Senacare Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an announced inspection of Senacare Limited on 24th and 25th April 2017. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

Senacare Limited is a domiciliary care agency that provides personal care to around 45 people in their own homes in the London Borough of Harrow. The majority of care packages are paid for by the London Borough of Harrow with two people directly funding their own care.

This was the first inspection of the service since it registered with the Care Quality Commission in August 2016.

At the time of the inspection there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had a recruitment process in place but this was not always followed therefore not providing appropriate information regarding applicants to ensure they were suitable for the role.

The provider had a policy in place in relation to the administration of medicines but at the time of the inspections Medicine Administration Record (MAR) charts were not used and care workers were not provided with appropriate information.

Risk assessments were not in place to ensure specific issues related to each person were identified and guidance provided as to how to reduce any possible associated risks.

The provider had a policy in relation to the Mental Capacity Act 2005 but was not always working within the principles of the Act.

Training and supervision for care workers was in place but some care workers had completed their induction training a number of months before starting work.

Visits did not always happen at the time recorded on the care plan and the rota.

The care plans did not identify a person's cultural and religious needs and some care plans did not provide any information about the personal history of the person receiving support.

Care plans were not written in a way that identified each person's wishes as to how they wanted their care provided. Daily records were focused on the tasks completed and not the person receiving the support.

Records relating to care and people using the service did not provide an accurate and complete picture of their support needs.

Regular audits had not been carried out to identify aspects of the service requiring improvement and action had not always been taken to address issues.

People told us they felt safe when they received care in their own home.

People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care.

People told us they were happy with the care they received in their home.

The provider had a complaints process in place and people knew how to raise any concerns. People could also provide feedback on the quality of the care they received during the spot check visits on the care workers.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to person-centred care (Regulation 9), the safe care and treatment of people using the service (Regulation 12), safeguarding service users from abuse and improper treatment (Regulation 13), the good governance of the service (Regulation 17), staffing (Regulation 18) and fit and proper persons employed (Regulation 19). You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider had a recruitment process in place but this was not always followed therefore not providing appropriate information regarding applicants to ensure they were suitable for the role.

The provider had a policy in place in relation to the administration of medicines but at the time of the inspections Medicine Administration Record (MAR) charts were not used and care workers were not provided with appropriate information.

Risk assessments were not in place to ensure specific issues related to each person were identified and guidance provided as to how to reduce any possible associated risks.

People told us they felt safe when they received care in their own home. The provider had processes in place to respond to any reported safeguarding concerns as well as incident and accidents.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had a policy in relation to the Mental Capacity Act 2005 but was not always working within the principles of the Act.

Training and supervision for care workers was in place but some care workers had completed their induction training a number of months before starting work.

Visits did not always happen at the time recorded on the care plan and the rota.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring..

The care plans did not identify a person's cultural and religious needs and some care plans did not provide any information about the personal history of the person receiving support.

People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care.

People told us they were happy with the care they received in their home.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Care plans were still not written in a way that identified each person's wishes as to how they wanted their care provided. Daily records were focused on the tasks completed and not the person receiving the support.

The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

Is the service well-led?

Inadequate

The service was not well-led.

Records relating to care and people using the service did not provide an accurate and complete picture of their support needs.

Regular audits had not been carried out to identify aspects of the service requiring improvement and action had not always been taken to address issues.

Senacare Ltd

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 the 24th and 25th April 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

One inspector undertook the inspection and an expert-by-experience carried out telephone interviews of people who used the service and relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service. The expert-by-experience at this inspection had personal experience of caring for older people.

Before the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

During the inspection we spoke with the provider who is also the registered manager. We reviewed the care records for seven people using the service, the employment folders for five care workers, the training records for 16 care workers and records relating to the management of the service. We also undertook phone calls with four people who used the service and 10 relatives. We sent emails for feedback to 16 care workers on two occasions and received comments from one care worker.

Inadequate

Is the service safe?

Our findings

The provider had a recruitment process in place but we found this was not always followed and it did not provide appropriate information regarding applicants to ensure they were suitable for the role. The registered manager explained when a new applicant contacted them they would ask the person to complete an application form and provide the contact details for up to three people to provide a reference. They would also complete a numeracy and literacy competency test as part of the interview. A Disclosure and Barring Service (DBS) check to see if the new care worker had a criminal record was carried out following the interview. During the inspection we looked at the recruitment records for five care workers. We saw the records for one care worker indicated that the professional reference had not been obtained from the most recent employer and the second reference had been provided by someone who had only known the applicant for one month. We looked at the employment records for another care worker and saw they had provided the contact details for three people who could provide references but only one had been obtained before they started their employment. The records for another care worker showed that one of their references had been provided in relation to where they were employed more than 10 years previously even though there were more recent employers who could have been contacted. The application form for another care worker did not include any dates in relation to their previous employment.

This meant that the provider could not ensure that care workers had the appropriate knowledge and skills to provide safe and suitable care as suitable references had not been obtained.

The above paragraph demonstrates a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had a policy in relation to the administration of medicines but at the time of the inspection Medicine Administration Record (MAR) charts were not being used to record when medicines were administered by a care worker. The registered manager explained that the local authority had carried out an audit of the service two weeks prior to our inspection and they identified that MAR charts were not being used. The local authority confirmed this audit was carried out during the first week of March 2017. The registered manager told us when care workers administered medicines they recorded this in the daily records of care they completed for each visit. We saw some of the information provided for the care workers did not include the details of the medicines, dosages and the frequency for administration. Where the medicines were listed there was no information on the frequency they should be administered. In addition there was no record of any restrictions or requirements when the medicines were administered for example any specific gaps between dosages or if the medicines should not be given with fruit juice. We saw the records for one person indicated they had been prescribed Warfarin and the information for care workers advised them to prompt the person to take their medicine if their relative was out. There was no mention of the Warfarin and the possible risks in case the relative had already given them the dose for that day as this would not be recorded.

Care workers had completed training as part of their induction in relation to medicines management. The registered manager explained they had developed a MAR chart which had been approved by the local

authority. The registered manager confirmed they were planning to introduce the new MAR chart during May 2017 and training all the care workers on how to complete it.

During the inspection we looked at the care records for one person which indicated the person's relative took the prescribed medicines from their original packaging and placed them in a dossett box. The care worker would then remove the medicines from the dossett box to administer them. The care worker should not administer medicines from a dossett box unless it was filled by a pharmacist as there would be no checks in place to ensure the correct dosage was being administered. We raised this with the registered manager who agreed to contact the relative to clarify the way the medicines should be administered.

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

The provider did not have risk assessments in place to ensure specific issues related to each person were identified and guidance provided as to how to reduce any possible associated risks when providing care. The provider had a risk assessment document which identified the risks in relation to care workers providing care but did not identify any specific risk for the person receiving care. For example, the risk assessment form identified if the care worker was at risk of injuring their back when moving the person but did not reflect any possible risks to the person when being moved.

Risk assessments were not in place in relation to skin integrity, nutrition, continence care, administration of medicines and pressure ulcer management. The moving and handling risk assessment form for one person stated that they were now being cared for in bed following a fall but there were no risk assessments in place relating to falls, skin integrity and incontinence to reduce the risk of pressure ulcers from developing.

As risk assessments had not been completed in relation to specific issues identified for each person the care workers had not been provided with guidance on how to reduce these risks.

We saw the records for one person included an occupational therapy assessment which indicated the person required a new hoist and sling to ensure they were moved with appropriate equipment. There was a report from the Occupational Therapist eight days later confirming the new equipment had been delivered and providing guidance for how it should be used specifically relating to the person's legs that could bleed if knocked whilst the person is in the hoist and bruising. The registered manager stated that care workers had been trained or observed using the new equipment to ensure they were complying with the guidance provided by the Occupational Therapist but there was no record that this observation had occurred. The moving and handling risk assessment had not been updated to reflect the changes in the person's support needs or the guidance provided with the new equipment.

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

People we spoke with said that they felt safe when they received support from the care workers and they had no concerns about their safety. Relatives told us "Yes, so far no harm and we feel safe", "Yes my family member feels happy and safe" and "Yes the care that they provide is excellent, in comparison to other companies."

We saw the service had policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. During the inspection we looked at the records for the two safeguarding concerns that had been raised and we saw these records included the records of the investigation, copies of

correspondence and the outcome.

We looked at how accidents and incidents were managed in the service. The registered manager told us a form was completed when an incident and accident occurred which included the details of the event, what action was taken at the time and any subsequent outcomes. We looked at the records for two incidents and accidents which were detailed.

The registered manager confirmed the number of care workers assigned to a visit was based on the information received from the local authority in the initial referral and when they visited the person's home to complete the risk assessment document.

The provider had appropriate processes in place in relation to infection control. The care workers were provided with appropriate equipment including aprons, shoe covers and gloves to use when providing support. The registered manager confirmed the care workers regularly used the equipment provided but there had been issues in relation to the use of shoe covers which he was addressing with the care workers when necessary.

Requires Improvement

Is the service effective?

Our findings

The provider did not have a process in place to assess the capacity of people using the service to make decisions in relation to their care and to meet the requirements of the Mental Capacity Act 2005.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The registered manager explained that if the referral stated the person lacked mental capacity to make decisions they would contact the person's relatives to be involved with any decisions. We saw that if a person had been identified as lacking mental capacity to make decisions as part of the local authority referral no action was taken to ensure the person's rights were protected. The provider did not have a system in place to assess the capacity of the person to make decisions in relation to specific aspects of their care.

We saw checks were not carried out to identify if a Lasting Power of Attorney (LPOA) was in place for a person which would name who could make decisions on their behalf. A Lasting Power of Attorney in health and care matters legally enables a relative or representative to make decisions in the person's best interest as well as sign documents such as the support plan on the person's behalf.

The registered manager informed us that following the audit in March 2017 carried out by the local authority they had been told to introduce a system to assess the mental capacity of a person to make decisions related to their care but, at the time of our inspection, they had not started to develop this process.

The above paragraphs demonstrate a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service were asked if the care workers usually arrived on time and we received mixed comments including "Yes very punctual, they have never been late", "No not always. To arrive on time would be impossible. Sometimes I get a call to say they'll be late. 5 –10 mins here or there is not a problem" and "Mostly. Most times they call." We also asked relatives if they felt care workers usually arrived on time and we also received a range of comments. These included "No they are sometimes late and they don't call to say so", "Mostly Yes. If they are 15 mins late they will not call. Once they were over 15 mins late and I had to call them twice, but it was only once", "Mornings no afternoons yes. They never call, supposed to be here at 9.00 and they come at 10.30 or 11.00", "Yes. She tells me the day before if she's going to be late", "In the

beginning it was a little upside down, but now they are much better. Yes they would call to say they'll be late" and "Yes 5 or 10 mins here and there but that's not a problem with traffic now a days. They do call to say they'll be late." Other comments included "Mostly late. On occasions they call to say they'll be late", "Yes. Nothing to complain about", "They are mostly late and they don't call at all. They can be 30 or 40 mins late. I have to ring them and I can't even leave a message. It rings a few times then cuts off", "We can't guarantee a time, they usually come around 10.30am" and "Mostly late at the weekends and they don't call to say they will be late. Twice no one came at all."

We also asked people and relatives if the care workers stayed for the agreed length of time. They confirmed that in most cases they did. Their comments included "Yes. They stay until they do their job", "Most times they do but if they finish earlier they go", "Sometimes they leave early, if I am there they stay for the correct time" and "I don't think we've been told how long they are supposed to stay, but it's usually 20 to 30 minutes."

During the inspection we looked at the records for one person who was not mobile and was dependant on the care workers to use a hoist to move them. The person also had a history of developing pressure ulcers. Their preferred visit times were 9am, 2pm and 4.30pm with no preferred time recorded on the paperwork for the evening call. We saw from the log sheets that on one day the morning call was at 11.20am for one hour with the lunch visit at 1.30pm. The mid-afternoon visit was at 3.50pm with the evening call at 5pm. We saw from the records that this variation in visit times happened frequently and could result in the person having to spend up to 16 hours in their bed. This could increase their risk of developing pressure ulcers.

The registered manager told us care workers completed timesheets which indicated the planned start and end time for each care visit but did not reflect the actual time of arrival and the length of time spent on the call. The only records which indicated the actual time of arrival and departure for each care visit was recorded on the record of care completed by each care worker when they visited each person.

This meant that people with time specific requirements for their care such as medicines may not receive their care in a timely manner to meet their needs.

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

The registered manager told us new care workers completed five days of induction when they completed the Care Certificate. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to care. The new care workers also completed additional training relating to moving and handling, safeguarding, medicine administration and first aid to enhance the information obtained from the Care Certificate modules. New care workers then went on to shadow an experienced care worker for between three and five days.

The shadowing records for two care workers indicated they had only completed shadowing on two days totalling six hours. The records for another care worker showed they had shadowed an experience care worker in November 2016 but a check to see if they had a criminal record had not been completed until January 2017. Another care worker completed the care certificate three months before they started working at the service.

The records for one care worker indicated they had completed their induction training and care certificate in September 2016 but did not start to work for the service until January 2017.

This meant there was a considerable gap between the care worker completing their training and starting to provide care during which procedures or best practice may change which could result in them not providing safe and appropriate care. We spoke with the registered manager about this and he confirmed that new care workers would be starting their role sooner as they now had

We recommend the provider monitor the times between induction and starting to provide care for new care workers to ensure no excessive timescales.

The care plans and assessments we looked at did not include the contact details for each person's General Practitioner (GP). We did note information from Occupational Therapists and Physiotherapists in some of the care records.

We asked people if they felt the care workers that visited them had the appropriate training and skills to provide their care. They commented "Yes. Sometimes they have a trainee with them. Then the office will call me to ask how the trainee was" and "Yes indeed." We also asked relatives their views and we received mixed comments "So far they are doing a good job", "Some are fully trained, the weekend staff don't have the right experience but I am always there to help", "I think they do, I just think they are over loaded with work and so that's why they are held up sometimes", "Yes I think the training is there but sometimes they don't use the sliding sheet when I think they should. My family member has bad bed sores", "Yes they do know what they are doing" and "I think so my family member hasn't complained."

The registered manager explained that quarterly spot checks and supervision meetings every six months were completed. We saw records of either a spot check or supervision in the five care worker employment files we looked at. They also confirmed all care workers would complete a range of annual refresher training courses and appraisal but at the time of the inspection this had not been carried out as no one had been employed for a year.

We saw care plans indicated if the person required support from the care worker to prepare and/or eat their food.

Requires Improvement

Is the service caring?

Our findings

The majority of care plans we looked at did not identify the person's cultural and religious needs for care workers or the preferred name the person wished to be called by. There was also limited information for the care workers in relation to the personal history of each person they visited where the information was available. This was discussed with the registered manager who agreed to ensure this information was included in the care plans.

We asked people if they were happy with the care and support they received from the service. They told us they were happy with the care they received. Relatives gave us mixed comments including " Yes but my family member's very confused because he doesn't always have the same carer", "Yes my family member's happy, but he really doesn't understand", "They are ok at the moment", "Not really because of the times" and "Happy with company but not with the lateness."

People told us they felt the care workers treated them with dignity and respect when they provided care. Relatives also told us that they felt care workers treated their family member with dignity and respect with comments including "Yes. Lots of love and affection" and Yes definitely." We asked care workers how they maintained a person's privacy and dignity when providing support. One care worker told us "When providing care ensure all the appropriate respect and professionalism is maintained."

People told us they felt care workers were kind and caring when they received support. Relatives we spoke with also confirmed they felt the care workers were kind and caring with comments including "Yes, very kind and caring and they always ask if he's happy and he is" and "Yes they are all nice and caring.

People using the service were asked if they felt the care workers supported them in maintaining their independence. They confirmed the care workers did and their comments included "Yes they do" and "Well they do, but I do help them when I can." We also asked relatives if they felt the care workers supported their family member in maintaining their independence. They told us "Yes they are helping her as much as they can. They are not forcing her but if she is happy to do something they will let her try", "Yes they take him out for walks" and "He is very independent and they help him to do." The care plans did identify what the benefits of receiving support would be which included the person maintaining their independence but did not include a lot of guidance for care workers on how to do this.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not written in a way that identified each person's wishes as to how they wanted their care and support to be provided.

The individual risk management for moving and handling and care plan document were used as the main source of information for care workers when providing care. These documents provided limited specific information as to what care was required and how it should be provided. For example one person's care plan informed care workers the person should have a strip wash in bed and then be transferred using a hoist to a wheelchair. The care worker should then make the person breakfast and administer medicines. In total the guidance for care workers on how the support should be provided for this person was two sentences in length.

The registered manager told us they had also introduced a task sheet which was attached to the front of some of the individual risk management for moving and handling and care plan documents. Some of these task sheets did include very limited information regarding the care but the main parts of the document had a list of tasks to be completed. For example one person's task sheet referred to the care provided during one visit as 'Incontinence management. Turn position in bed – record it. Prompt with fluids." These documents did not provide care workers with information on how each person wanted their support provided.

The care workers also completed daily records of care and support provided for people during each visit. We saw these records were also focused on the care tasks which were completed and did not provide information relating to the person's experiences and their views during the day. This meant a complete picture of the person during the day was not recorded.

The registered manager explained the individual risk management for moving and handling and care plan document was used to assess each person's needs. Information was also obtained from the referral paperwork received from the local authority. The individual risk assessment documents focused on the person's moving and handling needs as well as any possible risks for care workers when supporting people. The documents did not include information on their wider support needs and how the person wished their care to be provided.

We asked people if they were involved in decisions regarding their care and support needs. They told us they were or family members were involved. Relatives also told us that they were involved in discussions about the care provided for their family member. During the inspection we noted that people had not signed their care plans or any reviews. This meant the provider could not demonstrate that the person was involved in planning how their care should be provided or agreeing to any changes made.

Visits were not always arranged at the time preferred by the person using the service. We saw telephone monitoring call records for one person where they had repeatedly raised a concern that they wanted their visit at 8am and not at around 10am when the visit was scheduled. The registered manager explained that when the local authority contacted them with the care package they were unable to provide care workers

for the original visit time but they were available at 10am. The registered manager confirmed this change was not discussed with the person using the service or their relatives and there was no record of them agreeing to this change in their care records. The registered manager told us if they had no care workers available at the time shown on a care package referral from the local authority, the time would be changed instead of care workers being identified for the time requested by the person who would be using the service. In addition the times indicated on the rotas and timesheets did not reflect those identified in the care plans. This meant the care visits were not always happening at the time preferred by the person using the service.

The above paragraphs demonstrate a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people using the service and relatives if the care workers did all the care tasks they were supposed to during each visit. People told us the care worker did complete the tasks with comments including "As far as I know yes" and "They do general cleaning; I don't even have to ask they just do it." Relatives told us "They do what I ask them to do", "Yes they wash her etc" and "Yes they do but what I find is that the second carer doesn't pull her weight."

The provider had a complaints policy and procedure in place. We asked people and relatives if they knew how to raise a complaint with the provider and if they had ever made a complaint. They confirmed they knew how to make a complaint or if they had concerns they would call the office. People told us "Only the one, but that was dealt with when my relative made the call" and "Never had to but if I was unhappy I would tell them." Relatives told us "Yes, I had to call regarding late arrivals and also to ask if my family member can have the same carer because it confuses my family member, he wants [Care worker name] and [Care worker name] and he's very confused so he thinks that I change the carers and he shouts at me", "Yes, but nothing has changed, it's still the same. 11 am is too late for breakfast", "I have spoken about the lateness but now it's better", "Yes, but they don't ever return calls" and "I have spoken about lateness, they said leave it with me but next day they were late again."

During the inspection we looked that the records for the two formal complaints received by the provider. We saw these records were detailed and included information identified during any investigation, any correspondence and if the complaint was resolved. Information on how to make a complaint was included in the pack provided when people started using the service. There were no records of any concerns which had been raised but not dealt with under the complaints procedure.

People using the service were able to provide feedback on the care they received. The registered manager explained that people and their relatives could provide feedback on the service when spot checks on the care workers were carried out. People were also contacted by telephone to gain feedback on the care provided. At the time of the inspection the provider had not sent a questionnaire to people using the service but the registered manager confirmed it was planned for one to be sent out during August 2017.

Inadequate

Is the service well-led?

Our findings

During the inspection we found records relating to care and people did not provide an accurate, complete and contemporaneous record for each person using the service

The care plan for one person stated that the care worker should change the dressing on a person's pressure ulcer if it became contaminated with faeces but this should be completed by a district nurse as the care workers had not been trained on how to do this correctly to prevent cross contamination.

The rotas we looked at did not always include travel time between appointments which meant that care workers would not be able to arrive at the next person's house on time or they would need to leave the previous visit early.

The individual risk management for moving and handling and care plan documents did not always provide consistent information. This included the records for one person stated the care workers should assist the person to transfer into a chair every day but further in the document it stated the person should now remain in bed. This information was added at the same time but the front page was not amended. The document for another person stated their family administered their medicines but the rest of the documents identified that the care workers should administer the person's medicines during the care visit.

We saw care plans did not provide accurate information in relation to people's needs and support. This included the records for one person had contradictory information in relation to the administration of medicines. Documents stated that they were either independent with their medicines or required prompting but the log sheets for some visits indicated the care workers had given the medicines. The care plan for another person stated they should be repositioned during each visit but there was no way of recording to which side the person had been repositioned to ensure this was carried out as directed.

We saw from care plans that some people had prescribed creams applied by care workers but this was not recorded appropriately to ensure care workers were aware of the frequency of application and where the cream should be applied.

Some of the task sheets we looked at did not include the name of the person using the service and referred to them as service user. The task sheet for one person did not indicate their name or gender so it was very difficult to identify who the paperwork related to. This meant that provider could not ensure the correct paperwork was provided for each person using the service.

The issue with the accuracy of the records meant the provider could not ensure people received the appropriate care they required.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not identified, managed and mitigated risks to people. During the inspection we identified a range of issues including the lack of specific risk assessments, management of medicines and care worker training and supervision. These had not been identified by the provider using their existing processes.

The provider did not have a robust system of audits and checks in place to review the quality of the care and support provided. We asked the registered manager if any audits were carried out to monitor the quality of the service provided. He confirmed that at the time of the inspection no formal audits were carried out and if any documents were checked it was not recorded.

The registered manager explained the timesheets completed by care workers were only used to provide information to invoice the local authority. There was no system in place to monitor if care visits started at the stated time and were for the agreed length of time. The care workers recorded the start and end time of each visit on the log sheet where they described the support they provided during the visit. The registered manager confirmed that checks were not carried out of the log sheets to review if the times recorded were accurate. This meant that the provider could not ensure the care visits were carried out at the correct time and the invoice records were accurate.

At the time of the inspection the provider did not have processes in place to review complaints, incident and accident reports and safeguarding records to identify if any trends were present.

The provider carried out telephone monitoring calls to people using the service to gain their feedback on the quality of the care provided. The comments were recorded on a form with any outcomes or actions noted but there were no comments confirming these had been completed. We saw one telephone monitoring form which indicated that the care worker required training on how to use a hoist but there was no record of this being completed. Other monitoring forms showed that people repeatedly made comments about the time of their visits but no action was indicated. The provider did not have a system in place to record when each telephone monitoring call was made to ensure each person using the service was regularly contacted.

The provider did have a system for quality monitoring visits to be carried out every six months but this had not started yet as none of the care packages had been in place for more than six months.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager explained a new care planning system was to be introduced which identified when each care plan was due for review as well as when spot checks, supervisions and appraisals were required.

We spoke with the local authority to obtain their views on if the service was well-led. They informed us they had visited the service at the start of March 2017 which resulted in a detailed action plan being developed after they identified a number of issues. Following the discussion it was noted that some of the actions identified in the action plan had not been implemented at the time of this Care Quality Commission inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

We asked the people using the service we spoke with if they felt the service was well-led. We received mixed

comments which included "Yes I do", "My carers are absolutely brilliant, But I wish I could have the same carers every time. I understand if they are on holiday", "I think so yes. I am quite happy and they are very good with me" and "I'm very happy and have nothing to complain about." We also spoke with relatives who gave us mixed feedback which included "Its ok so far", "Sometimes but the lateness is a problem that affects the rest of his day", "At the moment I am happy and they are kind people", "I am very happy with the service", "No", "I am happy and the carers are good the way they treat my family member is second to none but I am concerned about the lateness and the bedsores" and "It seems to be but I have not had that much contact with the office. Both times they didn't turn up; I was annoyed but was at home so I dealt with my family member. If I wasn't at home I probably would have made a complaint."

We also asked care workers if they felt the service was well-led. One care worker commented "The service is well led. Carers are supported, service users are contacted re feedback about the service received and the staff are able to speak freely if they have any concerns whether it be about work or the service users they are supporting in the community."

We asked care workers if they felt supported by their manager. One care worker told us, "I am able to speak to my manager about any issues or concerns I may have. There is more often than not a message sent out expressing encouragement and gratitude for all the hard work that is being given."

The registered manager explained care worker meetings were held quarterly and more than half the care workers attended. We saw the minutes of previous meetings which included discussions about pay rates, ensuring they had enough supplies of gloves, timekeeping and reading the care plan. The registered manager told us the minutes were circulated to all the care workers after each meeting.

People using the service were given a booklet which included information on the philosophy, aims and objectives of the organisation, how care was provided and the contact details of the provider.

Care workers also received a handbook which included a summary of the main policies and procedures and how care should be provided. Therefore, both people using the service and care workers were given information in relation to how the service provided care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs or reflect their preferences. Regulation 9

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users. Regulation 12 (1) The provider did not assess the risks to the health and safety of service users of receiving the care or treatment and did not do all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (a) (b) The registered person did not ensure the proper and safe management of medicines Regulation 12 (2) (g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure service users

	were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those service) Regulation 17 (2) (a) The registered person did not have a process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. Regulation 17 (2) (b) The registered person did not have a system in place to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that people employed for the purpose of carrying on a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them.

Regulation 19 (1) (b)

The enforcement action we took:

Warning notice