Castlerock Recruitment Group Ltd

CRG Homecare - Hammersmith

Inspection report

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Date of inspection visit:
30 May 2017
01 June 2017
02 June 2017
07 June 2017
08 June 2017

Date of publication:
26 July 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this announced inspection between 30 May and 8 June 2017. CRG Homecare – Hammersmith is a domiciliary care agency which provides care to older people and people with physical disabilities in the London Borough of Hammersmith and Fulham. At the time of the inspection the provider was providing care to 312 people.

This was the first comprehensive inspection since the provider registered this location in January 2017. We carried out an inspection in October 2016 at the branch's previous location where we found that the provider was not meeting legal requirements; this was because they were not carrying out suitable recruitment checks on staff. At this inspection we found the provider had made improvements and was now meeting this requirement.

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 requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been in post since February 2017 and a new branch manager had recently been appointed.

At our previous inspection in October 2016 we found that the provider was not meeting legal requirements about how they carried out pre-employment checks for some care workers. At this inspection we found that the provider was now meeting this regulation. The provider carried out checks to ensure that care workers were suitable for their roles and we checked files to make sure this was taking place.

The majority of people we spoke with told us that their care workers did not arrive on time. We found evidence that a large number of calls were late. The provider was implementing a new system to monitor and improve this. We also found that calls were not always scheduled at the time that was agreed in the care plan.

Care plans were detailed in their scope and contained personalised information about people's needs and wishes and how they preferred to be supported. Plans included information about people's family members and family circumstances, their work histories and preferred names. We found in some cases these needed reviewing to make sure that they met people's needs, and that in some cases care tasks were not carried out. The provider had recently started auditing records of how care was delivered, but did not always pick up on discrepancies or ensured that care tasks were carried out as planned.

The provider had assessed risks to people who used the service and had plans to mitigate these, including mobility and falls risk assessments, assessing the safety of people's living environments and equipment used by staff. Care workers did not administer medicines to people but prompted them to do this, but this was not appropriately recorded or checked. The provider had assessed people's needs and understanding with regards to medicines but information about the support people received was not always consistent.

People did not always consent to their care, and the provider did not always check whether people had the capacity to make decisions or that representatives had the legal authority to consent on behalf of people. The provider had identified this as a problem, and had developed but not yet implemented a system to address this. We saw detailed information about people's dietary needs and care workers recorded how people were supported at mealtimes. There was evidence that staff had responded to concerns about people's health.

The provider met its responsibilities to report and investigate allegations of abuse, and had systems in place for monitoring and responding to complaints. People we spoke with knew how to make complaints, however two people told us that they had made complaints in relation to timekeeping but that this had not changed.

People told us that they were treated with respect by staff who offered them choices and upheld their dignity and privacy. Care calls were at least 45 minutes to an hour to carry out personal care. The provider did not have tools to monitor the consistency of people's carers; in many cases this was good but some people did not receive care from consistent staff which meant some people felt staff did not know them well.

Staff received regular training and supervision in order to carry out their roles, and managers carried out spot checks. There were measures in place to monitor this and ensure that this was carried out.

We have made two recommendations about how the provider ensures that care plans reflect how care was delivered and checks that staff have enough time to travel to their appointments. We found three breaches of regulations relating to the management of medicines, consent and good governance. You can see what action we told the provider to take at the back of the full version of the 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 safe in all aspects.

Staff prompted people to take their medicines, but plans were not always clear about how this was carried out and this was not recorded in line with best practice.

The provider carried out checks to ensure that staff were suitable for their roles.

Many people we spoke with identified punctuality as a problem. Many calls were significantly late, and the provider was in the process of implementing a system to monitor this, but this was not yet fully in place.

The provider had measures in place to identify and mitigate risks to people who used the service.

Is the service effective?

Requires Improvement

The service was not effective in all aspects.

The provider was not obtaining consent to care from the appropriate person, and in some cases had not completed an assessment of the person's capacity to make decisions.

Staff received appropriate levels of training and supervision which was monitored by managers.

Care plans had detailed information on people's health and dietary needs, and staff recorded the support people received to eat well and maintain good health.

Is the service caring?

Good

The service was caring.

People told us they were treated with respect and that staff upheld their privacy and dignity. There was information on care plans for how staff could promote dignity, and there was information on people's histories, family situations and preferred names.

Most people we spoke with told us they received support from consistent staff, but some people said that staff members changed too frequently. Many rotas showed a good level of consistency, but a small number did not.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us they were given choices and most people were involved in their care planning. Care plans contained detailed information on people's needs and preferences, however in some cases people's needs had changed but this was not reflected on care plans, and care was not always delivered in line with people's plans.

The provider had measures in place for monitoring and responding to complaints.

Is the service well-led?

Requires Improvement

The service was not well led in all aspects.

Quality audit tools were effective when these were well established in areas such as checking, supervision and recruitment of care workers. However, audit systems of care plans and how care was delivered were new, and did not always pick up on issues of concern.

Spot checks were carried out regularly of care workers, but there was not regular monitoring of people's satisfaction with the service.

Most care workers told us that managers were supportive and communicated well with them.

CRG Homecare - Hammersmith

Detailed findings

Background to this inspection

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

This inspection took place on 30 May, 1, 2, 7 and 8 June 2017. The provider was given notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was carried out by two inspectors on the first day and a single inspector who visited the office on subsequent days. Another inspector made calls to care workers. An expert-by-experience made calls to people who used the service and their relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to carrying out this inspection we reviewed information that we held about the service; this included the report of the previous inspection and notifications of events that the provider is required to tell us about. We also contacted a contract manager from the local authority.

During the inspection we reviewed records of care and support relating to 23 people and the recruitment and supervision files of 11 care workers. We reviewed electronic call monitoring data relating to nine people who used the service and the weekly rotas of 10 staff. We looked at information relating to the management of the service, including records of complaints, safeguarding, incidents, training, supervision and audits.

We spoke with 24 people who used the service and one relative of a person who used the service. We spoke with 15 care workers and the operations manager, area manager (who was the registered manager) and the branch manager.

Requires Improvement

Is the service safe?

Our findings

At our previous focused inspection in October 2016 we found that the provider was not meeting legal requirements. This was because they had not carried out pre-employment checks for some care workers.

At this inspection we found that the provider was now meeting this regulation. Prior to starting work, the provider had obtained photographic identification of staff and proof of address, and had requested two references from previous employers where required. The provider had verified that staff had the right to work in the UK and had carried out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. The provider told us that staff were required to undergo a DBS check every three years. We saw a list of checks for all staff which showed that this was in place and enabled the provider to identify when these needed to be repeated. Staff were assessed at interview for their awareness of different types of abuse, their responsibilities to report abuse and how to respond in the event of a serious incident.

The provider told us that their contract with the local authority specified that they did not administer medicines for people and only prompted people. This was verified by people who used the service who we spoke with and by checking care plans and records. Staff received yearly training in the safe management of medicines. The provider routinely carried out a risk assessment with regards to people's medicines. This included a list of prescribed medicines, arrangements for their collection and disposal, people's understanding of their medicines, whether people were able to take medicines independently, or required prompting or administration and who was responsible for this. This was used to assign a number which corresponded to a category of medicines support, but this was not defined on care plans or risk assessments. The provider assessed people's understanding of their medicines and any difficulties people had with taking these.

However, we found that some plans were not consistent on who was responsible for medicines. For example, one plan stated that a person's relative administered medicines, but that staff prompted with this. In another, it stated that a person was self-administering their medicines, but that staff prompted with medicines.

The provider did not use any form of medicines recording chart to record the medicines which people had been prompted to take. This meant that the provider was not working in line with 'The Handling of Medicines in Social Care guidance from the Royal Pharmaceutical Society of Great Britain', which states "When care is provided in the person's own home, the care provider must accurately record the medicines that care staff have prompted the person to take, as well as the medicines care staff have given."

We saw that in most cases, staff were not recording on people's daily records whether they had prompted the person to take their medicines. One person's plan stated that they were to be prompted to take their medicines twice daily, but this had been recorded once in the seven day period we looked at. For another person, this was to be prompted twice daily but was not recorded at all in the four day period we looked at. For another person, their care plan stated that they were to be prompted in the morning and at midday, but

in practice they were being prompted in the morning and evening, and was not recorded on two of these evenings in a five day period.

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

Some people we spoke with told us that staff did not arrive on time. Out of 13 people who expressed an opinion, eight people told us staff arrived always or mostly on time. Comments included, "I think a couple of times they come a little late. But it is ok I understand they have other people to see" and "Mostly they arrive on time." However, five people told us that they experienced significant problems with the punctuality of their care workers. Comments included, "No, I have to wait over two hours for someone to show. It is a headache as I can't do anything else I just have to wait for them", "They come any time, they do not come at the right times" and "No I don't think they have ever turned up on time. I have complained about it a few times but nothing ever changes."

The provider was in the process of implementing a new electronic call monitoring (ECM) system, as they identified that the previous system had weaknesses which meant it could be misused by staff. The new system required staff to use smartphones to touch an electronic tag in order to log in and out, and this tag was attached to the person's care folder. At the time of our inspection it was being monitored by a member of staff, and the provider told us it was in use for about 60% of calls, and was due to be used in order to arrange payment with the local authority from later in the month. The provider told us that as the system was still being implemented they were unable to verify the accuracy of their punctuality data at this point, but this showed that during the week commencing 22 May, out of 3498 planned visits, 500 were early and 1069 were more than 15 minutes late, but this data would not say how late the calls were.

We analysed the ECM data for nine people who used the service over a seven day period. This covered a sample of 280 calls. We identified 46 calls which were logged in more than 30 minutes later than the time planned on the ECM system, of which 12 were more than an hour late. Out of these late calls, 16 of these were scheduled on the ECM system at a time which was different to that of the care plan. This meant that many calls were significantly late, but the provider was unable at this point to collect reliable data on the extent of this problem.

This constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The provider told us, "We acknowledge that we have a few issues with call time matching the care plans as inherited from [previous providers] but we have made enormous improvements to ensure that this is completely eliminated. We are in the process of matching the care plan with our planned visit time with the newly implemented ECM system…the cases identified here are isolated ones and do not represent a true reflection of our service users' rota."

The provider told us that care workers were now grouped into three teams based on the geographical area they covered. Some staff were not given enough time to travel between calls. Out of 14 staff who expressed an opinion, nine told us they had enough travel time and five said they did not. Comments from staff included, "I have no problems with travel time at all, it's easy for me", "Travelling is OK for me, but some of my colleagues say it is not enough time", "To get to calls on time is impossible…I did raise it with the coordinator and for a week it was fine, but then went back to normal" and "There are days I start earlier to make up the time."

We looked at the rotas for 10 care workers for a seven day period, which covered a sample of 342 calls. We obtained information from the provider on how these staff travelled, and used a route planning tool to analyse whether staff had enough travel time in order to arrive on time. We found that although the majority had enough time, around 8% of calls would have been between 15-30 minutes late, and that 1% of calls would have been between 30-45 minutes late. This did not allow for delays caused by transport disruption. Out of the 10 care workers, six had enough travel time, and two staff had significantly problematic rotas. This meant that most, but not all staff, had enough time to travel to their calls.

We recommend the provider take advice from a reputable source on how to monitor and improve travel time for staff to arrive on time for calls.

People who used the service told us they felt safe when staff visited. Comments included, "I have not had any problems with anyone", "They seem OK" and "It is all OK." The provider had appropriate measures in place to safeguard people from abuse. This included yearly safeguarding training for staff and assessments of staff knowledge about abuse during the recruitment and induction process. Staff we spoke with told us they would report concerns to the office and that managers would take their concerns seriously. Where allegations of abuse were made, the provider met its responsibilities to inform the local authority and the Care Quality Commission (CQC), and took appropriate measures to gather evidence and pass these to the appropriate bodies such as the local authority and police. Incidents and accidents were monitored by managers and reporting forms contained prompts for staff to report incidents to CQC or the local authority if necessary.

The provider had carried out assessments of any risks to people using the service at the time of the assessment, and these were reviewed as people's needs changed. During the initial assessment, staff carried out assessments' of people's safety and that of the home environment. This included checking access to the property, verifying that fire escape routes were clear, whether fire hazards were present and whether smoke alarms were fitted. Risks were identified when people smoked in their homes, and risk control measures were present such as emptying ashtrays and reminding people to stub out their cigarettes. We did not see any people who may be at risk from flammable creams whilst smoking.

Staff assessed risks to people from the condition of the property and food hygiene. The risk assessment required the assessor to identify the location of the emergency cut off points for utilities, which had been completed throughout. Risks to people's personal safety were assessed in terms of their likelihood and severity, and where risks were identified a risk management plan was in place. This included risks of self-neglect and the risks from health conditions, although in some cases this required more information. For example, there was information on how people's mobility was affected, how staff should monitor the condition of people's skin if they were at risk of pressure sores and how people's diabetes was monitored through dietary intake, but there was limited information on how people with diabetes were affected by their conditions and signs staff should look for which might indicate the person was becoming unwell.

Moving and handling risk assessments had been completed by staff. This included checking any equipment that the person used to mobilise such as wheelchairs, zimmer frames and hoists. Staff had verified that the equipment was in good condition and that servicing was in date. There was information on factors which could affect people's mobility, including whether people were able to weight bear, or whether they could become confused or forgetful. Risk assessments identified people who were at risk of falling, and a falls management plan was in place when required, which included checking mobility aids and ensuring pathways were clear. Plans included detailed information on safer moving, handling and transfers, and staff received training in moving and handling as part of their induction and this was refreshed yearly.

Where people were supported with their finances, such as staff shopping on their behalf, this was recorded on their care plans along with an assessment of any risks such as loss or financial abuse. Staff had recorded transactions in a suitable book and receipts were kept of any shopping staff had done. This was signed by the person or a suitable representative, who retained a carbon copy of the record but was not always checked by managers.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us that staff asked their permission before supporting them. Comments included, "If they turn up then they usually tell me what they are going to do", "They only do what I want, I tell them what do to" and "If I don't want something I won't have it."

However, we found that the provider was not working in line with the Mental Capacity Act. 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.

Assessments indicated whether a person was able to give consent or to provide a signature indicating they had consented to their care. Most people had signed their care plans or care agreements, however in some cases the right person had not signed. For example, in four cases family members had signed on behalf of the person even though assessments stated that they had capacity, and in two cases staff members had signed on the person's behalf. In another two cases a person's assessment recorded they were able to sign their documents, but some documents were marked as "unable to sign" even though the person had signed other documents. In two more cases family members had signed as the person's Lasting Power of Attorney (LPA) for health and welfare, but the person's capacity to make decisions about their care had not been assessed, and the provider had not obtained evidence that the relative held an LPA. In some instances the provider had carried out best interests meetings with the local authority, even though it had not been established whether the person had mental capacity with regards to their care.

This constituted a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The provider told us, "Consent was an area we were most concerned about…we have devised an action plan for it." The provider had devised a new form with regards to capacity and consent. This prompted staff to carry out a mental capacity assessment with regards to making a specific decision, including whether a person was able to retain information long enough to make a decision and any measures taken to optimise the person's understanding in line with the principles of the MCA.

Staff told us that they received the training they needed. Comments included, "The training is actually OK, they are able to explain themselves and it is good that it is face to face", "The training is excellent. If you are unsure or don't understand anything, you can always come back, or get to do shadowing with another care worker" and "Refresher trainings are really good, they showed me some new things."

Staff received a three day induction which included the provider's mandatory training programme. This included moving and handling, basic first aid and life support, medicines and health and safety, including fire safety, which was refreshed every 12 months. Safeguarding training was carried out at induction and

every two years, and dementia awareness, infection control, fluids and nutrition, which was carried out every three years. Staff were assessed for their understanding at the end of their induction. The provider maintained a training matrix in order to monitor staff training and ensure that this was kept up to date.

Staff also undertook shadowing, signed policies to indicate their understanding and managers carried out observations before signing people off as able to work independently. Staff also received a six monthly inspection visit whilst working in people's homes from a supervisor; the provider maintained a system to ensure people received this on time.

Staff told us that they received supervision which they found useful. One care worker told us, "I'm happy with the supervision I get. It's usually around every 3-4 months I think. I discuss problems with clients and get to follow up on actions from previous meetings." Managers had systems in place to ensure staff received supervision regularly. Supervisions included discussing issues such as team working, use of electronic monitoring systems, issues and concerns, individual care plans, safeguarding and policies, and were used to identify objectives and areas for development.

People who needed support to eat and drink told us they received this from staff. Care plans documented people's nutritional needs and preferences in this area, and care workers documented how they had met these. For example, one person's plan had detailed information on their dietary needs, including the type of milk they preferred, the type of food they wanted and what they wanted to receive for breakfast. We saw that staff had recorded what the person had had to eat or drink in daily logs. In one instance we found that this was not taking place; the provider told us that the person was now independent in this area, and that their care plan needed revising.

People's assessments contained detailed information on people's past and current medical history and health needs. This included information on people's mental health, cognition and diagnoses, including how the condition affected their daily living skills. Staff also compiled a list of allergies. We saw examples of staff responding to people's health needs. For example, a care worker recorded that they had observed spots whilst checking a person's skin, and that they had contacted the person's GP. In another case, staff had recorded that the person was not feeling well and had made a GP appointment for the person.

In some cases people were described by staff as having 'undiagnosed dementia', which the provider told us was often used by the local authority. However, the use of this phrase indicated that people had a serious health condition without this being diagnosed by a qualified medical professional.

Good

Is the service caring?

Our findings

Out of the people we spoke with, nine people told us they thought staff knew them well. Comments included, "Over time I have got to know them really well and I think they know me too" and "We get on really well." Two people told us they didn't think staff knew them well, with comments including, "I have different people coming around all the time, so it is hard to know any one person" and "The carers change a lot."

Eight people told us that they were happy with the consistency of care, but three people told us that they experienced difficulty with this. Comments included, "You might get one for a month but then they change again" and "It changes all the time."

The provider told us they were unable to give figures on the consistency of care workers provided to people. In most cases logs of electronic call monitoring (ECM) showed that people received care from consistent staff. For example, one person had just two care workers covering their 28 calls in a week, and another person with 30 visits in a week had a single care worker covering these, except for that person's day off where a single worker visited them. However, we found two examples where care was less consistent. For example, one person received 21 care calls in a week, and this was covered by six different care workers. Another person had 28 care calls which were covered by five different workers. The provider told us they intended to implement a form of analysis so that they could address this. We saw evidence that when people had complained about the consistency of staff, the provider had taken steps to ensure that people had a regular care team.

We saw that people's care plans took account of people's views and gave personalised information about people's life story and personal preferences. Plans included information about people's family members and family circumstances and their work histories. There was also information on people's preferred communication methods and language needs, and people's preferred names, including information about when people did not like their names to be shortened. In one set of care logs, we saw that the care worker had remembered a person's birthday, and had brought them a birthday cake.

Most people we spoke with told us that they were treated with respect by their care workers. Comments included, "They speak to me in a nice way. They are always polite" and "They do take an interest in what I am doing."

We saw that visit times were of an appropriate duration for people to receive care. In most cases, where people required support with breakfast and personal care in the morning, visits were an hour, and never less than 45 minutes. The provider did not authorise 15 minute visits to ensure people had the appropriate amount of time for personal care so that they would not receive rushed care.

Care plans contained detailed information for staff on how best to support people, and this included guidance on how to protect people's dignity. This included taking steps such as covering a person with a towel whilst providing personal care. Everyone we spoke with told us their care workers respected their dignity and privacy. Comments included, "Yes, they will shut the door when it is required and little things like

that", "It is the little things like if I have company around they will take me to one side and ask me if I want something done" and "It must be difficult for them, but everything they do is really good."

The provider had signed up to the Dignity Challenge, and there was information provided on daily log books which set out the provider's expectations of staff to promote and uphold people's dignity.

Requires Improvement

Is the service responsive?

Our findings

Most people we spoke with told us they were involved in writing their care plans, and everyone we spoke with told us that staff ensured that they were given choices. Comments included, "They will give me a choice like what I want to wear, little things like that" and "I can choose things myself."

Care plans were detailed in their scope. The provider carried out an initial care needs assessment, which included the person's perception of their needs and those of their relatives, the person's preferred outcomes for their care, their family and friends network, lifestyle and history, current physical wellbeing and their past and current medical history. This information was used to compile a care plan. These included clear information on what people did not need or want support with, and information on what people could do for themselves. There were clear visit plans for staff with detailed information on how care should be delivered and a list of tasks to be carried out. This included details such as when a person preferred oils to be added to their water for bathing and instructions to turn on the television for a person and to leave the remote control where they could reach it.

Staff told us that they felt care plans contained useful information for them. One care worker told us, "I think there's loads of information in the care plan, and it is all detailed", but another said, "Where there are care plans, I find they have enough information in them. However, there are some people without a care plan in place. I have informed the office but nothing was done."

We found that care was not always delivered as planned. For example, many people's visit times were substantially different from those on the plan. For example, one person was due to receive a visit at 5pm, but on two days staff arrived at 3.45pm, and their evening visit was scheduled for 8pm, but in practice staff arrived at 9pm, and on one occasion this was 9.20pm. For another person, their plan stated they should receive support at 8:30am, but staff were usually arriving between 7am and 7.40am, and it was not clear that the person had agreed to this. Another person was scheduled to receive a fortnightly domestic call of 90 minutes, however staff only attended for 60 minutes. The provider told us that their quality assurance team had identified these issues and were in the process of matching up visits and checking whether people were happy with the time. The registered manager said, "On some visits [at the time we started the contract] we had three sets of times."

One person's plan said that staff were to provide personal care and apply a cream every morning, but records of care provided showed that this was no longer taking place; the person's care plan had been reviewed but this had not been noted. The provider told us that this person sometimes refused care, but it was not recorded by staff when this had taken place. Another person's package of care had increased in September 2016 to include an afternoon visit, but there was not a visit plan in place for this visit, so it was not clear what staff needed to do during this time.

People had received a review of their care package in the last six months. This discussed what care and support people received, including with medicines and finances, and whether there were any risk issues to consider. However, in some cases these did not address changes in people's needs. For example, one

person had not received a review this year, even though they received support in certain areas and that their visit times had changed. The provider told us that some areas of support were temporary, and that they would book an appointment to update the care plan to reflect the person's current care needs.

We recommend the provider take advice from a reputable source on how to ensure that care plans reflect people's current needs.

Five people we spoke with expressed concern about the standard of cleaning carried out by care workers. Comments included, "[They] could do with learning how to clean up", "They can hoover well but otherwise don't really do anything else." A relative told us, "I usually have to go back and clean up after they are done."

People we spoke with knew how to make complaints, however two people told us that they had made complaints in relation to timekeeping but that this had not changed.

We saw that the provider had measures in place for monitoring and responding to complaints. There was a system for tracking complaints, and complaints were investigated by the registered manager and where necessary they had apologised and made changes. For example, one person had complained about the way in which a lack of consistent staff had affected their relative, and managers wrote to the person to apologise and to give names of care workers who would support their relative in future.

Requires Improvement

Is the service well-led?

Our findings

A new manager had registered with CQC in February 2017 and was in the process of introducing quality control measures. More established systems were effective at ensuring that essential standards were maintained, however some systems were not yet established in a way that ensured high quality care was delivered. At the time of our inspection the registered manager had been appointed to an area manager role, and a new branch manager had begun that week. This was reflected in comments from people who used the service, most of whom were not sure who the manager was.

The provider had recently introduced systems for auditing records of care. This had begun in April, which meant that the majority of logs we viewed predated this, and where audits had taken place these did not always detect gaps in recording or discrepancies between care plans and what was recorded.

Managers completed a form in which they verified whether records of care met certain standards and whether action was taken in response. This included whether entries were dated and signed, were factual and whether essential messages from staff such as a change in a person's needs had been communicated to the office and recorded on the provider's electronic care notes system. We found a number of cases where care notes indicated that care plans had not been followed. This included when personal care was not delivered as planned, medicines were prompted for at different times or not recorded or when visit times varied substantially from what was planned. In some cases visits were not recorded at all by staff, and this was not always picked up by the audit. We used electronic care monitoring (ECM) records to confirm that visits were either made or had not taken place due to cancellations, and found no evidence of missed visits. Staff had not always recorded when care was refused or not needed. The provider told us, "We've asked people to give more context around recording, it affects training too and we're keen to roll this out."

Where audits had detected errors in recording, there was evidence that this was addressed with staff. The registered manager told us, "I noticed that communication logs were an issue, staff were filling in the time that's on their rotas, rather than the time that they had arrived." This was raised in branch meetings and in memos to care workers, and was not an issue in the logs that we viewed. The provider told us, "We've picked up on this point, you need to audit against the care plan", and that in other branches they were piloting a care plan that demonstrated how people's care varied based on their health, in what was called a 'good day versus bad day' care plan.

The provider carried out audits of people's care files, which verified whether care plans and risk assessments were up to date, and whether the provider held information on people's medicines, religious needs and details of their next of kin. These had been effective in that these documents were up to date, but did not assess whether documents were accurate or still met people's needs.

The provider used telephone monitoring as a means to measure people's satisfaction. This included checking with people whether they were happy with staff, asking how they were finding care, asking if care workers were punctual and completing the tasks people needed. This would flag up if changes were needed to care plans. We found examples of office based staff responding to concerns flagged up by this process,

but we found that telephone monitoring happened sporadically, with several completed for some people and none for others, and the provider lacked a system for monitoring this.

These issues represented a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The provider told us that they had reorganised the branch into three teams which covered different areas of the borough, and that staff had a named person to contact based on the postcodes they covered. Most staff we spoke with told us that they felt managers were supportive and responsive to concerns. Comments included, "I spoke to the coordinator about a concern and it was followed up straight away", "I feel supported in my role, they take the time to speak to me and do listen to me" and "They send work updates and rotas via text messages and email, which I find very useful. However, I can turn up to the office any time if I need to." Some staff we spoke with told us they felt there had been improvements in these areas. One care worker said, "Initially it was a bit rough, but they've now got on their feet and they're doing wonderfully well" and another told us, "The communication has definitely improved in the last year, things are getting better." An external survey had been carried out in September 2016 which was used to obtain the views of people who used the service and their families and care workers, but there had been significant changes to the organisation since this time.

The provider demonstrated tools they used to track some key areas such as checks with the Disclosure and Barring Service, staff appraisals, spot checks and supervisions, which were not in place at the time of our focused inspection. These showed the provider had effective systems for monitoring these areas, and flagged up to managers when action was needed. The provider told us, "It demonstrates the journey we have been on." The week before our inspection, the provider had implemented a quality audit report, which covered areas such as lateness, safeguarding concerns, complaints and missed visits.

The provider carried out 'inspection visits', which were spot checks on care workers when they were working in people's homes. These included checking whether the care worker had arrived and departed on time, whether entry procedures were followed including greeting the person, and whether tasks were completed appropriately and log books completed. Staff had received these within the last year, and this was monitored by the registered manager.

In response to concerns identified at the previous inspection, the provider had carried out an audit of staff files, which included checking whether staff had appropriate referencing, evidence of identification and had completed an induction and received mandatory training. This had been effective at ensuring the provider met regulations in these areas.

Care workers told us that generally communications with the office were good. One staff member said, "They send updates by email, which I think is really good because we can address it and access it right away; we get updates about our clients or any packages that need covering, including the rotas." However, one staff member told us, "It's more I'm having to chase them up rather than them calling me back."

Meetings were taking place every three months for the office-based staff. These were used to discuss areas such as how new ECM systems were being implemented, recording of concerns and the outcomes of recent audits. However, we found that care worker meetings did not take place regularly, and three had taken place since August, with none at all held from September to May. The most recent meeting had been attended by 16 staff. Care workers agreed that these were not a feature of the organisation, with comments including, "We don't really have team meetings", "I haven't been to any care worker meeting, I don't think there are any" and "I think the meetings are once in a blue moon."

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 Care and treatment was not provided with the consent of the relevant person. The registered person did not act in accordance with the Mental Capacity Act (2005) 11(1)(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe management of medicines 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established systems to assess, monitor or improve the quality of the services provided in the carrying on of the regulated activity or to maintain an accurate and complete record in respect of care provided to the service user 17(1)(2)(a)(c)