Capital Homecare (UK) Limited

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Inspection report

77A Woolwich New Road
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 17 and 19 February 2016 during which we found breaches of regulations. Medicines were not safely managed, risks to people had not always been adequately assessed and the provider did not have effective systems in place to monitor and manage areas of risk. Records were not always accurate and could not be promptly located, and the provider did not have an effective system in place to monitor staff training needs. These issues placed people at risk of unsafe care. We also found that the provider's whistle blowing policy provided no guidance to staff on how to report concerns externally if needed and that they had failed to submit notifications relating to allegations of abuse as required by the regulations.

Following the inspection we served warning notices on the provider and registered manager requiring them to comply with the regulations. Our concerns were so significant that we also imposed a condition on the provider's registration, restricting them from taking on any new service users without prior agreement from the Commission.

We undertook this announced focused inspection on 23 June 2016 to check that the provider had met the requirements of the warning notices. At this inspection we looked at aspects of the key questions 'Is the service safe?', 'Is the service effective?' and 'Is the service well-led?' This report only covers our findings in relation to the focused inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Capital Homecare (UK) Limited' on our website at www.cqc.org.uk.

Capital Homecare (UK) Limited is a domiciliary care provider located in the Royal Borough of Greenwich providing care and support to people across a number of London Boroughs. There was a registered manager in post at the time of our inspection. 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.

At this inspection we found that while a system had been implemented to monitor staff training and the provider had updated their whistle blowing policy, we identified continued breaches of legal requirements relating to safe care and treatment, monitoring the quality and safety of the service, and for failing to submit notifications as required.

Medicines were not safely managed because records relating to the management of people's medicines included conflicting information about the support they required and risks associated with specific medicines had not always been identified. Risks to people had not always been adequately assessed. There was not always sufficient guidance in place for staff on how to safely manage risks where they had been identified. The monitoring system used to ensure people received their visits as planned was not always effective and checks made on people's care records had not always identified issues or driven improvement. Records were not always accurate and could not always be located promptly when requested. We also

found evidence that the provider had failed to submit a notification relating to an allegation of abuse as required, despite these concerns being raised previously. CQC are currently considering the action to take to address these concerns.

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.

As a result of the findings of this inspection, we have reviewed the rating for the key question 'Is the service well-led?' which is now rated inadequate. This was because the provider had failed to make any significant progress in addressing the requirements of the warning notices we served following our inspection on 17 and 19 February 2016. The ratings for the other two key questions we looked at remain the same. The overall rating for the service is 'Inadequate' and the service is therefore in 'special measures'.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found that insufficient action had been taken to improve safety.

Medicines were not safely managed.

Risk assessments were not always accurate. There was not always guidance in place for staff on how to safely manage identified risks.

The provider had no effective system in place to monitor people's visits which resulted in people not always receiving their visits as planned.

The provider had updated their whistle blowing policy and staff were aware to report any concerns to external providers, if needed.

The rating for this key question remains 'Inadequate' because the provider has failed to make sufficient improvement to address the concerns found at our last inspection.

Is the service responsive?

Requires Improvement

We found that insufficient action had been taken to improve responsiveness.

People's care plans were not always accurate and did not always reflect the level of support they received.

The rating for this key question remains 'Requires Improvement' because the provider had not made sufficient improvement in the area we reviewed.

Is the service well-led?

Inadequate

We found that action had not been taken to improve leadership.

Quality assurance systems used to monitor the quality and safety of the service were ineffective and did not always identify issues or drive improvement.

Records could not always be promptly located or provided when requested.

The provider had not always submitted notifications to the Commission where required.

We have revised the rating for this key question to 'Inadequate' because of the issues identified at this inspection and because the provider failed to take sufficient action to address the issues identified in the warning notices we served following our last inspection.

Capital Homecare (UK) 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. We undertook an announced focused inspection of Capital Homecare (UK) Limited on 23 June 2016. This inspection was done to check that improvements to meet required legal requirements after our 17 and 19 February 2016 inspection had been made. The team inspected the service against aspects of three of the five questions we ask about services: 'Is the service safe?', 'Is the service responsive?' and 'Is the service well-led?' This is because the service was not meeting some legal requirements in response to parts of those key questions at the last inspection.

The inspection was undertaken by two inspectors and a pharmacist inspector, and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure the registered manager was available. Before the inspection we reviewed the information we held about the home. This included notifications submitted by the provider. A notification is information about important events that the provider is required to send us by law. We also contacted a local authority who commissioned services from the provider to get their feedback on the quality of the service. We used this information to inform our inspection planning.

During our inspection we spoke with the provider, the registered manager, seven staff, one person using the service and one relative. We looked at records, including 15 people's care records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 17 and 19 February 2016 we found a breach of regulations because medicines were not safely managed. People's medication administration records (MAR) were not always an accurate reflection of the medicines which people had received and did not always provide appropriate guidance on the level of support people required with their medicines. We also found that audits of people's medicines were not conducted effectively placing people at risk of not having any issues with their medicines being identified promptly.

The issues we found were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet the regulation. We also included the evidence of our concerns relating to the unsafe management of medicines in making a decision to impose a condition on the provider's registration, preventing them from taking on any new service users without prior agreement from the Commission.

At this inspection on 23 June 2016 we found that there were continued serious concerns about the overall management of medicines by the service which placed people at risk of unsafe support. Risks associated with people's medicines had not always been identified to ensure they were managed safely. Whilst the provider's risk assessment documentation included sections regarding medicines risks, we found that these had not always been completed. For example we found that where people had been prescribed medicines for conditions such as diabetes or Parkinson's Disease, the risks associated with taking or failing to take these medicines had not been considered. There were no plans in place as to how such risks should be managed, or to define the responsibilities for risk management where such support might be shared, for example with diabetes healthcare professionals.

People's records contained limited information about their medicines. For example we noted that records lacked information about the purpose of the medicines people had been prescribed, whether there were any potential side effects, and any supplementary information such as the need to take specific medicines in water or at specific times in relation to meals. This placed people at risk of receiving their medicines inappropriately, or of staff not being aware of the potential reactions people may have to the medicines they took.

We found conflicting information about the support people required with their medicines in their care records. For example, one person's care plan referred to them requiring support with their medicines during their morning visit, whilst their medicines risk assessment referred to their needing support three times a day. Another person's care plan stated they needed assistance with medicines four times a day, whilst their risk assessment stated support was only required in the morning and evening. This placed people at risk of not receiving support with their medicines at the correct times.

We also found that the provider did not have an effective system in place to identify the medicines people were currently prescribed when requested. For example, staff were unable to provide an up to date list of

one person's medicines when requested during the inspection. The medicines listed on the person's MAR reflected those listed in their risk assessment but we found that no record had been made to confirm the administration of one of the listed medicines during a five week period. The provider submitted an up to date list of the person's medicines following our inspection which identified a further seven medicines which were not listed on their MAR, or in their risk assessment. Staff were unable to demonstrate that the service had considered how all of these medicines were to be administered and therefore there was a risk that the person had received their medicines as prescribed.

These issues were a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

At our previous inspection on 17 and 19 February 2016 we found a breach of regulations because risks to people had not always been assessed by the service placing them at risk of unsafe care. We also found that where risks had been assessed, some people's risk assessments offered conflicting information and guidance was not always in place for staff to follow on how to manage identified risks safely.

The issues we found were a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet the regulation. We also included the evidence of our concerns relating to the failure to manage risks to people safely in making a decision to impose a condition on the provider's registration, preventing them from taking on any new service users without prior agreement from the Commission.

At this inspection on 23 June 2016 we found that whilst some improvement had been made in the provider's risk assessment process, these improvements were yet to be rolled out across the whole service. Subsequently we found continued concerns with the way in which risks to people were managed by the service because sufficient action had not been taken in response to the findings from our last inspection to ensure the safety of all people using the service.

People's risk assessments did not always contain adequate guidance for staff on how to manage risks, or contained conflicting information regarding the type of support people required. For example, one person's risk assessment identified that they were at risk of falls and required the use of equipment whilst mobilising to ensure their safety. However there was no guidance for staff in the person's care plan on how to manage the risk of falls, and no reference to the equipment they required to mobilise. In another example, one person's risk assessment had been completed to indicate that they did not require any manual handling support in one section, whilst another area of the assessment made reference to manual handling equipment which staff needed to use whilst supporting the person to mobilise. In a third example, we found that one person's risk assessment identified that they suffered from the condition of diabetes. However, there was no information or guidance in place for staff on how this condition should be managed. These issues placed people at risk of unsafe support from staff.

Areas of risk had not always been adequately assessed. For example, one person's file contained information from the commissioning local authority indicating that the person used a walking frame whilst mobilising but also stated that the person used a sling on one arm. However the person's risk assessment did not consider how the person would mobilise with a walking frame without the use of both arms which placed them in potential risk of unsafe support. In another example we found that one person's risk assessment had not been fully completed and therefore there was no evidence that the safety of electrical appliances within their home had been assessed to ensure they were safe.

These issues were a further continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

At our previous inspection on 17 and 19 February 2016 we found a breach of regulations because the system the provider used to allocate people's visits did not ensure they consistently received their care when required. We found that one person had not received any visits over the previous weekend because of failings in the way visits were monitored.

These issues were in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet the regulation. We also included the evidence of our concerns relating to the failure to monitor people's visits in making a decision to impose a condition on the provider's registration, preventing them from taking on any new service users without prior agreement from the Commission.

At this inspection on 23 June 2016 we found that the system for monitoring people's visits continued to be ineffective and this meant there was a risk that people did not always receive them as planned. For example, one person's visits were monitored electronically and the monitoring records showed that seven visits in the month of April 2016 had not been logged. We asked staff to demonstrate that the person received their visits on these occasions but they were unable to do so because no reason had been recorded as to why the visits had not been logged. In another example we asked one person whether they received their visits as planned and they told us whilst they were happy with the service they received, the staff member who visited them did on occasion cancel their visits as short notice and had cancelled a visit during the week of our inspection. Office staff confirmed they were unaware that the visit had been cancelled and therefore no attempt had been made to find another staff member to attend the call.

These issues were a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

At our previous inspection on 17 and 19 February 2016 we found a breach of regulations because the provider's whistle blowing policy did not include any guidance on how staff could raise concerns with external agencies if needed.

At this inspection on 23 June 2016 we found the provider had updated their whistle blowing policy and guidance was in place for staff to raise any concerns they had with relevant external agencies if they felt the need to do so. Staff we spoke with were aware of how to raise concerns with external agencies, including the local authority safeguarding team and CQC where appropriate.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 17 and 19 February 2016 we found a breach of regulations because people's records relating to their care and treatment had not always been adequately maintained or were inaccurate.

This issue was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet the regulation. We also included the evidence relating to the inaccuracies in people's care records in making a decision to impose a condition on the provider's registration, preventing them from taking on any new service users without prior agreement from the Commission.

At this inspection on 23 June 2016 we found that some people's care plans remained inaccurate and did not reflect the support they received. For example, we requested to see one person's care plan but the copy initially provided by staff indicated they received only one visit a day. Staff confirmed that this was incorrect and that the care plan was out of date. A revised copy of the person's care plan was later provided which showed they received support at three visits per day. However it included guidance for staff to monitor the person's medicines during their lunchtime call. We spoke to the person receiving support and they told us they needed no support with their medicines.

These issues were a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 17 and 19 February 2016 we found a breach of regulations because quality assurance systems used by the provider were not always effective and did not always identify issues or drive improvements. The provider was also unable to demonstrate how staff training needs were monitored to ensure staff remained up to date with their training, and records could not be located promptly when requested.

These issues were in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet the regulation. We also included the evidence of these concerns in making a decision to impose a condition on the provider's registration, preventing them from taking on any new service users without prior agreement from the Commission.

At this inspection on 23 June 2016 we found that improvements had been made to the monitoring of staff training needs. A system was now in place which identified when staff required refresher training and a staff training programme had been implemented to ensure staff were up to date with training in areas considered mandatory by the provider. However we also found continued concerns with the quality assurance systems used by the provider, and some records could not be located promptly when requested.

The registered manager and provider told us that they were in the process of undertaking checks on people's care plans and risk assessment to ensure they were up to date and reflective of people's needs. They also told us that they still needed to undertake these checks on a significant number of people's records although they were unable to provide an estimate of how many records had already been reviewed or still required reviewing. Subsequently we found the checks the provider had made had not identified the issues we found during this inspection. We also found that where checks had been made, they had not always identified issues. For example, we saw confirmation that one person's medicines records had been checked as part of an audit of their care file and that no issues had been identified. However, our review of their records found that they had two completed Medicines Administration Records in place for the same five week period. Staff we spoke with confirmed this was an error which had not been identified.

Records we requested could not always be promptly located or provided. We requested a complete list of people using the service be made ready for arrival at the service when we announced our inspection to the provider on 21 June 2016, and again on arrival at the service at which time a partial list was provided. We repeated our request for a complete list of people receiving services from the provider. The provider took more than two hours to provide a list that they told us was complete. However the number of names listed did not reflect the number of care files held within the office so we could not be assured it was accurate. We also requested to see the risk assessments for two people using the service which were initially provided in the files of their care plans. However one risk assessment was out of date and the other was missing. A staff member told us they would arrange to conduct a risk assessment for the person whose risk assessment was missing but later provided us with an assessment that they told us had been completed a month earlier but had not yet been filed. Staff also located an updated risk assessment for the second person which had been

conducted two months earlier but which they told us had not yet been filed. The failure to locate this information promptly or to ensure that the information available to staff in people's files was up to date placed people at risk should staff need to refer to the risk assessments at short notice.

These issues were a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

At our last inspection in on 17 and 19 February 2016 we found a breach of regulations because the provider had not always submitted notifications relating to allegations of abuse as required. The Commission is still considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. However, at this inspection on 23 June 2016 we found further evidence of a failure to notify the Commission of an allegation of theft which had occurred in the time since our last inspection.

This issue was a continuing breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service failed to demonstrate good management and leadership. The provider and registered manager had not implemented effective systems to address the concerns we found at our in inspection on 17 and 19 February 2016, and had failed to meet the requirements of the warning notices we served in respect of breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) within the required timescale. The provider and registered manager had also repeatedly failed to submit notifications to the Commission as required despite our identification of this issue previously. Because of these failings, and the continuing significant issues that we found at this inspection, we have adjusted the rating for the key question 'Is the service well-led?' to inadequate.