Humble Healthcare Limited

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Inspection report

Unit 9, Red Lion Court
Alexandra Road
Hounslow
Middlesex
TW3 1JS

Tel: 02085706279

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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

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.

At the last inspection of 8 November 2017 we rated the service Requires Improvement overall and in the key questions of Safe and Well-led. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe and Well-Led to at least 'good'.

At this inspection of 11 May 2018 we found they had not made the required improvements and have rated the service Inadequate overall and in the key questions of Safe and Well-led. We have rated the key questions of Effective, Caring and Responsive as Requires Improvement.

Humble Healthcare Limited is domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older people and younger adults with physical disabilities, learning disabilities and mental health needs. At the time of our inspection 24 people were using the service. All the people lived within the London Borough of Southwark and their care was commissioned by this local authority. Humble Healthcare Limited is the only location for this provider.

There was a registered manager in post; they were also the owner of the company. 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 and associated Regulations about how the service is run.

The provider had not made suitable arrangements to ensure that people received their medicines as prescribed and in a safe way.

The provider's governance arrangements had failed to identify when things had gone wrong and take action to put this right. For example, we found medicines administration records which had errors. These had been audited by the registered manager, although the errors had not been identified or investigated.

Some people were supported by staff who undertook shopping for them. There was no system to ensure that people were not financially abused because the staff did not keep records of expenditure and the provider did not carry out checks on this.

Records about people were not always accurate or complete. The provider had used the same information in a number of different people's care plans and this was not relevant to them and did not describe their needs. Therefore, there was a risk that people would receive care and treatment which was not appropriate and did not meet their needs.

Where risks had been identified by the local authority, the provider had not ensured that these were recorded within risk assessments or care plans and there was no guidance for the staff on how to minimise these risks.

The provider was unable to evidence that staff had been suitably trained and supervised to provide care and support to people who used the service.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 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.

The provider had procedures for recruiting staff but was not always able to evidence they had made the necessary checks on staff suitability.

Following the inspection visit the provider updated some of the care plans and risk assessments as a result of our feedback and sent us evidence of this.

Most people using the service were happy with the service they received. One person raised significant concerns but the provider spoke with this person to resolve these and they reported that they were satisfied with this. Some other people felt that the service did not meet their needs, whilst others were very satisfied and felt the provider did a good job. People told us that care workers did not always arrive on time but most people did not mind this and they said the care workers stayed for the agreed time. Most people explained that they usually had the same care workers, who they had a good relationship with and liked. A few people felt the attitude of some care workers needed to be improved but most people told us that care workers were kind, caring and compassionate.

The majority of people told us that their needs were being met. The relatives of some people explained how they felt the agency offered peace of mind and that they had seen improvements in people's health and wellbeing since they started receiving support from the agency. The provider was able to meet people's requirements about visits at certain times of the day. At the previous inspection we spoke with a representative from the local authority and they told us that this flexibility regarding visit times was something other agencies did not offer. The feedback from people using the service and their

representatives at this inspection confirmed this was still the case.

A small number of people felt that communication from the agency needed to improve but most people using the service, their relatives and staff told us that the registered manager was available when they were needed. Some people said that they had called the registered manager to request something, such as a change in the time of visits, and this had been arranged. The care worker we spoke with said that they could ''Ring [the manager] at any time, even two in the morning, and he answered the phone.'' They told us they felt supported by this. The provider also obtained regular feedback from people about the service they received, through telephone monitoring and asking them to complete surveys about their experiences.

The registered manager had recognised that they needed support and guidance to make sure the governance at the service was suitable. They had employed a consultant who had started to offer them advice and support. The consultant explained that they would continue to work with the provider to make improvements.

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.

People were placed at risk because the procedures for managing medicines were not always followed.

The risks for individual people had not always been assessed or planned for.

There were insufficient safeguards to protect people from the risk of financial abuse.

The provider was not able to evidence that the recruitment of staff included all the necessary checks on their suitability.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The staff did not always have the training, supervision and support they needed to make sure they provided effective care.

People's needs were assessed, although the records of these were not always complete or accurate.

People consented to their care and treatment.

People who received support at mealtimes were happy with this support.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Some people did not feel the care workers or the provider provided a caring service.

Most people felt they were involved in making decisions.

Most people felt that care workers were kind, caring and polite.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Most people felt their needs were being met, but plans of care were not always accurate, complete or relevant. Therefore there was a risk that people's needs would not be met.

People knew how to discuss a concern and the provider had a system for dealing with this.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's systems for monitoring and improving the quality of the service were not effective.

Records were not clearly or accurately maintained.

The provider had not taken sufficient action to address the breach of Regulations identified at the last inspection.

Humble Healthcare Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 11 May 2018. We told the provider two working 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.

The inspection visit was carried out by one inspector. Before the visit we spoke with people using the service and their relatives on the telephone. Some of these phone calls were made by an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at all the information we held about the service. This included the last inspection report and any notifications. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection we met the registered manager, the external consultant who was supporting the provider and one care worker. We spoke with 15 people who used the service and the relatives of seven other people on the telephone.

We looked at the care records for five people who used the service, the records of recruitment, training and support for five care workers and the records used by the provider to monitor the quality of the service. Some of the records we expected to see were not available. For example, there were no communication log books to show how four of the five people had been cared for and not all medicines administration records were available.

At the end of the inspection visit we gave feedback to the registered manager and external consultant.

Following the inspection visit the registered manager sent us records of further staff training and support by email. They also updated two people's care plans and risk assessments as a result of our feedback. They sent us copies of these so we could see the changes they had made.

Inadequate

Is the service safe?

Our findings

We asked people using the service and their relatives if they felt safe with the agency. One person's relative said, ''We have had a different experience with three different carers and there have been some hiccups along the way.'' But they went on to tell us, ''I spoke with the office and they listened to me, I feel [person] is in safer hands now.'' Other people told us they felt safe with the care workers and being cared for by the agency. Some of their comments included, ''I am happy with the care I am receiving, they do a good job and make me feel safe'' and ''I feel safe and the carers respect me.'' The relatives of people also felt the service was safe. One relative said, ''We feel that [person] is safe using the service and they adapt to [person's] needs so it works well.'' Another relative told us, ''We feel 100% safe and are very happy to have this agency.'' However, when we inspected, we found practices which were not safe and placed people at risk.

At the inspection of 8 November 2017 we found that there were procedures for the safe administration of medicines but the staff did not always follow these because they did not record medicines administration accurately.

At the inspection of 11 May 2018 we found that procedures were not always being followed by staff and we also found the provider did not ensure that staff were suitably qualified or their competency assessed at giving medicines.

The provider told us that five people using the service received support to take their medicines. We found evidence in a sixth person's care records that they were supported by staff to take their medicines. For example, their care records stated, ''All of [person's] medicines are administered.'' In another part of their care records the plan referred to ''prompting'' the person to take their medicines and in a different section the care plan stated, ''assist with medicines.'' We discussed this with the registered manager but they were not able to tell us the level of care and support this person received with their medicines

There was a risk that people had not received their medicines as there was insufficient recording to show that they had. We asked the registered manager to show us all of the completed medicines administration records for these people. There was no record of administration in January 2018 for one person, for January and February 2018 for another person and February 2018 for a third person. There were no records of medicines administration for the sixth person. We asked the registered manager about this and they were unable to explain this.

The medicines administration records for two people contained gaps in recording which had not been identified or explained. There was an audit form attached to these records which had not identified the gaps. For example, there was no record for the administration of one medicine for a person in December 2017. There was no explanation to state what had happened or if there was a reason why this had not been administered. Two of another person's medicines administration records for March and April 2018 included gaps where no administration had been recorded. For the March 2018 record the provider had recorded that the person was in hospital for five of the days. However, the records stated that some of the person's medicines had been administered on these days and showed no administration on other days. Therefore

there was a risk that people had not received their medicines as prescribed.

People were at risk because the staff who were responsible for administering medicines were not appropriately skilled or qualified. Three of the five staff records we looked at did not contain evidence that they had received training in medicines management or had their competency assessed to make sure they could safely administer medicines. A fourth member of staff had received training and had their competency assessed on 20 and 21 February 2018. However, medicines administration records showed that they had been administering medicines to one person since 1 February 2018. The recruitment record for this member of staff showed they had no previous experience of care work and there was no evidence of previous training in medicines management. The provider's own procedure for managing medicines stated, ''Only staff who are either qualified or authorised should administer medicines.''

None of the care records we look at included details of people's medicines or any risks associated with these. Therefore these risks had not been sufficiently assessed and there was a possibility that they would receive care and treatment which was not safe and did not meet their needs. For example, the staff had no information on possible side effects from the medicines people were prescribed or why people had been prescribed these medicines.

The provider had not always assessed the risks to people's safety and wellbeing. The local authority assessment in one person's file included information about daily visits from community nurses to administer insulin. However, the person's care plan and risk assessment did not contain any information about this or the risks associated with being an insulin dependent diabetic. There was no guidance for staff on how to respond if the person became unwell in relation to their diabetes. Therefore they were at risk because the staff may not be able to identify this or know how to respond.

The risk assessments for all five people whose records we looked at were not always clear. For example, two people's records contained an assessment for catheter use when this was not relevant to their needs. The provider had used the same information for different people therefore these assessments were not a true reflection of their needs and this meant they were at risk of receiving inappropriate care. For example, three people's risk assessments referred to a hoist which had been serviced on exactly the same date. None of these people used a hoist. There was no information about the hoist used for a fourth person who did use this piece of equipment. Neither their care plan or risk assessment included information about the type of hoist, the procedure for assisting the person to move, information about when the hoist was serviced or what to do if something went wrong.

The local authority assessment for another person stated that the person ''must have their pendant alarm'' because they were at risk of falling. The person's care plan and risk assessment did not contain any reference to this and there was no guidance or reminders for the staff to ensure the person had their pendant alarm before they left at the end of their visits. Therefore there was a risk that this may not happen.

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

Following our inspection, the provider sent us evidence that they had provided training regarding medicines management to 16 of the care workers who were employed by them.

The provider also reviewed the risk assessments for the two people where we had discussed the risks which the local authority had identified. They had updated the risk assessments and care plans for these people and sent us copies to show that this information had been highlighted for the staff to be aware of these risks

when supporting these people.

Some people were supported with shopping. Care workers used their debit cards or money to purchase shopping they needed. One person told us, ''They do some shopping for me, but they are not very reliable and sometimes they are really bad.'' They did not explain this further. However, we looked at the care records for another person who received support with shopping. There was no record of the financial transactions which had taken place and receipts for purchases we placed loosely within the communication logs. For example, within the communication log for April 2018 we found nine loose receipts, one for a purchase in February 2018. The other purchases had been made within April 2018 but details of these were not recorded in the communication logs of the visits or on a separate record. There was a note on the logs to say that they had been audited but there was no reference to the financial transactions or evidence that these had been checked. Without a proper system to record and audit when the staff had handled people's money there was a risk of financial abuse.

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

The provider had procedures for the recruitment and selection of staff which included undertaking checks on their identity, eligibility to working in the United Kingdom, employment history, references from previous employers and a check with the Disclosure and Barring Service (DBS) to identify any criminal records. Two of the staff files we examined did not contain a recent check with the DBS but instead contained checks made by previous employers dating from 2015. The provider used an on line system to register to check up to date criminal records for the staff. They were not able to log on to the system to show us when we asked to see the most recent checks for these two members of staff. They explained that this was because they had forgotten their password but assured us that the checks were in place. Two of the five staff whose files we looked at had worked at other care agencies within the last few years. They had not put these care agencies as referees and the provider had not sought a reference from these agencies. Whilst both care workers had two references in place these did not relate to care work and therefore there was no evidence of their conduct in previous similar roles. Only one of the five files contained evidence of the recruitment interview. Therefore the provider was not always following their own recruitment procedures when recruiting staff.

People using the service and their relatives told us that care workers did not always arrive at the same regular time, although most people were happy with this arrangement. Some of the comments we received included, ''The time keeping is variable, but [person] can be flexible so it is not imperative as long as they come'', ''They usually arrive on time give or take 10 minutes, I don't think I have had them much later than that really'', "The staff do not arrive on time and they never let me know what is going on, I think communication could be improved when they are going to be late'', ''They are not always on time'' and "Sometimes they are not on time, but they will always let me know as we have an arrangement that they will call me on my mobile phone to let me know."

The provider employed enough staff to meet the needs of people using the service and was always able to allocate a care worker for each visit.

The provider had suitable procedures for preventing the spread of infection and they supplied gloves, aprons and hand gel to the care workers. However, the relative of one person told us that the care workers did not check the use by and expiry dates on food they prepared for the person and therefore they had been placed at risk by being given food which should have been disposed of. The relative told us that they now made regular checks themselves on their relative's food because they did not trust the staff to do this.

Requires Improvement

Is the service effective?

Our findings

The staff had not always received the sufficient training and therefore did not always have the skills to meet people's needs. The registered manager told us that all staff undertook training in line with the Care Certificate when they started working at the service. They explained that they had an external provider who carried out this training. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. The provider's website stated that, ''Our staff have regular training covering manual handling, safeguarding of vulnerable adults, emergency first aid, health and safety, food hygiene, medication dementia and infection control.'' However, we looked at the training records for five members of staff who had been employed in 2017. Only one file showed evidence that the member of staff had completed this training. This had been undertaken two months after they started working at the service. Two of the staff had undertaken relevant training with previous employers and the certificates of this training were in their files. However, some of this training had taken place a long time ago, with one member of staff's records showing training in 2013, and the other member of staff had completed some training as long ago as 2011. There was no evidence that they had undertaken more recent training or that the provider had assessed their competencies and skills to make sure their knowledge and skills were up to date. There was no evidence of any training for two of the staff.

The staff files did not contain sufficient evidence of supervision, meetings or discussions about the staff work or unannounced spot checks to observe them in the work place. In the files we looked at there was evidence of one spot check for three of the staff but none for the other two. The only other record of assessment, appraisal or supervision for the five members of staff was a record to show that they had undertaken two visits shadowing the registered manager when they started work and one record showing that the member of staff's competency at administering medicines had been assessed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit the registered manager sent us copies of spot checks they had undertaken on seven different care workers between December 2017 and April 2018. Although these did not relate to the five staff files we had viewed during the inspection visit, they did show evidence that some assessment and monitoring of staff was taking place.

People using the service were referred by the local authority who had undertaken an assessment of their needs. The provider kept a copy of this assessment and also carried out their own assessment by meeting with the person and their representative. Most people told us that they had been asked about their needs and preferences. There were records of assessments, although these had not always been accurately completed because the provider had used the same information in different people's assessments and this was not always relevant to their needs.

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 to 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.

People told us they had been involved in planning their care and had consented to this. However, only one of the five records we viewed included a signed consent to the care plan. The assessments from the local authority gave information about people's mental capacity, although this had not always been clearly recorded within care plans . Moreover, there was a lack of information about how the staff could present choices to people to help them understand and make decisions about their care. However, people using the service told us that the staff asked for their consent before providing care. The care plans did not include clear information about how the provider had worked with others to make decisions in people's best interests when they lacked the mental capacity to do so themselves. However, the relatives of people who we spoke with told us they had been involved in planning care.

Some people were supported during mealtimes. People told us they were happy with this support. People told us that the care workers provided them with meals when they needed and made sure that drinks were available.

Information from the local authority included some details about people's healthcare conditions. These had not always been recorded clearly in care records. However, there was evidence within the logs of care that the staff recorded and reported when a person became ill. The care worker we spoke with described an incident when a person was unwell and the action they had taken, which included informing the provider and calling for an ambulance.

Requires Improvement

Is the service caring?

Our findings

A small number of people told us they had not had a good experience with some of the care workers. One person told us, ''When the carers come everything is a rush and they can't wait to get out of here. They just do everything as quickly as possible, so they can sign off.'' Another person explained, ''I am just not comfortable with some of the carers, but they just keep sending the same ones and ignore my requests for different carers.'' A third person told us that most of the care workers they had were kind and polite but they went on to tell us that two care workers were ''horrible and took advantage of [them].'' One of these people told us, ''The care workers always make me feel like they are doing me a favour and I should be grateful." Our inspection findings were that the care workers did not always receive adequate training, support and supervision to make sure they were kind and respectful towards people. The provider did not arrange regular checks on their competency to make sure they were behaving appropriately and there was no evidence that concerns raised with the registered manager about staff attitude had been discussed with individual staff so that improvements could be made.

However most people told us they had a good relationship with their care workers. They told us that care workers were kind, caring and compassionate. Some of the comments from people using the service and their relatives included, ''I find the carers extremely respectful and they always listen and take their time, no rushing or trying to leave when I need assistance or something a little extra might require attention", "The staff are respectful and wonderful in every way, I cannot fault them", ''They are good and well meaning'', "They are kind and you can tell they care by the way they chat and take time to be gentle and caring", ''They are completely and utterly kind, very caring, polite and very respectful", ''I like the carers- they do a good job and look after me with patience and respect", "The staff are good kind people", ''The carers are very helpful, very kind and always caring and most respectful", ''I have had the same two carers for quite a while now and they are more like friends I think", ''[Person] can be very difficult to care for and extremely reluctant to accept help, but they manage to coax [them] with great calmness'', ''The staff are all kind and do a very good job when they are here. I do not think that anything is too much trouble, they make me feel comfortable'' and ''They will put their hand to anything and always have time to chat with [person] and make [the person] feel at ease."

Some relatives told us how the provider gave them peace of mind and that they felt happy with the service. One relative explained, ''They help and support with absolutely everything, they really do. I am so relieved it has taken a great strain off my shoulders.'' Another relative told us, "I could not be happier with the service, it has taken me months of searching to find an agency where the carers can speak [the same language as my relative]. My [relative] has dementia and now cannot understand English, so [they were] frightened and frustrated with other carers.''

Most people using the service told us that they were involved in making decisions about their care. One person said they did not always feel this was the case with the overall care package, but they felt care workers allowed them to make decisions each visit. Other people told us they felt empowered to make decisions about their care. They said they were involved in the initial care planning and were offered choices

at each visit, with one person telling us, ''They respect my choices and I decide when things should happen and how.'' The relatives of people using the service told us that they were well informed and included in decision making

People using the service told us that the care workers respected their privacy when providing care by knocking on doors and making sure doors and windows were closed when providing care.

The relative of one person explained that the provider had sourced care workers who met the cultural needs of their family member. However, the provider had not acknowledged anyone else's cultural needs within their care plans. Under the section, ''Cultural Needs'' within the care plans the registered manager had recorded, ''No cultural needs'' and there was no evidence that this had been discussed with the person.

Requires Improvement

Is the service responsive?

Our findings

People told us they had a care plan and that they agreed with this. Some of their comments included, ''I know all about my care plan and yes this is reviewed, and they leave a copy here in a file, so I can look at it" and ''I do have a care plan and they talk about it, but I do not need to get concerned about that they deal with it for me.'' The relatives of other people explained that they were consulted. One relative said, ''I am fully involved in planning [person's] care plan and we regularly review it.'' Another relative told us, ''We are included every step of the way with care planning and altering of it when required.''

We saw that everyone had a care plan which outlined how they should be cared for at each visit. However, care records for four of the five people we looked at contained the name and references to a completely different person. In addition, the care record for one person referred to their surname (without a title) instead of their first name in some records and their first name in other records. All of the care records contained information which was either wrong, contradictory or about another person. For example, three care records referred to the use of a hoist stating that staff should be ''aware of the correct procedure'' for this and giving a date when the hoist had been services. However, none of these three people required the assistance of a hoist and their care plans stated, ''No equipment is used with assisting this client.'' In another instance under a section entitled ''Nutrition'' the provider had recorded, ''Not required morning visit with personal care only.'' However, the person received three visits each day, all of which included support at mealtimes with another section of the care plan stating, ''prepare [person's] breakfast'', ''support with [lunch] meal, preparation and prompting'' and ''support with [tea time] meal, preparation and prompting.'' Therefore, the care plans were not an accurate reflection of people's needs and there was a risk that people would receive care and treatment which was not appropriate, did not meet their needs and did not reflect their preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit the registered manager sent us evidence that they had reviewed and updated the care plans for two people. They had revised some of the information within these which helped to clarify the needs of these two people, although further work to improve the personalisation of these would reduce the risk of them receiving inappropriate care and support.

People told us that they were happy with the care they received. They said that care was arranged and provided at a time they chose. At the last inspection in November 2017 we spoke with a representative commissioning care on behalf of the local authority. They explained the provider was able to accommodate visits when people wanted these at a specific time, for example very early or very late. People using the service and their relatives confirmed this. In addition, relatives told us the provider was able to meet needs that previous care agencies had not. With one relative telling us, ''I am so relieved with the way the carers manage [person's] needs on a day to day basis, they are so knowledgeable about [person's] illness and know exactly how to keep [person] calm."

The provider had a procedure for dealing with concerns and complaints. One person told us they had concerns which they felt had not been adequately addressed. They said that they had asked the registered manager to speak with them but this had not happened. We spoke with the registered manager about this. They said that they had since spoken with the person and resolved their concerns which were about the allocated time of their visits. The registered manager showed us a record of the discussion that had taken place with this person and the action they had taken to resolve the concerns. Most people using the service and their relatives told us they could speak with the registered manager if they had any concerns and felt that these were appropriately dealt with. Some of their comments included, ''If there are any problems we call the agency and they are good at listening'', "if I have any concerns I have got the manager's number and I could always call that; he does seem to listen very well when I speak to him and tries to help''

The provider was not offering care to any people at the end of their lives at the time of the inspection. However, we noted that information which the staff may need should someone become very ill or pass away was incomplete. For example, one person's care records stated that they had no family contacts. However, the section ''End of life wishes'' did not contain any information except, ''Arrange with family.''

Inadequate

Is the service well-led?

Our findings

At the inspection of 8 November 2017 we found that the provider's audits did not always identify when something had gone wrong or action was needed to make improvements.

At the inspection of 11 May 2018 we found that this was still the case. Although the provider had carried out audits of medicines administration records, communication books and care plans these had not always been effective and they had failed to identified errors and breaches of the provider's own policies and procedures. In addition, they had not carried out audits of financial transactions when the care workers had assisted people with shopping. This meant that they could not be confident that people were adequately protected from the risks of financial abuse.

The provider had introduced audits of medicines administration records. However, we found that the audits of three of these had failed to identify or thoroughly investigate mistakes made by the staff. In one case, the staff had failed to sign to show the administration of one of the person's medicines for the whole month. The audit of this record stated, ''Checked and realised that the carer is administering the right dosage to the client.'' Under the section asking whether any gaps had been identified the person completing the audit had recorded, ''No.''

One medicines administration record for another person included a gap where no administration details had been recorded for one medicine during the evening of one day. The other medicine the person was prescribed to take in the evenings had been signed for. The person completing the audit had written that the person had refused medicines on this date. There was no record of their investigation into this and furthermore the communication log book for this date stated the person had ''self-administered'' their medicines with no reference to one medicine being refused.

The record for a different month's medicines for the same person included an audit which stated the person had been in hospital for five days that month. However the medicines administration record wrongly recorded administration of three of the person's nine prescribed medicines on three of these dates and no administration of these three medicines on two different dates. This had not been investigated or explained. In addition there was a gap which did not describe whether medicines had been administered or not on a different date. The provider's audit had failed to identify this.

There was no evidence that the provider had discussed these errors with the staff involved so that they could learn from their mistakes and improve practice. Additionally, the provider's audits of one person's communication logs repeatedly identified that hand written notes were not legible. However, there was no indication that the registered manager had addressed this with the staff concerned and no improvement in the legibility in the most recent records.

At the inspection of 8 November 2017 we found that records were not always accurately maintained. At the inspection of 11 May 2018 we found that this was still the case.

Communication log books were the forms used by care workers to record the actual care provided to people using the service. We looked at the care records for five people. There were no communication log books for any month in respect of four of these people. At the beginning of the inspection we asked the registered manager if all records for people using the service were present and available for inspection. They confirmed they were. Having failed to locate the communication log books for four of the five people we asked the registered manager why this was the case. They were unable to explain why these records were not available. The provider's procedure was to audit communication log books to make sure people were receiving care as planned. They were unable to do this because they had not collected these records.

Furthermore the relative of one person told us, "I would say my main concern has been the incomplete filling out of forms and the log book. There have been big gaps and inconsistencies and sloppiness. The log book actually ran out of space and they didn't notice and did nothing about it.'' The provider could not evidence all of the medicines administration records for four of the six people who received medicines. From the records we reviewed we identified that the staff had used correction fluid to cover up errors making it difficult to judge what action had been taken regarding these errors.

Quality satisfaction surveys, some staff appraisals, some spot checks on staff and other records did not include a date. Therefore it was difficult to ascertain when the record had been created or whether it was still relevant. There was some unclear and confusing information within other records. For example the care record for one person stated that they started using the service in March 2018. However, other records of their care, which included a telephone monitoring call, indicated they had been using the service since at November 2017. Another person's care records stated that the initial assessment of their needs was made in July 2017 but also showed that the review of their care was made on the same date. Furthermore, the dates on some records did not make sense. For example, we were shown a communication log book which stated that it had been completed on 15 May 2018, which was four days after our visit. In another instance the audit for the 1 – 30 April 2018 medicines administration record for one person had been recorded as having taken place on the 4 April 2018.

The records for one member of staff indicated that the provider had failed to follow robust recruitment and induction procedures. For instance, the records included a performance agreement and review dated 18 May 2018 which stated the member of staff had, ''proven in shadowing assessment and induction training [their] quick thinking nature and how to establish a positive rapport with clients.'' However the record to show that this member of staff had shadowed an experienced worker was dated 19 and 21 May 2018 stating that on these dates they shadowed for 45 minutes and one and a half hours respectively. A letter offering the member of staff employment following receipt of satisfactory checks had been made was dated 22 May 2018, although one of their references was not obtained until 25 May 2018. The record of their recruitment interview was 18 May 2018.

The provider had a file containing meeting minutes. The meetings held monthly from November 2017 to March 2018 contained exactly the same wording, the same agendas, discussions, attendees and actions. The only difference was the date. Therefore it was difficult to assess whether these minutes were a genuine reflection of discussions or if the meetings actually took place.

This was the fourth inspection of the service since it started operating in 2016. The provider has been in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at all four inspections. Whilst some improvements were made before the last inspection of November 2017, there was no evidence that action had been taken to make further improvements since. Following the last inspection we requested the provider supply us with an action plan telling us how they would meet the breach of Regulations we had identified, however they did not provide us with a plan.

The above evidence shows a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service and their relatives had varying opinions of the quality of service provided with some people explaining that they were very happy with the service, whilst others raised some concerns. For example, one relative explained that they did not feel the service was well organised or that there was a good overview from the provider. They told us, "I feel that we are very much left to be the project managers and if we were not on top of things ourselves things could easily go very wrong.'' Three other people shared a similar view and their comments included, ''I strongly feel that the manager should make himself more visible and actually do the occasional spot check if he is to have any idea what is going on outside his office walls", "The manager really should meet all his clients and their relatives face to face" and "I think that the service could be improved if the management were more visible and if they took more control of actually managing the day to day service because if [person] did not have us controlling things it probably would not work."

Other people using the service and their relatives told us they did not feel any improvements were needed. Some of their comments included, ''Of course I think that this is a good service they are my lifeline when my [relative] is not here", ''I think that the manager is very good'', ''We feel that it is a good service, but it is not without hiccups. The good thing is that we have one point of contact if we call the office and are not shoved from pillar to post'', ''It is a good service they have helped me immeasurably over the past year and I could not have done without them'', ''At the moment I am happy and there is nothing that I can think of that they should change yet'' and ''They listen, they act and most of all they really seem to care and want to help.''

The provider had employed an external consultant who was planning to help the provider make the required improvements.

The registered manager explained that they had plans to change to a new care planning and visit scheduling electronic system. They told us that they were receiving training about the system. They felt that once this was in place their overview of service delivery would improve.

The provider had asked people using the service and their relatives to complete surveys about their experiences. We saw a selection of completed surveys but most of these did not have a date or reference for us to identify when they had been completed and whether they had been completed by/or on behalf of all of the people using the service. The completed surveys indicated that people were happy with the service. Some of the comments from people included, ''I receive the best care and will not change for another agency'' and ''The service I am getting is excellent.'' In a recent email the local authority had forwarded to the provider a relative had stated, ''[Person] us happy, the staff are always on time and outstanding in the way they care for [person].''

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure that care and treatment of service users was appropriate, met their needs or reflected their preferences because they did not design care and treatment with a view to achieving service users' preferences and ensuring their needs were met. Regulation 9(1) and (3)(b)

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 that service users were protected from abuse and improper treatment. Regulation 13(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 registered person did not always provide care and treatment in a safe way for service users because they had not assessed the risks to the health and safety of service users or ensured the safe and proper management of medicines. Regulation 12 (1) and (2)(a) and (g)

The enforcement action we took:

We have issued a warning notice telling the provider they must make the required improvements by 31 July 2018.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not operate effective systems and processes to: Assess, monitor or improve the quality of the service Assess, monitor and mitigate risks Maintain an accurate, complete and contemporaneous record in respect of each service user Regulation 17(1) and (2)(a), (b) and (c)

The enforcement action we took:

We have issued a warning notice telling the provider they must make the required improvements by 31 July 2018.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure that staff

were suitably qualified, competent, skilled or experienced because they did not receive appropriate support, training, professional development, supervision or appraisal.

Regulation 18(1) and (2)(a)

The enforcement action we took:

We have issued a warning notice telling the provider they must make the required improvements by 31 July 2018.