Eleanor Nursing and Social Care Limited

Eleanor Nursing and Social Care Ltd - Leegate Office

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an inspection of Eleanor Nursing and Social Care Ltd - Leegate Office on 5, 6, 7 and 9 November 2018. At our previous inspection on 30, 31 August and 4 September 2017 we found a breach of regulations relating to the safe care and treatment of people.

This service is a domiciliary care agency. It provides personal care for people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At the time of the inspection they were supporting approximately 520 people. Not everyone using Eleanor Nursing and Social Care receives a regulated activity. The Care Quality Commission 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.

There was a registered manager at the service. 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.

There had been concerns about the high number of safeguarding and quality alerts received since the provider's commencement of a large contract for one local authority. At the time of the inspection one local authority that commissioned the provider's services were working with them to support them to make improvements.

Risk assessments and care plans contained some information for staff, but we saw many examples of incomplete record keeping, including a lack of written risk management guidelines. Therefore, we could not be assured that people were protected from avoidable harm.

Medicines were not always accurately recorded when care workers administered them, so it was not always possible to determine what medicines people had taken and when.

The provider had appropriate safeguarding procedures in place and care staff were aware of these. Care staff had received training in safeguarding procedures and demonstrated an understanding of the signs of abuse and how they were expected to respond to this.

Care staff had a good understanding of their responsibilities under the Mental Capacity Act 2005. However, records were often unclear about whether people had capacity and records were often not signed by the person using the service or their legally authorised representative. Therefore, we could not be assured that people's rights were being protected.

Staff had a good level of knowledge about people's current circumstances and supported people to meet their needs in a caring way. However, care records contained very limited details about people's individual

needs or preferences.

People we spoke with and their relatives told us they were involved in decisions about their care and how their needs were met.

Recruitment procedures ensured that only staff who were suitable, worked within the service. There was an induction programme for new staff, which helped prepare them for their role. However, care staff did not receive regular supervisions, spot checks or appraisals of their performance. Care workers received appropriate training to help them carry out their duties.

People told us they were supported with their nutritional needs where this formed part of their package of care. However, care records contained very limited information about people's dietary needs and care workers responsibilities in relation to this.

Appropriate and thorough investigations were not always conducted into complaints and incidents that occurred during the delivery of care.

Information was not reported to the CQC as required. We found evidence of safeguarding incidents that were not reported in line with requirements. An action plan was in place which mirrored the findings in our inspection, but the service needed more time to implement this.

Care staff gave good feedback about the managers of the service and confirmed they were able to speak to them in order to raise any concerns.

During this inspection we found breaches of regulations in relation to safe care and treatment, complaints handling, staffing and submitting notifications to the CQC. You can see what action we told the provider to take at the back of the full version of the report. We are considering what further action we are going to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. Risk management guidelines were not always in place in relation to identified risks.

People's care plans and risk assessments were incomplete and sometimes contained errors.

The provider did not always operate safer recruitment procedures to help ensure that staff were suitable to work at the service. We identified two examples of candidates without references from their most recent health and social care employer.

Procedures were in place to protect people from abuse and care staff were aware of these.

Is the service effective?

Requires Improvement

The service was not always effective. The provider did not always ensure that care was delivered in line with people's valid consent. Care records did not always contain details of people's capacity and care documentation was sometimes not signed by people using the service. Care staff had a good understanding of their legal obligations to deliver care in line with people's consent.

Staff received an induction and ongoing training, but did not receive regular supervision, spot checks or appraisals of their performance.

Care records contained information about people's healthcare needs. People told us they were supported with their nutritional needs where this formed part of the package of care required. However, care records contained very little information about what these were.

Is the service caring?

Requires Improvement

The service was not consistently caring. Care records contained very limited details about people's individual needs and preferences. People we spoke with and their relatives told us they were satisfied with the level of care given by staff.

People told us their privacy and dignity was respected and care workers gave us examples of how they did this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. We saw written examples of people's complaints not being thoroughly investigated.

Care records contained some information about people's social and recreational needs.

People's needs were assessed before they began using the service and care was planned in response to these needs. However, care records contained very limited personalised detail about people's preferences in relation to how they wanted their care to be delivered.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Notifications were not submitted to the Care Quality Commission as required.

The service had an action plan in place which covered the issues we found with service delivery, but they needed more time to implement this.

Care workers gave good feedback about the management within the service and told us they felt able to raise any concerns with them.

Eleanor Nursing and Social Care Ltd - Leegate Office

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.

The inspection was prompted in part by our receipt of numerous quality alerts and some safeguarding incidents from one local authority commissioning care. The information shared with the Care Quality Commission indicated potential concerns about lateness, early departures, the provision of sufficient travel time between care calls, missed calls, medicines errors, neglect and inappropriate pressure area care as well as inappropriate moving and handling techniques being used.

The inspection took place on 5, 6, 7 and 9 November 2018. The inspection was conducted by two inspectors on each day of the inspection. The inspection was also conducted by two experts by experience who assisted us by conducting telephone interviews with people who used the service after our inspection, over the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced on the first day of our inspection, but we told the provider we would be returning on the remaining days.

Prior to the inspection we reviewed the information we held about the service which included the previous inspection report and had discussions with various staff members from local authority safeguarding teams.

We spoke with 24 people using the service and four of their relatives. We spoke with 10 care workers after our visit over the telephone. We spoke with the quality manager, the registered manager of the service, a quality assurance officer and other members of the senior management team including the provider's chief executive officer. We also spoke with two care coordinators who were responsible for the rotas. We looked at

a sample of 26 people's care records, 10 staff records and records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when with their care workers. Their comments included "Yes I feel safe. The carer is very efficient and very gentle" and "Yes I feel safe; no issues whatsoever." However, despite these positive comments, we found that the provider had not always done all that was necessary to protect people from avoidable harm.

At our previous inspection we found risk assessments were not always in place for people who smoked, those with pressure area needs, those at risk of falling and those people at risk of urinary tract infections (UTIs). At this inspection we found appropriate risk management guidelines were still not in place when these risks had been identified either by the referring local authority or by the provider. For example, we identified one person who smoked in their bed. Their risk assessment confirmed that they had been given some advice in relation to this. For example, they were told to keep a bowl of water beside their bed in order to put out their cigarettes. However, there was no specific risk assessment conducted which considered the risks associated with smoking. For example, no consideration had been given to the type of cream they used on their skin or the person's bedding to check if these were flammable and increased the risk of fire. The person had been assessed by an occupational therapist less than one month prior to the provider's assessment and they had confirmed that the person was unable to use their hands and arms functionally. However, this was not considered by the provider to determine the risk of injury to the person from smoking. We spoke with the provider's quality manager and they told us the person had been offered a visit from the Fire Service, but they had declined this. The provider was unable to provide evidence of this conversation with the person. The quality manager stated that they did not think the person was at increased risk as their home was easily accessible by the fire service in the event of a fire and they felt they were able to use their hands and arms functionally which demonstrated that they had not fully considered the risks.

We identified examples of people with pressure area needs who did not have specific pressure sore risk assessments in place. For example, we saw the care record of one person who had been discharged from hospital approximately two weeks prior to using the service, after being admitted with skin breakdown on their thigh. However, the pressure area care section of their care plan stated that they did not suffer from pressure sores and there was no mention of their skin breakdown. Another person's care record stated that they had recently developed a pressure sore and were waiting for a cushion to assist with this. However, there was no pressure ulcer risk assessment in place and no instructions for care staff in how to manage their existing pressure ulcer.

Further to this, we saw some examples of care records for people who required the use of a catheter without having appropriate directions in place for care workers in how to manage this. One care record we saw, did not contain any indication that the person used a catheter, but their daily notes, which were completed by care workers at the end of their visit, indicated that they were in fact emptying the person's catheter bag. There was no information in the records we viewed about the potential risks of urinary tract infections (UTIs) through using a catheter or any instructions about preventative measures. The provider agreed that this person's care plan required updating and agreed to do so as soon as possible.

We saw numerous examples of people identified as having a risk of falls, with no specific risk management guidelines for care staff in how to manage this. For example, we saw one section of one person's care plan stated that they were prone to losing their balance. However, no specific risk assessment was conducted and there were no written risk management guidelines in place for care staff. In another person's care record, we saw referral information indicated that they were unable to mobilise and they required the use of a hoist. However, their care plan stated that they were able to mobilise, but were at risk of falling. We saw there was no risk assessment in place about the risk of the person falling. Staff were not clear about the person's moving and handling needs or whether they were at risk of falling. When we spoke with a quality assurance officer they told us the person was initially able to mobilise, but had recently declined in their ability to do so. However, when we spoke with the quality manager, they confirmed that the person was never able to mobilise independently. Therefore, we could not be assured that care staff had access to clear and consistent information about the person's moving and handling needs. The provider agreed that this person's care record required updating and agreed to do as soon as possible.

Equipment that was used in people's homes for the purpose of safely moving and handling people was not always checked by the provider to ensure it was safe for use. We identified two examples where people who required the use of a hoist did not have their equipment checked to ensure it was safe for use. Another person required the use of a bath chair and needed an occupational therapist to assess its safety, but the provider had not contacted them to do so.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we received a concern that correct moving and handling procedures were not being followed. When we spoke with care workers we found that they were clear about their responsibilities to assist people in accordance with people's care plans. One care worker told us they "get training… and look at people's care plans where everything is written down." Staff training records confirmed that care workers received moving and handling training every year and care workers confirmed this was a practical session where they practised using the equipment as part of their training.

Thorough, questioning investigations were not always conducted into safeguarding matters and accidents and incidents. We saw examples of records of incidents that had occurred whilst people were receiving care and the provider's investigations had not addressed all of the issues raised. For example, one matter involved a person falling due to a care worker providing them with a chair that had been deemed unfit for use by healthcare professionals. The provider's investigation did not address what actions were taken to ensure the person was safe and whether appropriate learning had taken place as a result. Another investigation involved an allegation of neglect. The investigation documentation indicated that care workers had been interviewed in relation to the allegation that they had not provided personal care and their response was that the person had declined this as well as declining appropriate nutrition. However, the investigation did not address why the care workers did not report these matters to the office for further enquiries and any necessary action to be undertaken. Two further investigations involved allegations that care workers did not provide care to people when they were scheduled to do so. On both occasions it was alleged that the care workers left entries on people's contemporaneous care logs to indicate that care had been given. However, the provider's investigations into these matters did not question whether care workers had dishonestly completed these entries and did not conclude whether they had provided the required care or not.

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

Environmental risk assessments were conducted prior to the delivery of care. These involved asking questions such as whether there were any potential hazards within the person's home or whether they had any pets that care workers should be aware of. There was also a fire action plan in place for people. This stated where the emergency escape routes were within the person's home and where within their home the person could take refuge in the event of a fire. The risk assessment also specified whether there were any problems in areas of the person's home and what these were, such as lighting, the temperature of their home or particular power points. There was also a section for the provider to write an action plan. We saw one person's risk assessment specified that the person had steep steps leading to their house and care workers were required to be mindful of this.

Staff received emergency training which covered what to do in the event of an accident, incident or medical emergency. Care workers told us they understood how they were supposed to respond in emergency situations and this involved contacting the emergency services in the event of an accident or incident or take other necessary action, which could be informing a GP and office based staff. One care worker told us "We report when things go wrong."

Prior to our inspection we were alerted to a number of medicines errors that had occurred in the course of care staff providing people with care. We received a concern that care staff were not competent to administer people's medicines. At this inspection people we spoke with confirmed they received their medicines on time and care workers handled this correctly. Most people told us they administered their own medicines, but care workers reminded them to do this. Care workers were responsible for administering medicines for some people, but we found that this was not always recorded in the records we looked at. We found medicines administration records (MARs) were sometimes not being filled in when required. These were usually reviewed on a monthly basis by office based staff known as care coordinators who identified any issues and took action as a result. However, we identified four examples of MAR charts not being fully filled in which had not been identified by office staff, so it was not possible for us to see what medicines had been administered by care workers. We also saw one example of the person's medicines care plan containing incorrect information about what medicines the person was taking. We spoke with the quality manager about these discrepancies and they explained that care coordinators were checking people's MAR charts on a regular basis, identifying issues and ensuring care staff received further medicines administration training where this was needed. They explained that it would take a little further time for these changes to become fully embedded.

Care workers told us they had received medicines administration training. They had a good understanding of the procedure to be followed when they were administering medicines to people and confirmed they always read the MAR chart as well as people's care plans prior to providing people with care. One care worker told us, "You're supposed to fill in the MAR chart after you give people their medicine."

Care workers had a good understanding about how to safeguard people from abuse. They understood the procedure they were required to follow if they suspected someone was being abused and they had a good understanding about the different types of abuse. Care workers received annual training in safeguarding adults and records confirmed this. Their comments included, "We've had training in recognising different types of abuse" and "I would report my concerns to the office… I'd make sure something was done about it." The provider had an appropriate safeguarding adult's policy and procedure in place.

Safeguarding matters were investigated by the local authority as needed. Local authority contacts confirmed that the provider attended meetings as required.

Prior to our inspection we received concerns about the timeliness of care visits, care workers not staying the

full allocated length of time as well as care workers leaving calls early. We also received complaints that care workers were not given sufficient travel time to attend to people on time. We received mixed feedback from people regarding whether their care workers arrived on time and if they stayed for the full length of their visit. Comments included, "The carer always arrives on time and she lets me know if she's running late", "They mostly arrive on time" and "Some of the carers don't put the right timings in the book. They're arriving late and they're not giving me the full allocated time, but they're writing it in the book that they have been." We reviewed daily notes that had been filled in by care workers at the end of their visit. We identified some examples of care workers not staying for the full length of their visit and in some instances we found that care workers did not record when they left the person's home. Therefore, it was not always possible to determine whether the care worker had stayed for the full length of the visit.

We analysed staffing rotas for 10 care workers covering 589 calls for the week commencing 29 October 2018. On the basis of our analysis we found that the vast majority of care workers were given sufficient travel time to attend to people on time or within 15 minutes of the call. Care workers told us changes were being implemented to their rotas and some improvements had been made in relation to travel time. One care worker told us "There were problems before, but things are much better now."

The provider had also implemented a new electronic monitoring system. This allowed the provider to electronically monitor when care workers attended to people and when they left as they were required to log in using this system. However, at the time of our inspection, this system had not been fully embedded and there was therefore no reliable system in place to monitor care workers attendance to people other than through the receipt of a complaint from the person using the service. We were told by the quality manager that they were working to increase compliance with the electronic monitoring system, but it would take some time for this to be fully embedded.

We spoke with the quality manager about how they assessed staffing levels. They explained that the initial needs assessment and initial referral from the local authority were used to consider the amount of support each person required. As a result a decision was made about how many care workers were required per person and for how long. Care workers confirmed enough of them were sent to provide people with care. One care worker told us "I can't think of a time where I thought they [the provider] weren't sending enough of us out to people… if there was a problem like not having enough time for the call, we would report it."

Systems were in place for the operation of safer recruitment procedures, but these were not always followed. We looked at the recruitment records for 10 staff members and saw they usually contained the necessary information and documentation which was required to recruit staff safely. Files contained photographic identification, evidence of criminal record checks and people's right to work in the UK and application forms with their full employment history. References were usually obtained from people's previous employers, but we did identify two examples where the most recent health and social care employer had not been contacted to provide a reference.

The provider had appropriate infection control procedures in place and care workers demonstrated a good understanding of these. Care workers confirmed they had received infection control training within the last year and records confirmed this. They gave us examples of how they protected people from the risk of infection. One care worker told us "We wear gloves and aprons and make sure we wash our hands thoroughly."

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found mental capacity assessments did not always conclude whether or not people had capacity. At this inspection we found people's needs were not met effectively as the provider did not always ensure care was provided in line with people's valid consent. 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.

We checked whether the service was working within the principles of the MCA, and found that the provider was not always meeting the requirements of the MCA. For example, we saw numerous records where documentation was not signed and 'UTS' was recorded which meant 'unable to sign', with no further explanation about the reason for this. We also saw some care records for people with cognitive impairment, but there was no mental capacity assessment in place to demonstrate that they consented to their care or a decision had been made to provide this in line with their best interests. For example, one person experienced visual hallucinations, but it was not clear whether they had capacity to consent to their care. Another person's care plan was signed by their next of kin, but it was not clear whether they had the authority to do so and no mental capacity assessment had been conducted despite the person being described in their care plan as having dementia and poor cognition.

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

We spoke with care workers about their understanding of their responsibilities under the MCA. Care workers were clear that they obtained people's consent prior to delivering care and they also had a good understanding of what they would do if they thought someone did not have the capacity to consent to their care. One care worker told us "If I thought someone didn't have capacity, I would report it" and another care worker said "I get permission first."

Care workers did not receive regular supervisions or appraisals of their work. Senior staff told us supervisions were supposed to take place every three months and appraisals of care workers performance were also supposed to be taking place on an annual basis. However, records indicated that supervisions, spot checks and appraisals were not taking place on time and we identified some instances where care workers had not received either supervisions or spot checks for some time. For example, we saw one care worker's record stated that they had completed their induction on 19 – 23 June 2017. However, since this time they had not received a supervision, spot check or appraisal. Another care worker's file indicated that they had not received a supervision, spot check or appraisal since August 2017. We spoke with the human resources (HR) manager about these lapses and they confirmed that since they had started a new contract at the end of 2017, they had struggled to remain up to date in their monitoring of care workers. Care workers gave mixed feedback about whether they received supervisions or spot checks. Most care workers confirmed they have received unannounced spot checks, but most confirmed that they had not attended a supervision

meeting. One care worker told us "They really need to be having meetings with the carers. They don't appreciate us."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Care staff confirmed they had received a comprehensive induction prior to starting work. The provider arranged an induction for new care workers which consisted of a five days training programme which covered all 15 standards of the Care Certificate as well as practical training with moving and handling and medicines administration. Care workers confirmed they had received this and found it useful to their roles.

People gave us mixed feedback about whether they felt staff had the appropriate skills and knowledge to meet their needs. People's comments included, "I think they seem to know what they're doing", "I'm sure they know what they are doing" and "They don't understand my condition; when I get depression they don't encourage me to go out." Senior staff told us and care workers confirmed that they completed training as part of their induction as well as regular ongoing training. Records confirmed that almost all care staff had completed mandatory training in various topics within the last year which included safeguarding adults, medicines administration and dementia.

At our previous inspection we found care records did not contain enough information for care workers about diabetes management. At this inspection we found risks to people's nutrition were not appropriately assessed and recorded and this included people with diabetes. Care records did not contain information for care staff about people's dietary needs so care staff could offer appropriate advice and did not include information such as the signs of hyperglycaemia. For example, we saw one person's care record stated that they had experienced a mild seizure from a diabetic coma in the past. However, their care record did not include any advice for care workers about how they were required to monitor the person, what advice they could give about their dietary needs or the signs that they were experiencing another diabetic arrest. We spoke with the quality manager about the need to include dietary information on care records for people with diabetes. They told us that this would create a challenge for them as care workers may not be able to accept people's choices if they chose not to take the dietary advice offered. The quality manager agreed to consider the matter further.

People were given adequate support with their healthcare needs and people's care records included sufficient details about these. The care plan template that was used by the provider included different sections that prompted the field care supervisor to ask various questions about people's healthcare needs. This included people's eyecare, their hearing and their dental care. Where people had particular needs, information was included and care workers were prompted to provide the appropriate support. For example, one person's record stated that they needed support with their oral hygiene and one of the care worker's tasks for the care call was to support them in brushing their teeth.

When questioned, care workers demonstrated they understood people's health needs. They told us they would read the care record prior to providing the person with care and would contact their care coordinator at the office if they had any questions.

Requires Improvement

Is the service caring?

Our findings

People we spoke with and their relatives gave good feedback about the care workers. Their comments included "My carer is really caring" and another person said "They are very kind. They do their job nicely."

Our discussions with care workers demonstrated they had a good understanding of the people they were supporting. Care workers told us they often worked with the same people and this had ensured they had got to know them well. However, some care workers said they sometimes worked with people they had not seen before and this could cause some initial problems. Care workers comments included, "It's good when you really get to know someone and you can have a bit of a relationship and really understand what they need" and "Sometimes you see people for the first time and they might get a bit annoyed because it takes longer for you to understand how they like things done." Care workers gave us examples of the personal preferences of some of the people they were supporting as well as some information about their lives such as their families and previous occupations. Some examples centred around people's habits and daily routines and some people confirmed their care workers knew them well. One person commented "The carer was saying to me this evening that she's been reading up on vascular dementia to understand it better." However, care records contained limited information about people's preferences and individual needs. For example, most people's care records contained no information about whether people had any particular routines or whether they required the use of any particular hygiene or personal grooming products when their care was being delivered.

Prior to our inspection we received a concern that people's needs were being neglected and they were not being treated with respect. At this inspection we found people were treated respectfully and their needs were met when they were seen by care staff. People told us their privacy and dignity was respected. They confirmed they were treated with respect and care workers were polite. One person's relative said "The carer is very good and treats my wife well; she's a godsend." Care workers gave us examples of how they promoted people's privacy and dignity. One care worker told us "I try to care for people the way I would care for my family."

Care records contained a section for recording people's cultural and religious requirements. However, in most instances we found little or no recorded details. Senior staff confirmed that people were asked questions about whether they had any areas of need in relation to their culture or religion, but this was usually declined. When we spoke with care workers they had a good level of knowledge about people's culture and any spiritual beliefs and how this could impact on the care they provided. One care worker told us "I have clients with different religions. I follow their wishes. For example, one lady does not want us to wear shoes in her house and I make sure I follow this."

Requires Improvement

Is the service responsive?

Our findings

People using the service and their relatives told us they were involved in decisions about the care provided. Comments included, "We are and were involved from the beginning" and "Someone from the agency came here to review the plan."

However, despite these positive comments from people we spoke with, we found that senior staff at the service did not investigate and respond to all complaints received. The service had a complaints policy which outlined how formal complaints were to be dealt with. This stipulated that complaints were supposed to be investigated within 20 working days of receipt and they were supposed to respond to the complainant in writing. However, we identified two examples of complaints that were not investigated appropriately. For example, one person complained that their care worker had recorded that they had visited them and ensured they were well when they hadn't actually visited. However, the investigation document did not consider whether the care worker had in fact dishonestly recorded seeing the person. Another complaint from district nurses was that the care worker had again not seen the person using the service, but had left a written record stating that they had. Again, the investigation document did not consider whether the care worker had falsified records.

People we spoke with and their relatives confirmed they knew who to complain to where needed.

Care workers told us they offered people choices as a means of promoting their independence. One care worker told us "We give people choices and make sure they are in charge." People's care records contained some information about how care workers could support people to be independent, but the level of detail within these records was inconsistent. Some care records included specific details about people's moving and handling needs and what people could do for themselves. From this, it was possible to infer what support people required. For example, people's moving and handling assessment included questions such as whether they were able to get out of their chair. Care records included a section entitled 'How best to support' which contained instructions for care staff. For example, in one care record it stated that the person needed help with washing and dressing, emptying their urine bottle and preparing meals and drinks. However, we found in other people's care records, details were limited and it was not possible to determine exactly what assistance the person required.

People's needs were assessed before they began using the service and care was supposed to be planned in response to these. Assessments covered a range of the person's needs including their physical health, dietary requirements and mobilising. However, people's care records were lacking in detail and care records did not contain sufficient information for new care workers. We identified examples of tasks being completed that were not in the person's care plan, but were required to be completed. The quality manager explained that care workers were given additional instructions on their rotas which were more up to date than people's care plans. For example, we read one example of a person having their catheter emptied by care staff, but details of the person's catheter needs were not in their care plan. This meant that people's care plans were not updated when people's care needs changed. The quality manager agreed that this was the case, but explained that this was not an issue because care workers relied more upon the contents of

their rotas as opposed to what was written in the care plan. However, people's rotas did not include risk assessments, but included a list of tasks care workers were required to complete along with some additional comments from people using the service and their relatives that were relevant to the tasks. This meant that care workers were relying on incomplete written information in the completion of their work. The provider confirmed that these people's care plans were being prioritised as requiring an update which would be completed as soon as possible. When we spoke with care workers, they told us they read people's care plans as well as their rotas and if they had any queries, they would consult their care coordinator. One care worker told us "I read the care plan, the rota and the daily record… if I have any questions I can call the office."

Care plans were completed with the people who used the service or their relatives by field care supervisors. They provided some information about how the person's needs should be met. However, information about people's personal preferences about how they wanted their care delivered and their life histories was lacking in detail. This meant we could not be assured that people were receiving the type of care they wanted from care workers who were new and did not yet know the people they had started caring for. We spoke with care workers about whether they were aware of people's personal preferences in relation to their care and they told us they learned about people's personal preferences once they got to know them. One care worker told us "You get to know how people like things done as you get to know them."

Care records contained some information about people's social interests and recreational needs as the provider's template form included a section where this information was supposed to be recorded. For example, we saw care records that stated whether people liked to watch television when they were at home and others stated that some people liked to listen to music. However, information about what type of television programmes people were interested in or what type of music they liked to listen to was not included in their care record. Therefore, this information was of limited assistance to care workers in their delivery of personalised care. Care workers told us they spoke to people when delivering care and got to know them and their interests as they were doing so. However, they did not have access to clear information in the event that people were feeling tired or withdrawn due to their health care needs and/or were unable to communicate their preferences.

Requires Improvement

Is the service well-led?

Our findings

Providers are required to notify the Care Quality Commission (CQC) about significant incidents including safeguarding concerns. During our inspection we identified five safeguarding incidents that had not been reported to the CQC as required.

The above issue constitutes a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Systems for monitoring the quality of the service were in place and had identified the issues we found during the inspection. An action plan was in place, however, the provider needed more time for improvements to become fully embedded. For example, the provider had invested considerable funds into its electronic monitoring systems, but training was still being provided to care staff in using this and the provider needed time to ensure staff were using it effectively.

We spoke with members of one local authority commissioning care at the service and they confirmed they had been communicating with senior staff from the service to monitor the completion of their action plan. However, they told us that investigations into concerns were not conducted appropriately to ensure that all issues were addressed. We spoke with the quality manager about these issues and they confirmed they were putting measures in place to ensure that improvements were being made.

The provider monitored the quality of the service by obtaining feedback from people and we saw copies of this contained within people's files. The quality manager explained that if issues were identified, these would be dealt with individually by the relevant staff member. We saw evidence of monitoring forms in the care records we viewed and saw this was mostly positive.

Prior to our inspection we received concerns from care workers about the changes made to the organisation, particularly in relation to their rotas. Care workers told us changes had been made to their rotas and as a result they now saw clients who lived within a similar post code in order to reduce their travel time. Care workers felt the changes had destabilised some of the care packages and complained that some people using the service were now seeing new care workers. As part of our inspection, we spoke with care workers about the changes that had taken place. Care workers we spoke with told us they felt the changes were beneficial and reducing their travel time had a positive impact and reduced the likelihood of late calls. One care worker told us "I know what they're trying to do and I think it's a good thing" and another care worker said "My rota is so much better than it used to be, so I'm happy about that."

Care workers confirmed they had a good relationship with senior staff at the office and felt comfortable raising concerns with them. Their comments included, "They're very nice. You can walk in and talk to someone if you have a problem, you don't need an appointment" and "Everybody is very helpful."

Staff had a good understanding of their roles and responsibilities in relation to people using the service and their position within the organisation in general. They told us that their role and responsibilities were

clarified with them when they first joined the service. Staff provided us with detailed explanations of what their roles involved and what they were expected to achieve as a result. We saw copies of people's job descriptions and saw that the explanations provided tallied with these.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay of incidents that occurred whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity. Regulation 18(2)(b)(e)(f).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always ensure that care was provided with the consent from the person using the service. Regulation (11)(1).

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not effectively operate systems to investigate, immediately upon becoming aware of, any allegation or evidence of abuse. Regulation 13(3).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that persons employed received appropriate supervision and appraisal to enable them to carry out the duties they were employed to perform.

Regulation 18(2)(a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess the risks to the health and safety of service users of receiving the care and do all that is reasonably practicable to mitigate any such risks. Regulation 12(2)(a) and (b).

The enforcement action we took:

Warning notice.