Nestor Primecare Services Limited

Allied Healthcare London Central

Inspection report

66 Prescot Street
London
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Ratings

Overall rating for this service	Requires Improvement

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

Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out this announced inspection between 7 and 24 November 2017. At our last inspection in February 2017, we found breaches of legal requirements relating to risk management, medicines and record keeping. Following the last inspection, we issued two warning notices and asked the provider to complete an action plan to show what they would do and by when to meet these regulations.

We found that the provider had taken action to improve risk management and the management of medicines, but there were still some areas where the provider was not meeting these regulations. The provider was still not meeting regulations relating to record keeping although there had been some improvements.

Allied Healthcare London Central provides support to 482 people. This service includes a domiciliary care agency. It provides personal care to people living in their own homes in the London Boroughs of Southwark and Lambeth. It provides a service to 301 older adults, younger disabled adults and children. It also provides care to 22 people living in their own homes at night under the Night Owl Scheme in the London Borough of Southwark, and Nightingale Nursing Bureau, which provides nursing care to two families who care for children with complex needs.

Additionally, the provider told us they managed care and support to people living in five specialist 'extra care' housing services from this office. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service. Two of these were in the London Borough of Lambeth, which were Lingham Court, which provided care to 26 people and Charleston House, which provided care to 22 people. In the London Borough of Southwark there were three extra care services which were Tayo Situ House, Lime Tree House and Lew Evans House, which provided care to 31, 46 and 32 people respectively.

We visited these services as part of our inspection of this location and have included our findings in this report. However, we found that in practice the regulated activity of personal care for these services was not managed from the registered location, which was not compatible with the provider's registration arrangements. After the inspection, the provider told us they would be applying to the Care Quality Commission to register these services separately.

Not everyone using this service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Since our last inspection, the provider had appointed a new branch manager who had applied to become a registered manager. There was a separate registered manager in place for the Nightingale Nursing Bureau. 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. We found that the branch manager had no direct oversight of the extra care schemes managed from this location.

The provider had implemented an improvement plan for addressing concerns about the service. This had been very effective in some areas. For example, the provider was now managing medicines safely within the domiciliary care service, but within the extra care services records relating to medicines were not always completed or audited effectively and in some cases did not ensure people had the right medicines. The provider had reviewed risk assessments and care plans to ensure that care was delivered safely and in a person centred way, and these documents contained considerably improved detail on how to meet people's needs. In some cases the provider did not ensure that people had access to pendant alarms which people used to call for help in emergencies, and although there was a register of equipment, in a small number of cases appropriate checks had not been carried out of these. The provider did not have the right tools to make sure they were assessing people's capacity to make decisions for themselves so they did not always obtain consent to provide care.

Staff received appropriate training and supervision to carry out their roles and were recruited in line with safer recruitment processes. However the provider did not always obtain the right references to make sure that staff had previous good conduct when they had previously worked in health or social care. There were systems of spot checks and observations of competency to make sure that staff had the right skills to carry out care.

At our last inspection we found the provider was not safely using electronic call monitoring systems to ensure staff arrived for visits. We found that this had improved, but that staff frequently arrived late for calls. There had been previous concerns about the risk of missed visits, but there were now measures in place to address this. However, sometimes only one care worker attended a double handed call.

There were measures in place to ensure that people received the right support to eat well and staff made sure people accessed medical care when they needed it. The provider had a system to monitor and record complaints, but some people we spoke with did not feel that complaints were always well addressed. People told us that they were treated with respect by staff, but not everyone received support from consistent care workers. We saw that people were treated well by care workers in communal environments.

People received high quality care from the nursing bureau, which had strong measures in place to address risks to people who used the service and detailed plans for delivering complex care packages.

We have made a recommendation about how the provider ensures that people wear emergency call pendants. We found breaches of regulations relating to consent to care, management of medicines and good governance and a breach of regulations relating to the provider's registration arrangements. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Measures had been taken to improve the safety of the service, but it was not safe in all respects.

The provider had greatly improved measures for recording and addressing risk, but some areas such as checking the servicing of hoists and the use of pendant alarms did not fully address risks to people's safety. There were measures in place to safeguard people from abuse.

The provider had safer recruitment measures in place, but did not always obtain references appropriately.

There were improved measures in place to monitor calls and ensure these were not missed, but a high proportion of calls were still late, and sometimes only one care worker had attended a double handed call even though this may not be safe.

The provider ensured that medicines were safely managed within the domiciliary care agency, but these measures were less robust in the extra care settings.

Is the service effective?

Requires Improvement

The service was not effective in all respects.

The provider did not have suitable systems in place to assess people's decision making abilities in line with the Mental Capacity Act 2005 (MCA) and did not always obtain consent for care from the relevant person.

People received support to stay well and access medical help when needed. There was detailed information on people's nutritional needs and how these were met.

Care workers received an extensive induction and regular refresher training to ensure they had the right skills. There were systems in place to supervise staff and carry out observations of competency.

Is the service caring?

Good

The service was caring.

The majority of people told us that staff treated them with dignity and respect and that they had a good rapport with their care workers, but some people told us that they did not always receive consistent staff.

There were communication plans in place to support care workers to communicate well. Plans included substantial detail on how to support people in line with their wishes and to maintain their independence.

Is the service responsive?

Good

The service was responsive.

There were plans in place to ensure that people received person centred care and these had been reviewed in the past six months.

The provider had measures in place for monitoring and responding to complaints, but some people we spoke with were dissatisfied with how complaints were responded to.

Is the service well-led?

Requires Improvement

The service was not well led in all respects.

There were measures to improve the quality of the service which had been very effective in some areas. However, audits were not taking place at a suitable rate to ensure all records were accurately completed. There was a system in place for monitoring the quality of the service people received.

The provider was not operating in line with their registration in terms of the extra care services.

Allied Healthcare London Central

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.

Since our last inspection between 21 and 24 February 2017 there had been 33 safeguarding concerns relating to the service. Of these, 16 related to late or missed calls, of which 14 had been substantiated. Three allegations related to financial or material abuse, of which one had been substantiated and resulted in criminal prosecution of a care worker. Nine related to neglect or inappropriate care, one of these had been substantiated. Five related to physical or emotional abuse, one had been substantiated but this did not relate to the conduct of a staff member and one was still being investigated. We had also been contacted by the local authority who had concerns about the measures the provider had in place to address missed calls. We used this information to inform our inspection planning.

This inspection took place between 7 and 24 November 2017 and was announced. We gave the provider 48 hours' notice of this inspection as we needed to be sure that staff we needed to speak with would be available. Between 7 and 9 November four inspectors, a pharmacy inspector and a specialist professional advisor who worked as a nurse visited the office. One inspector visited Lime Tree House, Charlestone House and Tayo Situ House on 13, 14 and 15 of November. One inspector visited Lingham Court on 20 November and Lew Evans House on 21 November. One inspector returned to the office location on 23 and 24 November.

Between 7 and 9 November three experts by experience made calls to people who used the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 10 November one inspector made calls to care workers from the domiciliary care service.

We looked at records of care and support relating to 54 people, and records of medicines support for 40 people. We spoke with 41 people who used the service and eight relatives. We looked at records of recruitment and supervision for 11 care workers and records relating to training and team meetings. We looked at records relating to the management of the service, including audits of finances, medicines, logs of care, branch-wide audits, action plans and records of incidents, accidents and complaints. We accessed the provider's electronic call management (ECM) system in order to view records related to the movement of care workers. We spoke with the branch manager, the care delivery director, the manager of the nursing bureau, five care quality supervisors and 19 care workers. We carried out observations of communal activities, including lunch clubs, at the five extra care services.

Requires Improvement

Is the service safe?

Our findings

The provider used an electronic call monitoring (ECM) system to monitor when care workers arrived and left calls. This was in place under the terms of the provider's contract with the London Borough of Lambeth. Following our focussed inspection in February 2017, we issued a warning notice regarding the provider's use of ECM, as staff were only logging in for 68.5% of the time which meant that calls could not be safely monitored.

Since our focussed inspection, the local authority told us they were concerned that the provider's use of ECM had consistently fallen since April and was at 56.27% for the week of 9 October. Since the provider had met with the local authority to discuss these concerns, we saw that the provider had taken action to address this, which included taking management action against staff who were identified as not regularly logging in. This had resulted in substantial and continual improvement in the use of the system since this meeting, which was at 70.5% during the week of 6 November. This represented only a small improvement in performance since our last inspection but demonstrated that the provider was now taking action to improve in this area, which meant the provider had now complied with the warning notice.

We found that frequently planned visit times on this system did not match those which were agreed on in people's care plans. The provider told us they were in the process of addressing this. What this meant in practice was that staff received a high number of alerts telling them that staff had not arrived on time. For example, during the week of 18 September, monitoring officers would receive an average of 71 alerts during a day to tell them that staff had not arrived for a call rated 'red', which was a call which was sufficiently high risk if missed that staff would be alerted if a care worker had not arrived within 15 minutes of the visit time. This was higher at weekends, with staff receiving 86 alerts on the Saturday. There was some evidence that this situation was improving, as during the week of 13 November this had dropped to an average of 60 alerts per day. The branch manager told us, "To be honest it's getting better. I have a weekly meeting with the admin team to monitor the alerts. I think the problem we're having is the issue of templating. We're still getting a lot of alerts due to the templates, but it's workable."

We looked at possible missed calls for the period of 24 August to 28 September 2017. We saw the provider had recorded that 21 calls had been missed or may have been missed, however, there had only been one proven missed call during this time, which was detected on the day it happened and a care worker had been sent to the person the same day. The provider had reported this to the local authority and undertaken an investigation as to why this occurred. These issues were addressed with the scheduler and care worker and highlighted that the ECM system had been malfunctioning on the day in question. This meant that the provider had improved measures in place for preventing missed calls. The provider told us they would speak to staff to ensure that calls were not incorrectly recorded as missed.

We asked 19 people who used the domiciliary care service if their care workers arrived on time, and 11 said care workers were frequently late. Comments included, "The times are varied and we are not given any indication of changes in the times or who will be coming", "In the main, they're not bad at timekeeping. Sometimes they are 5 to 10 minutes late because of a bus or something but nothing of any significance" and

"They arrive more or less within an hour of the stated time."

Under the terms of the provider's contract care workers were permitted to arrive within 15 minutes of the planned visit time. For the week of 18 September the system showed that 29% of calls were more than 15 minutes later than the planned time. The difference between planned visit times on the system and those agreed in care plans, and the previous low usage of the system meant that we could not be certain that the figures for punctuality generated by the ECM system were reliable. In the course of our inspection, we looked at a sample of 268 calls for 19 people who used the service, which was around 5% of calls for the week, and compared data on call logs and ECM against people's care plans. We found that in practice care workers arrived more than 15 minutes late 35% of the time, and that they arrived an hour late or more 9% of the time.

We found some examples where timing caused people difficulties. For example, one person's medicines needed to be given at 12:30pm, but in practice during the week we saw care workers arrived at 1pm, but on one occasion this took place at 1:30pm and one visit was at 2:30pm. Another person required repositioning due to the risk of pressure sores, but during the period we looked at, 16 morning visits were all late in relation to the visit summary, with 13 of those morning visits being over an hour late. Another person was living with diabetes and required staff support to prepare breakfast. In relation to their care plan their morning visit was more than 45 minutes late on 16 occasions during the month of October 2017. Within the extra care services, one person told us that they wanted to get up at 9am but that care workers frequently arrived closer to 11am. We identified five occasions where this had taken place.

The provider told us that within extra care services it was not always possible to support everyone at the time based on the care plan due to staffing resources, however this risk was mitigated due to the presence of 24 hour staffing and alarm systems.

Staff we spoke with said that often double handed calls were late and they had to "rejig" rotas to see if someone else was available or do other calls first and go back to the double handed call later. They said that sometimes it meant that people who needed two staff to support them had to have their call later than planned or they had to find another member of staff who could step in and help. We found at least five occasions where only one care worker had attended a double handed call. There were three occasions in September where this had taken place, and a family contacted us to tell us about two recent occasions where only one care worker had arrived. Additionally, one care worker had written in the logs on two occasions that only one care worker had arrived, although a second care worker had signed this log, so it was not clear why this was recorded. The provider told us they believed this to be a documentation issue but were unable to contact the care worker who had written this as they had left the organisation. These examples represented a small proportion of the calls carried out by the provider, and there was no evidence that care workers had carried out unsafe hoisting whilst attending these calls. However, double handed calls were in place to ensure that people were moved safely and this was not always taking place. One person told us, "On many occasions only one carer has turned up and I have to help in fact this is a weekly occurrence especially on Saturdays."

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

The provider told us that they intended to introduce a rounds-based system from January 2018 in order to improve punctuality and continuity of care, and that public transport delays frequently affected punctuality. The branch manager told us, "We tell staff if you're on your own don't try and move the person, start in the kitchen…We're trying to get people working in pairs".

Following our previous inspection, we issued a warning notice relating to how medicines were managed in the domiciliary care agency. We found there had been substantial improvements in the management of medicines and the provider had met the requirements of this warning notice, however we found instances in the extra care services where medicines were still not safely managed.

At this inspection, we checked medicines risk assessments, medicines administration record (MAR) charts and medicines audits. We saw (through audits) that prescribed medicines were available at people's homes and this assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people who used the service .

We looked at 19 care plans for medicines within the domiciliary care service and found that people's medicines preferences and risks were documented so that staff knew how to safely give medicines to meet people's preferences. We found that there were clear instructions on what help people needed with their medicines for example, help with application of patches or creams. Care plans we looked at had details to help staff monitor people for side effects. For example we saw a medicines care plan which explained the signs of a hypoglycaemic event for a person taking medicines for diabetes. We found that people's allergies were documented in their personalised medicines plan but not on the MAR chart.

We found that the self-administration of medicines were risk assessed initially by the service and documented in the care plan. This included individual items such as inhalers, creams and patches. The provider did not administer medicines covertly to people, in accordance with their policy. Staff we spoke to were able to tell us the details of who to contact in case of concerns with medicines or advice about self-care using medicines.

The medicines risk assessment outlined who was responsible for ordering and receiving medicines for people. Where the provider was responsible for ordering medicines, this was done through requests at individual surgeries and documented when the medicines required collecting. Medicines received by the provider were checked by the care worker for accuracy before administration and any discrepancies were followed up with the GP or pharmacy. If medicines were out of stock, staff told us they proactively investigated alternatives with the GP or pharmacy. Unwanted medicines were returned to the nearest community pharmacy for appropriate disposal in line with good practice.

People received their medicines as prescribed, including controlled drugs. We looked at 19 MAR charts and found minimal gaps in the recording of medicines administered, which provided an overall level of assurance that people were receiving their medicines safely, consistently and as prescribed. We found that there were separate charts for people who had patch medicines prescribed to them, such as pain relief patches and also topical medicines. These were filled out appropriately by staff. There was a process to update MARs when medicines were started, changed or stopped and the field care co-ordinators were responsible for this. However we did not see evidence of this checked by a second trained staff member after the MAR chart was drawn up to reduce the risk of errors, which is not in line with NICE good practice guidance.

On MARs we saw that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. Staff were trained about when to offer these medicines including looking for non-verbal cues and symptoms that might be demonstrated. This was documented in the medicines risk assessments that we saw. Staff we spoke to were able to demonstrate the reasons for giving these medicines, how many to give, what to expect and what to do in the event the medicine did not have its intended benefit.

Medicines were administered and recorded by staff that had been trained in medicines administration. We

also saw evidence of annual competency checks so that staff had an annual review of their knowledge, skills and competencies relating to managing and administering medicines. We talked to a member of staff about giving medicines to a person and were assured that staff had a caring attitude towards the administration of medicines for people. For example, if a person refused their medicines initially, staff would try to administer their medicines a short time afterwards. For medicines that were time specific, staff were able to demonstrate the correct times these should be given and sought to prioritise these medicines when administering them.

Staff checked what medicines people took when they arrived at the service and recorded it on the personalised medicines plan. They sought this information from the person directly, but referred to their community pharmacy or GP if required for clarification. There was a process in place for sharing accurate information about people's medicines when they moved from one care setting to another, for example a copy of the MAR chart was sent with the person if they were admitted to hospital along with their medicines.

We found that the provider had a medicines policy which reflected current guidance. Staff had access to this policy when needed but informed us that it did not accurately reflect practice. For example, the policy stated that formal audits should take place twice a year. However, staff told us, and we saw evidence of, MAR chart audits that were done more frequently within the domiciliary care service (for example when there was a new person to the service or a new care worker administering medicines). Staff checked that people received their medicines at four different time points; every four weeks when there was a new MAR cycle, twice yearly audits, when people changed their medicines and during unannounced spot checks, which were documented in care worker files. If medicines gaps on the MARs were identified, these were followed up with the care worker to ensure people had received their medicines. Medicines errors were discussed in weekly meetings and learning shared amongst the rest of the team, although we did not see evidence of this documented.

Within the extra care services there were similar arrangements for managing medicines but this was not always safely managed. The provider told us that within Southwark, managers were responsible for compiling MAR charts from care plans, whereas within Lambeth arrangements were in place for pharmacies to compile the MAR charts. For one person, staff were responsible for applying a lidocaine patch on the person's back; this was recorded on the MAR chart but was not mentioned in the care plan, risk assessment or visit summary. For two people at Charleston House, we found occasions where staff had not signed for medicines, where these had been audited the audit had not always detected these. This included an antibiotic which had not been signed for two days before the course was completed. We found one person's MAR chart at Tayo Situ had not been fully completed, which had also not been noted by an audit.

For two people, care plans stated that care workers physically assisted the person with medicines, however we found that some care workers stated that they had administered these medicines. One person's family had complained that the person's medicines had been left out for them, but these had been signed for. In response the provider had updated the person's risk assessment and discussed this person's requirements in team meetings. However, the risk assessment for this person still said that the person did not require support with medicines, but their visit plan said that staff needed to administer this person's medicine. The MAR chart had been audited, but this did not address that there were some gaps in signing, and on some other occasions the person's MAR chart said that they had refused their medicines, but their daily logs had indicated that the care worker had administered their medicines.

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

Following the inspection in February 2017 we found the provider was not meeting regulations regarding safe care and treatment and issued a warning notice regarding this. This was because the provider did not always make sure that equipment used for moving and handling was safe to use, did not always adequately carry out risk assessments for moving and handling and, where people had risks relating to health conditions, these had not been properly assessed or addressed.

At this inspection, we found the provider had was now meeting the requirements of this warning notice. All risk assessments for people had been extensively reviewed since our last inspection and signed off by a senior manager, although a small proportion required final agreement. We found that risk assessments relating to manual handling had the dates of servicing of equipment and there was considerable detail on how to carry out moving and handling operations safely and in a way which met the person's needs and preferences. The provider had a register for monitoring the dates of servicing for moving and handling equipment. However at Charleston House there was some equipment such as hoists which were due for a service and for one person in the domiciliary care agency records showed that the person's hoists were due for a check but this had not taken place, which the provider arranged.

Within the nursing agency, nurses were required to check on equipment such as ventilators and saturation monitors. There were clear instructions for nurses on how this should be done, including photographs, and nurses had recorded that this was taking place. There were also detailed instructions for how this equipment should be used, including how equipment may become detached when the person moved, and instructions for how nurses should respond in the event of a child suffering breathing difficulties.

Risk assessments included information on handling constraints, the number of people required to move a person safely and any relevant health issues. Risk assessments demonstrated considerable knowledge of the person's mobility needs and preferences and were of a high standard. For example, one person's plan included information such as "I am able to maintain sitting position in bed with slight support" and highlighted that the person had "poor standing tolerance." There was evidence that supervisors had raised concerns about lifting and handling, for example when the environment was too cluttered to do this safely. In some cases there was also information on how the person should not be transferred.

Where people had health conditions such as diabetes or dementia, risk assessments detailed how these conditions affected the person and what measures were in place to manage these. There was information for care workers on warning signs that staff should look out, such as signs of low blood sugar and what they should do in that situation. Risk assessments highlighted where people may be at risk of urinary tract infections, including signs of these. Where a person was at risk of seizures, there were plans in place for how to reduce the risk and how to respond to a seizure taking place.

We reviewed six staff files which included all of the pre-employment checks carried out by the service. In all of the staff files reviewed, there were copies of application forms which had information about people's employment history including a record of a full employment history or a record of when gaps in employment had been discussed. Records of interviews were also kept which demonstrated the decision making process that managers followed to determine if someone was suitable for the role.

The service had carried out appropriate disclosure and barring service checks (DBS) for each member of staff prior to them starting work at the service. The DBS provides information on people's backgrounds, including convictions, to help providers make safer recruitment decisions. Candidates were given the opportunity to disclose any convictions as part of the application process prior to the DBS checks being applied for.

The service requested references for all new employees prior to them starting work with the service. It was the company policy to attempt to obtain two references however where this was not possible, a letter was inserted into the staff member's file stating that attempts had been made to obtain a second reference but in order to prevent delays in the new member of staff starting they were prepared to accept only one reference. In three of the files viewed there was only one reference and none of the references which had been received came from health and social care organisations which the applicants were either working at, at the time of application or had previously worked for. This meant that the provider did not obtain satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health or social care, or children or vulnerable adults, and also did not obtain satisfactory verification of the reason why the applicant's employment in that position ended.

For one of the three care workers, the provider supplied additional evidence to suggest that they had attempted to contact one of the applicant's most recent employers which was a health and social care organisation however they had been unable to obtain a reference from them. The person had worked for other health and social care organisations however none of these had been contacted. For another member of staff subsequent information was provided that they had attempted to obtain references from two prior employers, one of which was a health and social care organisation however, had not received a response and therefore sought a personal reference instead. For the third person, there was an attempt to contact a previous employer however the person's most recent employer, which was a health and social care organisation had not been contacted and only one reference from a non health and social care organisation was provided.

This constituted a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

For all of the staff files, there was appropriate proof of right to work in the UK which included copies of documentation such as passports. The service asked new employees for documents which proved their identity, address and national insurance numbers. All files contained copies of the documents provided.

Each staff file contained a copy of the member of staff's contract which had been signed by both the employee and employer. Staff spoken with told us that they thought the service carried out a thorough recruitment process and kept in contact with them to let them know when they could start and arrange training. Within the nursing service, the provider had carried out suitable pre-employment checks, including checking references and ensuring that nurses had up to date personal identification numbers (PINs) with the Nursing and Midwifery Council (NMC).

We spoke with people who lived in the extra care services about the use of pull cords, which were in place in all five services. The majority of people we spoke with told us that care workers arrived promptly when they called for them. Comments included, "They come when I pull it", "They came up pretty quick", and "It was taking 30 minutes for them to come, since I complained it got better." In four of the five services this was a handset based system, with a single member of staff designated to carrying the handset and answering calls; at Lew Evans House the provider had arranged for three staff to carry handsets at all times in order to improve responses. At Tayo Situ House, the emergency call system was not handset based and required a single member of staff to monitor this at the reception desk at all times. We saw that this was a specific role that a staff member was allocated to, and this was monitored throughout our visit. However, the provider told us that the system was not suitable for an extra care setting as it lacked a backup, meaning that calls could potentially be missed, and were working with the local authority to replace this.

As part of the emergency call system in extra care services, some people had pendant alarms which they

wore to alert care workers in the event of accident or illness. One family member told us they had concerns that although their relative's pendant should be switched over at a particular time, this was not routinely being recorded. We pointed this out to the provider who implemented a checklist for care workers to complete on these visits. However, we found another three cases where people's risk management plans and visit plans required staff to ensure that the person was wearing their pendant but this was not routinely recorded by staff. Another relative told us their family member was sometimes not supported to wear their pendant.

We recommend the provider review systems for ensuring that people are wearing their pendants to address particular risks to people's health and safety.

The vast majority of people we spoke with told us that they felt safe when their care workers visited. Comments included, "Yes I do feel safe and by and large the carers are excellent" and "Yes I have complete trust in my carers so far." A small number of comments were less positive, for example one relative told us, "On the whole I think my [family member] is safe but at holiday times she never knows who is coming and she gets very frightened if she has strangers."

Most staff spoken with said they thought that the people they supported were safe. Since our last inspection between 21 and 24 February 2017 there had been 33 safeguarding concerns relating to the service. Of these, 16 related to late or missed calls, of which 14 had been substantiated. Three allegations related to financial or material abuse, of which one had been substantiated and resulted in criminal prosecution of a care worker. Nine related to neglect or inappropriate care, one of these had been substantiated and appropriate action taken to address this. Five related to physical or emotional abuse, one had been substantiated but this did not relate to the conduct of a staff member and one was still being investigated.

Where allegations of abuse had been made, we found that the provider had taken action to address these, including notifying the local authority and carrying out an investigation, and where necessary further action had been taken against staff members. The provider maintained an electronic system for monitoring incidents and accidents, which included records of subsequent actions and investigations in response to concerns. The branch manager told us, "I always look out for these things".

Where people were supported with their finances, there were arrangements in place for recording these transactions. Within the extra care schemes we saw that there were measures to ensure that money was stored securely and that staff, and where possible, the person had signed logs of transactions. There were regular audits of these carried out by a manager.

Staffing levels in the extra care settings were adequate to meet people's needs, with staff roles arranged on a rounds system to ensure that people knew exactly who they would be supporting based on their allocated roles. At Tayo Situ House there had been concerns relating to staffing levels at weekends when some staff had been unavailable, however the provider had recruited additional care workers from other locations in order to address this. This showed that the provider had learned and made improvements when concerns had been raised about the safety of the service.

Requires Improvement

Is the service effective?

Our findings

The provider had policies and procedures which correctly outline the provider's responsibilities in line with the Mental Capacity Act 2005 (MCA). The Act 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.

However, people's rights may not have been protected as the provider's care plans were not designed in a way which met the requirements of the MCA. For example, The provider had a 'Best Interests Plan' which asked whether the person had been diagnosed with dementia, had difficulties with short or long term memory or required another person to make best interests decisions on their behalf. This meant that the provider was not routinely meeting its requirements to assess whether people were able to make specific decisions for themselves. For example, one person's plan stated that their 'memory is poor and unable to make decisions', but it was not clear if this was for all decisions such as day to day ones. For another person, we saw that their partner had been interviewed for a quality review as the person had 'physical disabilities and mild impairment', but there was no evidence that the person was involved in the process, even though their consent form stated they had capacity.

The majority of people had signed consent forms with no concerns about whether they were able to do so. However, for one person, we saw that their consent form had recorded that they were unable to sign due to tiredness. This was recorded in May 2017 but there had been no follow up to this to ensure that they had consented to their care plan. One person's relative had signed a statement to say they were authorised to consent to the plan 'in accordance with the person's best interests' but there was no evidence that they had the legal authority to do so.

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

The provider told us they would arrange training for field care supervisors on documenting consent, and would discuss with their head of risk the limitations to their framework for assessing capacity. Staff we spoke with were able to give some good examples around giving people choices and asking first, such as asking people what they wanted to wear each day or giving them a choice of drink.

People told us that the provider understood their needs. One person said, "The [care workers] fully understand my [family member's] needs." An assessment of needs was carried out as part of the care planning process. This included asking screening questions in areas such as nutrition, continence, medicines, skin integrity, washing and dressing, and identifying whether support was required in areas such as finances, sleeping and breathing. These were used to compile a visit summary and care outcomes for the person. There was also a clinical checklist, which was completed in a way to identify people's needs in areas such as their mobility, continence, behavioural and psychological needs and skin integrity. We found that

files had been audited in a way which ensured that people's health needs were identified, and that these were appropriately assessed, and we saw evidence of unassessed needs being identified by managers and acted on appropriately.

Care workers received an induction when they joined the service. The branch manager told us, "We sit with them first and explain what the job is, and we put them with another care worker to shadow." This included a full corporate induction where they were given information around company policies and given the opportunity to ask any questions. Staff also completed a booklet which contained the information they were required to know in order to be able to carry out their roles. The booklets were signed off by managers as part of the induction process to confirm staff had the knowledge and skills required.

New staff attended an induction at the head office where training sessions covered; introducing health and social care, role of the worker, duty of care, personal development, the principles of care, handling information, working securely, lone working, person centred support, information security, professional boundaries, management of medicines, MCA and Deprivation of Liberty Safeguards (DoLS), early warning systems, prevent, whistleblowing, the principles of emergency aid, moving and assisting, pressure area care and healthcare tasks. All training was delivered by the in house trainer and covered the training determined as mandatory by the provider. Care workers also undertook e-learning relating to health and safety, safeguarding adults, fire safety, fluids and nutrition. Care workers were also given the opportunity to shadow other staff before they were allowed to work alone. All staff were up to date with the required mandatory training and there was a system in place for arranging for staff to attend refresher training at head office when they needed to. A care worker told us, "If any of our training has run out we can't be on the system." There was evidence that supervisors were checking that care workers were not carrying out tasks that they were not trained for. For example, the provider had been asked to arrange to support a person with drawing up insulin, and had requested training from the district nursing service for this. However, at a routine check a supervisor had noted that some care workers had been doing this at the family's request, and had told staff to stop this before they received the training.

Care workers received a series of supervisions when they first started at the service to offer support and allow for staff to identify if there were any areas where they felt they needed additional training or guidance. These included; completion of a first shift pre-start form followed by a first shift review form telephone call, then four week monitoring, eight week monitoring and then six monthly reviews.

Care coaching also formed part of staff training and supervision. Each member of staff received a care coaching passport which covered supporting a customer to eat and drink, supporting mobility and movement, supporting washing and dressing, support with toileting, support with medicines, communication, reducing pain and discomfort, and general company standards. These were signed off by another member of staff who was assigned to do the care coaching and any issues or further training requirements were able to be recorded in the passports.

Care workers received a six monthly review and an appraisal each year which included comments from both the staff member and the manager. Appraisals covered what was going well for staff and allowed them to address any areas for improvement.

Care workers also had field supervisions. Field supervision forms completed covered company procedures such as wearing name badges, uniform and ensuring their safety and security. They also covered whether the care plan and medicines administration recording (MAR) chart were checked at the beginning of the visit and that they were signed before leaving. The second section was observations about the delivery of care which included communication, infection control, use of equipment, supporting nutrition and hydration,

personal care, medicines and any other comments. The third section was around promoting dignity and customer welfare which included asking the care worker to talk about how they supported the person, the person's care plan and how they ensured the person was protected from abuse. Staff said that they did have supervision a couple of times a year however they felt that they would like it more often as they sometimes felt a little isolated. Care workers said that on the whole they felt that when they did have supervision it was meaningful and they were able to speak openly. The provider told us they would consider increasing the frequency of staff supervisions.

There was also a log book audit form completed as part of the spot check process to ensure that records were accurate and legible. Care workers said that they were given a lot of training when they started working at the service. Within the nursing bureau, records showed that the staff's knowledge and skills were appropriate to the care the children required. All the care plans showed the skills required to deliver the care. The agency clinical lead provided most of the nurses' training. The records showed that the clinical lead had regular individual supervisions with the staff and also group supervision with the nurses caring for the children. They were minuted and circulated to all the nurses.

There was evidence that the provider had measures to ensure good working with other agencies. Plans were clear about what the care workers responsibilities were and what was done by other workers such as district nurses. There was correspondence with district nurses where concerns relating to wound management and diabetes had been identified, and the provider told us that within the extra care services they were able to refer people directly to district nursing teams without going through the person's GP service.

Correspondence on files showed when assessments and reviews had identified health concerns that needed to be referred to the GP. We saw letters to GPs on two people's files where supervisors had identified concerns relating to a person's memory and risk of falls. Care workers also completed Early Warning Signs (EWS) forms where they had concerns that a person's health was deteriorating, and recorded that a GP visit or appointment had been arranged in response. People we spoke with told us that care workers arranged suitable support when they were unwell. Comments included, "This Sunday I wasn't feeling too good, and [my care worker] noticed right away and asked if I needed a doctor" and "If you're not well you see the manager here and they arrange for you to see the doctor."

Each person had a personalised nutritional care plan in place and staff recorded the support people received with meals, including what the person had eaten. These were clear about people's responsibilities, such as what staff were required to do and what support was provided by others such as family members. Plans included information on special measures such as a soft diet. Information included whether a swallowing difficulty had been highlighted, the need to cut food into pieces and details such as when a person was unable to raise their hand and how this affected their eating and drinking. There was detailed information on people's likes and preferences, such as what choices people would like to be offered for breakfast and how they liked their drinks to be served. Care workers routinely recorded what a person had had to eat and drink.

Good

Is the service caring?

Our findings

The majority of people we spoke with told us that they felt staff treated them kindly, but some people raised concerns about the consistency of staff.

Comments from people who used the service included, "They're good boys and girls, they're looking after me very well which I appreciate", "They're looking after me, definitely" and "They're very nice, I don't have any complaints about the staff." A relative told us "You can hear them greet mum even if they don't know I'm here." People told us that they were able to speak with staff and enjoyed their company. Comments from people included, "They always ask how I am and greet me", "I have a good natter with my carers about football, cricket, music and other interests. We also have a laugh and a joke. They tell me they like coming to me as I can converse with them" and "I have a good rapport with my carers; I can talk to them and have a laugh and a joke with them and if I am worried about anything I can tell them."

However, some people told us that they did not always receive consistent care. One relative told us, "They chop and change carers even though they were regulars, so when Mum and Dad have formed a bond with them it's stopped" and "We have quite a few carers so the whole thing lacks consistency. Staff turnover is an issue and it means there's no chance of having any sort of rapport." In the nursing service records showed there was continuity of care. Only the five staff identified and trained provided care to the children. For one child, they had three care assistants and for a second child they had two nurses. There were contingency measures in place to provide care for the child. For example there was another agency that was involved in giving care to one child. The relative was always involved well in advance of any changes.

Staff we spoke with talked about people as individuals and gave examples of how each person was supported slightly differently. For example, people had their own routines and were able to tell staff in which order they wanted things done such as when they had personal care. Comments from staff included, "It challenges you as a person, you get to know people really well and want to do your best for them" and "I treat the people I support in the same way I would like my family to be looked after."

We made observations of the lunch clubs which took place every day at the five extra care services. We observed caring interactions, with staff asking permission to support people, encouraging people to eat and making sure they were happy with their meals. People were referred to by name and we saw a number of positive interactions. For example, at Tayo Situ House we observed the staff team encouraging people to eat, and then playing music and encouraging people to dance and clap along if they chose to do so. At Lingham Court, we observed a high number of staff supporting people, however some people we spoke with told us this was not usually the case. One visitor to the service told us, "If you listen to the tone of voice [staff] use with residents, I don't find it gratifying."

People had communication plans in place in order to support staff to communicate with them and obtain their views. These included detailed information on the support people required to communicate. Some highlighted the need for care workers to ensure that people had their glasses or hearing aids in place at the start of the visit. There was a high level in detail in these plans, for example one person's plan stated 'Speak

to me and face me, turn to my left ear as my right ear is damaged' and another person's plan included that the person lip read as they were deaf, and instructed staff to write down information if the person was confused about what they were saying. For one person, we noted that an initial assessment had highlighted that the provider needed to liaise with the family of a person who did not speak English, but the provider was able to provide a care worker who spoke the person's language. Some care plans also highlighted food which was not to be served due to the person's religious beliefs.

For all people who received personal care, there was information on how best to provide this in a way which met their individual needs and wishes and respected their privacy. This included the use of specific toiletries and products, and important details such as what people could do for themselves and what staff could support them with to maintain their independence. Where people had two flannels, whereby one was used for their face and one was used for the lower half of their body, this was highlighted in plans including what colour flannel was to be used where.

Out of the 25 people we asked in the domiciliary care service, 21 people told us they were treated with dignity and respect. Comments included, "They always knock on the door before coming in and they protect my modesty during strip washing. They listen to me and do what I want", "They absolutely do, they always cover my private parts when washing me and absolutely protect my dignity" and ""I like to wash myself so they enable me to do that."

Good

Is the service responsive?

Our findings

People we spoke with told us that the service was usually responsive to their needs. One person said, "They put themselves out to help" and a relative said "The [care workers] arrived whilst my [family member] was on the floor. They immediately phoned the office and stayed whilst the ambulance came. They really gave us extra support."

Care plans contained information on people's hobbies and religious beliefs and were frequently highly personalised. There was extensive information on what support care workers were required to provide, and information on what other people such as relatives provided. Care outcomes were described, with information on what was important to the person, including the need to maintain their independence. There were personalised plans in place which covered a diverse range of needs, including personal care, continence and sleeping. Continence plans included whether people used pads and had useful information relating to whether people used incontinence pads and how they used the toilet or commode. People's plans had all been reviewed in the past six months, and there was a noticeable improvement in the level of detail which had been introduced since the last inspection.

This information was used to compile a detailed plan which was in place for each visit. These were clear about the order tasks were to be done in, for example whether people preferred to have a hot drink before having a shower, whether people preferred baths or showers and the days that particular tasks were due to take place. We saw one plan which included information about the level of prompting a person required, and even included that the person liked to have the crust cut off of their bread. For three people's plans, we observed that there was a great amount of detail about how to support the person, but the visit summary lacked information on what exactly was to be done on each visit.

There was some variation in the quality of care plans at the extra care services. For example, at Tayo Situ these were very detailed, but at Lime Tree House these were less so, but did include exactly what needed to be done on each visit. At Charleston House, Lingham Court and Lime Tree House we found situations whereby a person's needs had changed and they were now receiving additional visits in order to fully meet their needs, but care plans had not yet been updated to reflect these. Similarly, there were two care plans within the domiciliary care service where planned times had been changed, but the plan had not been updated to reflect this. The provider told us that most, but not all care plans had been fully updated at the time of our inspection.

Staff were able to give examples where they had requested people's care plans to be reviewed as they thought that their needs had changed however a couple of staff said that when they did this, they did not feel that management always listened or acted upon it as quickly as they could have done.

There were examples of the provider arranging activities at the extra care services. For example, at Tayo Situ House the activities included nail polishing and afternoon bingo, and at Lime Tree Court there was a singing group. There were daily lunch clubs taking place in all five services and some services had access to a visiting hairdresser.

Within the nursing service, care plans were written by the clinical lead and were detailed. They were person centred and had input from the guardian and the children. The care plans showed who was responsible doing what, where and at what time. All risks were assessed and this included clinical risk assessment, equipment risk, environmental risk and risk to staff when they travelled alone at night. Care plans were put in place to manage these risks effectively and were supported by guidance and illustrated by pictures. Records showed that staff recorded all the care in the log book. They were evaluated monthly and at eight and 12 weekly intervals with the involvement of the guardians. All the evaluations had comments and were signed by the guardians. All the comments were positive. There was not a single negative impact recorded on the staff's interventions. There was also a checklist for staff to help them ensure that they had carried out all the checks and care in an orderly manner.

The provider maintained a system for recording and monitoring complaints. There was evidence that complaints had been recorded and that appropriate actions had been taken such as speaking with staff or adjusting rotas. There was also evidence of the provider responding to concerns raised in reviews. For example, one person had complained about the low continuity of staff, and the provider addressed this by arranging for the person to meet with new care workers so that they could see if the person was suitable, and to arrange shadowing for new care workers. Daily logs for this person showed that this was taking place and in a subsequent review the person had said they were satisfied. Some people had highlighted that visit times had taken place at times that did not suit them, and the provider had taken action to address this, although we saw one situation where a person had complained that visits were earlier than their preferred time, there were still some occasions where this was happening.

However, some people we spoke with were unhappy about the ways the provider had addressed complaints. One relative we spoke with said that they had asked for specific care workers to work with their family member, but other care workers were still being scheduled. Comments included, "They don't read the care plan, it's very clear what needs to be done", "I've had meetings and emails and nothing has changed" and "You have to phone constantly and do all the chasing as they never ring back. This means that things are either not resolved or take a long time to be resolved."

Staff said that if anyone wanted to raise a concern then they referred them to the office or their manager. They said that they asked people at each visit if they were happy and if there was anything else they needed to encourage them to raise any issues as soon as possible.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection there had been a number of changes in how the service was managed. There was a new branch manager and teams had been restructured in line with the boroughs in which care was delivered.

However, we found in practice that the provider was not working in line with their registration. This was because the registered location was the branch office, and although documentation relating to the extra care services was kept at the branch office, in practice, all five services operated their own rotas, and the process for allocating staff to support people was carried out at the service. This was done effectively, with a robust system of staff roles which meant that each care worker would know who to support and when. However, it meant that the regulated activity of personal care was not managed from the branch office. The provider was required to submit a statement of purpose, which included a list of locations at which the services provided for the purposes of the regulated activity are carried on. As these services were not registered, they were not included in the provider's statement of purpose. It also meant that the Care Quality Commission was not able to provide individual inspection reports or ratings for these five services independently of the domiciliary care service.

This constituted a breach of regulation 12 of the Care Quality Commission (Registration) Regulations 2009.

Following our inspection the provider told us that they would be applying to register the five extra care services separately in order to comply with this regulation. We also found that the effect of this was that some crucial information was not held at the location where care took place. This included audits of medicines and finances and some team meeting minutes. At Charleston House we found that care plans and risk assessments were not kept on the premises at all, including in people's flats. Staff we spoke with erroneously told us that this was either to comply with the provider's registration or the Data Protection Act. Staff showed us that they were working from the care plan provided by the local authority, rather than the provider's care plan, even though in some cases these were two years old. Staff were well informed about people's needs and how to support them, but told us that they would need to obtain a care plan or risk assessment from the office if they needed it. People who used the service at Charleston House did not hold copies of their plans and in some cases were unaware of the contents. The provider agreed that the documents should be held at Charleston House and told us they would take action in order to address this.

We also noted that the branch manager had applied to be the registered person responsible for meeting regulations at all five extra care services in addition to the domiciliary care service, but did not have oversight or line management responsibilities for all these services. The provider submitted notifications of significant events, including allegations of abuse against members of staff in a timely fashion and was displaying their registration and ratings at their registered location.

Following our last inspection, the provider had voluntarily sent us a weekly update on how they were meeting their action plan. The branch manager said, "We've spent a long time on this action plan." As part of this, files were checked and signed off by a senior member of staff. We saw examples of where these checks

had highlighted issues with the risk management plans and had addressed these. The action plan also addressed how risks and medicines were managed, and there had been clear improvements in these areas within the domiciliary care service.

The provider had a process in place for addressing poor performance of staff. A number of staff had been identified as not using one of the providers systems appropriately and as a result, the staff involved had been asked to attend disciplinary hearings to discuss the reason that they had not been following company processes. Staff were given the opportunity to explain why they had not followed the processes and account for their actions. Staff were informed that as part of this process they may be given a formal warning and steps were identified for staff to follow to ensure that they followed company policies in future.

We also saw that if staff did not adhere to requests such as attending team meetings, this was discussed in supervision sessions to ensure that they understood the requirement to attend and prevent disciplinary action in future.

Across the branch, there was a high level audit carried out in order to check the dates that people's care plans had been updated, log books and medicines checks and checks of equipment. There was also a framework for checking that care workers had received timely spot checks, supervisions, appraisal, up to date training and attended team meetings. These were scored on a red, amber, green rating system, and at the time of our inspection no records were scored red and 0.19% were scored amber. The branch manager told us, "We were on 37% three months ago." Supervisors carried out either care quality reviews or telephone monitoring; these included checking whether people were happy with the punctuality and conduct of care workers, and whether people were satisfied with the care they received.

We found that audits were not always effective in ensuring that accurate records were maintained. The provider told us it was their policy that medicines records and logs of care were checked every six months, and that only five pages were checked as part of this, although managers told us this was not always enough. There were occasions where medicines records were audited more often than this. We found instances on logs where visits were not recorded, for example one audit had pointed out that only one worker had signed for a double handed call, but had not detected that some visits had not been recorded at all. The provider told us that missed visits would be detected by the call monitoring system, which was supported by our checks of this system, but a complete record of care had not been maintained. Another audit had said that there were no issues with a log book, but that care workers had consistently failed to record a midday visit for seven consecutive days. These visits were cancelled in the agency's system but there was no evidence that this had been explored by the auditor. In some cases we found that medicines charts in the extra care services were recorded with respect to a single care worker on a single day, this meant that there were no problems reported, even though other days on the chart had not been signed for by other care workers, although the provider told us that missed medicines would be detected as these were provided in dosset boxes.

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

The provider told us that in future they would audit care logs and medicines records on a monthly basis.

Systems of checks varied across the extra care services. For example, at Tayo Situ House spot checks were carried out regarding each person on a daily basis, including checking the quality of cleaning, visit logs, tasks completed and whether any actions were needed. This had been introduced in response to concerns about the quality of care, but there were not comparable systems elsewhere. A staff member told us, "I feel

like after each shift managers should be checking up." Within the night owl service we observed the manager reviewing logs at the time of our visit and they were contacting staff with any concerns. A staff member told us, "My manager reads the notes and contacts me to say 'why did you write that?'"

We found that within the extra care services there were systems in place to engage with people who used the service. For example, at Tayo Situ House there had been recent family and friends meetings to discuss concerns, particularly relating to the quality of the building, staffing levels and team work. At Lew Evans House the housing officer with the local authority told us they were responsible for tenants meetings, but arranged this in partnership with the provider. Team meetings took place amongst the staff at each of these locations, and were used to discuss issues relating to the service, including team work and individual people's needs. Handovers took place on a daily basis and were recorded in communication books.

We received mixed responses regarding communication with the office. For example, some people said to us, "It is easy to get through to the office and they do resolve my issues to my satisfaction" and "It is easy to get through and I feel they do listen to me." However, some other comments included, "It is easy to get through but they forget to ring you back as promised" and "You don't get appropriate follow ups as promised." One person told us, "There is not just one person you can deal with, they keep passing you around from one person to another."

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The provider did not give the Commission a statement of purpose containing a list of the locations at which the services provided for the purposes of the regulated activity are carried on or, where appropriate, revise the statement of purpose 12(1)(2)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure that care was provided with the consent of the relevant person as 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 did not operate systems effectively to improve the quality and safety of the services provided in the carrying on of the regulated activity or maintain securely a

accurate, complete and contemporaneous record in respect of each service user 17(1)(2)(a)(c)