risks to people's health, safety and wellbeing, which placed people at risk of suffering harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the significant failings, people reported that they felt supported by staff in relation to medicines One person told us, "Yes, it's all in a box. I am happy with them [care staff]." A relative said, "They are very good at managing that [medicines]."

Staff demonstrated an understanding about their responsibilities with medicines. One staff member said, "Yes, the training was good and interesting. Certain things like why it is important to give certain medicines with food and why we see certain people at certain times."

Staff had not always been recruited safely or in line with the provider's recruitment policy. The policy said, 'The offer will be subject to 2 satisfactory written references: one from the last employer of the candidate.' However; of the three staff files we reviewed, one staff had received three references from friends and another staff member had received two references from friends and relatives. This showed that the provider had failed to seek assurances as to the character of new members of staff.

We also found concerns in relation to DBS checks. A DBS check is when the Disclosure and Barring Service complete a criminal record check and ensure that people are not barred from working with vulnerable adults or children. One staff member had a DBS in place, but it had been photocopied in a way that meant their individual DBS number was not available. Another staff member had a DBS in place that was issued on the 6 September 2018 but their start date was the 9 September 2017 and there was no record of a DBS being in place for the first 12 months of their employment. A third staff member had a DBS in place that was issued in March 2015. This DBS stated this staff member had conditions that may impact on providing safe care and treatment to people. However; there was no evidence of this being reviewed by the registered manager. This meant that the systems in place did not ensure people were protected from potential harm and did not provide assurance that people were cared for by staff who were suitable for the role.

The provider had failed to ensure that recruitment procedures were robust or effective in ensuring that staff were of good character and had the skills or competence required for their role. This showed a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff did not always arrive on time for their visits. One person said, "Now and then they are a bit late." A third person told us, "No not always [on time]."

We found there were ineffective systems in place to monitor and confirm the times that care staff recorded for their visits were accurate. One staff member said, "The only thing we go by is the client letting us know." This showed that there were not effective systems in place to ensure people were receiving stable care and support in line with their care plan; receiving consistent care is important as staff are familiar with people's needs and risks and this ensures people are kept safe.

The service had a safeguarding policy in place; this said that it was the responsibility of all staff to 'participate in safeguarding adults training.' However; training records showed that only six staff had completed safeguarding training. The four remaining staff members were supporting people to keep safe

from potential abuse as part of their role, which meant people were at risk. Furthermore, the service did not keep a record of any potential safeguarding incidents and there was therefore no way of tracking trends and outcomes of people affected by potential abuse. This demonstrated that there were inadequate systems in place to safeguard people from the risk of suffering harm.

However; people and relatives told us they felt safe receiving care and support from staff. One person said, "I do feel safe." One relative said, "Yes, [person] does feel safe. [Person] would say if [person] didn't." Another relative told us they had, "No concerns with the staff."

Staff understood their roles and responsibilities around safeguarding people from abuse. One staff member told us, "There are lots of different types of abuse such as, financial, emotional and physical abuse. If I suspected anything I would whistleblow straight away, first to my company and my manager." Another staff member said if there was a safeguarding incident they would "report to manager, and record in the client's home and care plan."

The service had an infection control policy in place and there was evidence within people's care plans of staff being advised on how to manage infection control. For example, in one person's care plan it said, 'Place blue shoe protectors over your shoes.' This showed the service were supporting people in a safe manner to reduce the risk of infection.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 15 September 2017 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found staff did not always receive training, supervision and appraisal as was necessary to enable them to carry out their duties effectively. During this inspection we found that this breach had not been addressed.

Staff had not completed the appropriate training that would enable to them to carry out their role effectively. We viewed 10 staff training records we viewed and found that four members of staff had never had dementia training, including the registered manager. We found that six members of staff had never completed training on mental capacity and nine members of staff had not completed training on pressure sores. Staff were providing support to people affected by these care and support needs, which meant people were at risk of receiving inadequate care and support.

There was no guidance available to tell us how often training should be done. The registered manager advised there was no system in place to monitor what training staff had or had not completed and when training was due. The registered manager also told us that staff did not have to complete a set list of training before being able to provide care and support to people. This demonstrated that staff were not supported to ensure they had the suitable skills and knowledge to deliver effective care and support.

The registered manager told us there was no induction system for new staff. We reviewed three staff files and found no record of staff having completed an induction. The service had an induction policy that said, 'It is a condition of working within Allcare Agency Ltd that all staff members undertake a period of induction, which will last for up to a four-week period.' This policy had not been updated in line with the guidance that all policies were to be updated annually. The provider had failed to ensure that staff were supported to learn about their roles, the service and the people they were supporting.

We found no evidence to confirm that staff were receiving regular supervisions where their role was reviewed to ensure they were working in an effective and safe manner. The registered manager told us they completed staff supervisions, "Whenever I can. I will work with my staff, I will talk to them, I try and put it in black and white but don't always." We reviewed three staff files and found there was no written record of staff having had a supervision. The supervision policy said supervisions played, 'An important role in protecting both clients and staff, by developing and maintaining high standards and by supporting and developing individual staff members continuous personal development.' This demonstrated that the systems in place to evidence how staff were supported to provide effective care and support were inadequate.

Records showed that not all staff received an annual appraisal and development review. We reviewed three staff files and found one person had an annual appraisal form completed despite having only worked for the service for two months and had not received a supervision instead. Their objectives were not detailed. One objective said, 'Courses' with no further information. It was therefore not clear what the manager or this staff member had identified they needed to develop on to provide more valuable care and support. Another staff

member's appraisal from June 2015 advised they would like to complete training in Parkinson's and the notes from the registered manager advised this had been arranged. However, the training records indicated that this had still not been completed. The service policy on appraisals said, 'Training requirements to meet the objectives of the business' would be reviewed. This demonstrated that the service was not working in line with its own policy to ensure staff received sufficient reviews and support to carry out their role effectively.

The provider had failed to ensure staff received adequate training and support and there was insufficient evidence to show that staff were able to carry out their role effectively. This demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these failings, people and relatives told us they felt staff understood their role. One relative said, "Yes, from what I have seen they know what they are doing." Another relative told us, "Staff are good."

Staff told us they completed an induction and had access to regular training. One staff member said, "I went out with [registered manager], I shadowed her. It was good." Another staff member told us, "We just had a first aid course, it was helpful. I have also done a few online, these test you. I have done safeguarding, moving and handling, infection control, dementia." Staff also told us they met with their manager for supervisions. One staff member said, "Every three months. Yea, they are good. It is good communication. We are busy with the calls so this is our time." Another staff member told us, "Yes, I enjoy the one-to-one talking to my boss."

The service did not complete pre-admission assessments, or meet with people prior to providing care and support. The service received an 'Individual Service User Placement Agreement' from the local authority but this document contained no information about people's individual care and support needs. This showed that the service was not assessing people's needs and choices to ensure they could deliver effective care and support.

We reviewed individual care plans and found that contact details of other health and social care professionals were mostly blank. There was no evidence of the service engaging with other services to offer holistic care and support in line with people's needs.

Staff had mixed views on how they worked with other health and social care professionals to offer holistic support. One staff member said, "I have always got on well with [health and social care professionals] when I have seen them." However, another staff member said, "It is rare that we bump into other health professionals." A third staff member told us, "We don't see an awful lot of [health and social care professionals]."

However; one person told us of a time they were supported to receive support from another health and social care professional. They said, "[Staff] called an ambulance and stayed with me and my [my relative] to help with everything. They then actually came to the hospital." This showed that individual records did not always match the care and support that was being provided for people to evidence that the service was working in a collaborative and effective manner.

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

possible.

Staff demonstrated an understanding of the MCA. One staff member said, "Everybody should be assumed to have capacity, unless told otherwise." Another staff member said they consider if, "[People] can make their own choices or if they need help to do that."

People told us that staff always asked for their consent before providing care and support. One person said, "[Staff] knock on the door first." Another person told us, "[Staff] do yes, they ask me politely."

All staff could explain how they gained consent from people. One staff member told us, "You can either ask them, so verbal consent." Another staff member told us about a person who is unable to communicate verbally, "[Person] raise a hand, thumbs up."

Records confirmed that people had signed a form to consent to receiving care and support. This showed that the service ensured people were receiving care and support in line with best practice.

Requires Improvement

Is the service caring?

Our findings

People and relatives had mixed feedback about their involvement in making decisions about the care and support provided. One person said, "Not aware of any care plan. Communication from administration is non." Another person told us, "I am not involved in the meetings." However; one relative told us, "Yes [care plans] are reviewed."

Staff told us it was the responsibility of the registered manager to review care plans. One staff member said, "Yea, always. My boss reviews their care plans." However; the registered manager told us, "Care plans aren't being reviewed." Records confirmed that care plan reviews were not being documented. One person's care plan said, 'None set' under their review date. Another person's care plan said, 'No date set, I speak with [relative].' This showed that people and their relatives were not always consulted and therefore may not have felt they were receiving care and support that was tailored to their preferences and may not have felt the service understood their changing needs.

Instead the registered manager told us, "A schedule for the next week is left in each person's home for the person and their relatives to review." This schedule detailed which staff member would be visiting the person, and at what times. There was also space for daily notes and a feedback sheet. However; one relative told us, "Hit and miss with knowing who will come and what time they will come to drop off the paperwork. Sometimes I don't get [the schedules] until Wednesday or Thursday and it is all change again on Friday. It is a nightmare."

Ensuring people received consistent care and support would enable them to feel comfortable and confident with the service. It would also ensure staff who were familiar with people's individual needs and preferences were able to support people in an effective manner. This demonstrated that the service was failing to provide kind and caring support.

Within individual care plans we did not see any evidence of people's preferences or protected characteristics being discussed. For example, there was no record of people's sexuality or relationships or if they had any cultural or religious needs that needed to be taken into consideration. This showed that the service did not have systems in place to ensure staff were working in line with best practice guidance to protect people from potential discrimination and ensure their care was person-centred. This meant that new staff or other professionals may not have known how to best support a person in line with their individual preferences.

However; people told us they did not feel judged while receiving care and support. One person told us because they felt, "Vulnerable, [because they were] elderly and disabled." Staff demonstrated an understanding of how to support people in a fair and caring manner. One staff member said, "Everybody has the same rights and opportunities as everyone else." Another staff member told us, "Each individual is entitled to individual care. We treat them as individuals." The service had an equality and diversity policy in place that said, 'We aim to be an inclusive organisation, where individual differences are respected.'

People and their relatives told us staff were polite and caring. One person told us, "Yes, very kind." A relative said, "[Staff] are caring and very professional." Another relative told us, "I always find [staff] very considerate, they know [person] well."

Staff told us how they built positive relationships with people. One staff member said, "One [person] can just about talk, we take more time listening to [person] and getting to know their ways." Another staff member told us, "Just by talking to them and giving them the care that they need." We asked staff how they shared information about people with other carers; one staff member said they would "Write it in their notes, I would then put it in the group chat and the other carers could try and help."

Records confirmed that people received emotional support in a way that suited them. One person's care plan said, '[Person] will shake feet when [person] is annoyed or frustrated.' This showed that staff ensured people were treated in a compassionate and considerate manner.

People told us they were supported to be as independent as possible. One person said, "When I am cleaning my teeth, they could put the toothpaste on the brush but they ask me if I can do it and I do." Relatives confirmed that staff encouraged their family members to do things for themselves. One relative told us, "They do encourage [person] but they don't force [person]."

Staff could give examples of how they promoted people's independence. One staff member said, "I am all for people being as independent as they can in their own home. If they can do it, don't do it for them. Let them do these things, don't take it away from them." Another staff member told us about a person they are supporting who can no longer grip onto things, "We bought [person] a 'helping hand' to manage this, we tried to promote [person] being able to pick things up. It makes [person] feel better. We are trying to boost [person] up and show [person] they can do things without us."

Records confirmed the importance of people maintaining their independence was considered. One person's care plan said, '[Person] does bits [person] can get to, the carers help wash rest of body as [person] is very independent.' Another person's care plan said, '[Person] will need some assistance eating if [person] asks if not let [person] do as much as possible as [person] likes to be independent.'

People and relatives told us they felt staff worked in a manner that ensured people's privacy and dignity was respected. One relative said, "They come in and help [person] wash every day. I always find them very considerate."

Staff demonstrated an understanding of how to respect people's privacy and dignity whilst providing care and support. One staff member said, "If [person] have people there we ask them to leave the room while we are doing certain things." Another staff member told us, "I cover people up, making sure they have appropriate clothing on."

Records confirmed that maintaining privacy and dignity was important. One person's care plan said, 'Leave [person] for their dignity while [person] toilets.' Another person's care plan said, '[Person] will call you when [person] is ready for their shower.'

This showed the service supported people to maximise their independence and ensure their privacy and dignity was respected.

Requires Improvement

Is the service responsive?

Our findings

Care plans were in place but were not person centred and were not sufficient in detail. People's individual diagnoses and care and support needs were not recorded. There was no evidence of people's likes or dislikes being recorded. We also found that people's medical history was blank. One person's care plan said, '[Person] is depressed, sometimes gets down and feels low.' However, their general health was recorded as, 'Good'. We did not know why this person felt 'down' or 'low' or what staff were doing to support this person. Another person's care plan said, '[Person] has good and bad days only upper body'. We did not know if this person had any underlying conditions that affected their mobility or what a 'good' and 'bad' day looked like. There was no guidance for staff about how to support this person with this. Furthermore, this person's behaviour was described as, 'Depression and mood swings,' but there was no further information about why they might feel this way or how staff were to support this person. A third care plan recorded, 'Daily routines: always resting, tv on all the time.' However; later, in this person's care plan it said, '[Person] has an active social life.' As there were no further details it was difficult to know how this person wanted to spend their time and how best to support them to maximise their wellbeing.

Staff told us they did not always find care plans helpful. One staff member said, "Some of them are so long, it is unbelievable." Another staff member told us they did not feel the care plans gave, "Details about a person and their life or interests," and they often went to support people not knowing who they were. This showed that it was therefore difficult for staff to know how to support people appropriately and line with their personal preferences. This placed people at risk of not consistently receiving the care that they required or care that was person-centred.

People's care and treatment plans did not always meet their needs or reflect their preferences. This demonstrated a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite records not evidencing that people received responsive care, people and their relatives told us the service responded to people's changing needs well. One person said, "They do a good job as far as I am concerned I can rely on them." Another person told us of a time their family member was taken to hospital and said, "Allcare were so good at covering the care that my [family] would have given me. I was worried and my children were. They came to the rescue. I was so grateful." One relative said, "[Person] might tell them if [person] doesn't like something and they will sort other things."

We reviewed the provider's complaints policy and noted that it had not been updated in line with the guidance that said all policies were to be updated annually. The registered manager advised they did not keep a formal record of complaints.

People and relatives told us they knew how to make a complaint and were satisfied with the management of complaints. One person said, "Yes, I go to [registered manager], occasionally the [staff] will leave a bit earlier." Another person told us, "In general [registered manager] will always listen and will have good explanations of why things have gone wrong. [Registered manager] apologises." One relative said, "I have no

qualms with [staff]." Another relative told us they had never had any complaints to make.

Staff told us they would support a person to make a complaint if they wanted. One staff member said, "They would know to ring the boss. But if they wanted to send a letter or an email I could help." Another staff member told us that on the weekly scheduling sheets there was a place for people to leave feedback about the service. They said, "There are always ways of expressing views."

This showed that although people felt they could make a complaint, records were not always maintained to reflect this or to show how issues were resolved.

The service supported people who were receiving end of life care. We did not see of end of life care plans evidencing what people's individual care and support needs were. We did not see any records to evidence that staff had completed training in end of life care. This meant that staff were not adequately equipped with the skills and knowledge to ensure people received the best quality of care when they were at end of life.

Staff told us they knew how to support people who had an end of life care plan in place. One staff member said, "Yes, you take things more slowly with them, you give me more time to them if you can." Another staff member told us, "Make them comfortable at all times. Caring is caring, but at end of life it is little bit more special."

This showed inconsistencies within the service about how to provide end of life care. Although staff demonstrated an understanding of how to offer appropriate care and support, they were not always up to date with best practice and records did not guide them on how to support people appropriately. As a result, people were at risk of receiving inadequate care and support and could not be assured their symptoms would be managed in a safe and effective manner.

Inadequate

Is the service well-led?

Our findings

At the previous inspection on 15 September 2017 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that there were not effective systems in place to manage the quality of care delivered. During this inspection we found that this breach had not been addressed.

Following on from the last inspection the registered manager was requested to complete an action plan to address how the identified breaches would be addressed. This action plan was due on the 7 November 2017 and was submitted on 8 August 2018. We found that it did not address all the points that had been raised. This showed that the registered manager was unable to effectively manage their workload and respond to concerns adequately.

During this inspection we found that the actions had not been addressed. Firstly, the action plan said the service was aiming to recruit a new office administrator and a new team leader; these staff members would assist with reviewing people's care plans monthly.

The registered manager advised they were still in the process of recruiting an office administrator and training a staff member to be the team leader. The registered manager said, "Care plans are updated when needs change but not reviewed as part of a rota or system. These are not happening monthly; the goal is to." This showed the service continued to have an ineffective staffing team that could ensure people's changing needs were being regularly reviewed and guide staff on how to provide high quality care and support.

Secondly, the action plan said the new office administrator and team leader would be completing supervisions and appraisals, spot checks and overseeing staff members training and creating a training matrix. We found that supervisions, appraisals and spot checks were not consistent and were not being recorded. The registered manager said, "Spot checks get done if and when, not on a regular basis. They tend to happen in an unofficial capacity. These then get turned into spot checks. Spot check forms sometimes get completed." This demonstrated that staff were not receiving sufficient and consistent support, guidance and feedback about the quality of the care they provided to allow them to carry out their role effectively.

We also found that there was no training matrix in place and there was no system to monitor what training staff had completed or when training was due. This showed there were no effective systems in place to ensure staff were adequately trained and able to offer support in line with best practice.

We discussed the action plan further with the registered manager who acknowledged, "I know this means the action plan has not been met." This demonstrated that the registered manager knew what actions needed to be taken, but had not successfully put the processes or systems in place to ensure these actions were met. As a result, people were continuing to receive care that was not driven by a culture of good governance.

People and relatives told us that the management of administrative tasks was not always sufficient. One

person said, "I think the carers are very good but I am not so keen on the administration." A relative told us, "The only thing that lets the service down is [registered manager's] paperwork."

The service had business plan in place, but this did not identify areas for improvement. The registered manager had not submitted a PIR to the CQC. The CQC had sent a request and this had not been picked up. The registered manager advised they would complete this after the inspection.

The provider failed to ensure there were effective systems and process to assess, monitor and improve the quality of care provided by the service. This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to comply with Registration regulations. Regulation 18 says that the registered person must notify the CQC of any incidents which occur whilst regulated activities are being provided that affect a person or the providers ability to carry out their regulated activity.

The registered manager advised they did not know about their legal duty to notify the CQC of incidents including where serious injury had occurred or where a person in receipt of a regulated activity had passed away. During the inspection we showed the registered manager the Care Quality Commission website which gave guidance about notifications. At the end of the inspection they told us, "I am quite shocked at learning about notifications." This showed the registered manager was unaware of their responsibilities and the requirements of their role. This demonstrated a breach of regulation 18 of the (Registration) Regulations 2009.

People and their relatives told us they were asked about their opinions of the service and could give feedback if they wanted to. One person said, "They have a weekly sheet at the end of the week that you fill in, asking about the quality of care. I always put excellent." A relative said, "We get a survey sheet every week and I provide good feedback."

The service sent out annual surveys to people and their relatives to gather feedback. We saw evidence of returned surveys for 2018. The feedback from people and their relatives was mainly positive. One person said staff are, 'Very friendly and helpful.' When asked if there was anything they think the service could improve on, they said, 'Nothing you are doing a great job.' However, another person said they would like, 'More communication on lateness.' However; we did not see evidence of the registered manager reviewing or responding to these concerns.

Staff told us they had opportunities to provide feedback about the service. One staff member said, "On the rota we get each week we get to write things down if we feel we can't say anything to [registered manager] or don't have the time. I am honest, I don't have anything to moan about." We spoke to staff about team meetings. One staff member said, "We have team meetings, yes, quite often. We discuss things that have happened." After the inspection the registered manager emailed us records of team meeting agenda's; these looked at topics including dress code, people's support needs and workload. However; we were advised there were no team meeting minutes available.

This showed that there were ineffective systems in place to demonstrate a culture of learning and continuous development to ensure people were receiving high quality care.

People and relatives told us they felt comfortable talking to the registered manager. One person said, "[Registered manager] will always listen and will have good explanations of why things have gone wrong. They apologise." A relative told us, "[Registered manager] is excellent, if I felt I had to discuss anything I

would have no qualms speaking to her."

Staff spoke positively about the registered manager. One staff member said, "I am quite happy, I wouldn't be here after four and half years if I wasn't. I am happy with [registered manager]." Another staff member told us, "It is a good firm to work for, I can't fault it. The company are very caring." This showed that people and staff felt supported by the registered manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager did not know of their legal obligation to notify the Care Quality Commission of any incidents that affected people in receipt of a regulated activity.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Individual care plans and records did not evidence the service was working in a person-centred way and responding to individual needs and preferences in line with best practice.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not always recruited in a safe manner and people were not always cared for by staff who were suitable for the role.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found staff did not always receive an induction, training, supervision and an appraisal to enable them to provide effective care and support to people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not have a robust system in place to record and understand individual risks to people which meant they were not kept safe from potential harm or injury. The service did not ensure people were supported with their medicines in a safe way.

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems in place to oversee and manage the quality of care and support delivered to people.

The enforcement action we took:

Warning Notice.