Quality Home Care (Barnsley) Limited

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Inspection report

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13 February 2018
14 February 2018
16 February 2018
28 February 2018

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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

The inspection of Quality Home Care took place on 13, 14 February 2018 with telephone calls being made to staff on 16, 19 and 28 February 2018 and a follow up visit on 20 March to view requested information that had not been received. We previously inspected the service on 12 July 2017. At that time the service was not meeting the regulations related to safe care and treatment, safeguarding service users form abuse, good governance and fit and proper person employed. The service was rated Inadequate.

Following the last inspection, we met with the provider to confirm what they would do and by when to improve the key questions of safe, effective, caring, responsive and well led to at least good. The registered provider told us the improvements they would make to comply with the regulations. On this inspection we checked and found the necessary improvements had not been made.

Quality Homecare (Barnsley) Limited is a domiciliary care agency registered to provide personal care for people living in their own homes. Not everyone using Quality Home Care receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. At the time of the inspection the agency was supporting approximately 63 people.

There was a manager at the service who was registered with the Care Quality Commission (CQC.) A registered manager is a person who has registered with CQC 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.

There were continuing issues with risk management at the service. Risk assessments did not always provide sufficient information to provide direction for staff, or information about how to reduce risks.

At our last inspection we found a system was not in place to ensure sufficient time was left between visits, so people received their medicines in accordance with the prescription to reduce the risk of accidental overdose. At this inspection we found no improvements had been made in this area and medicines errors caused by visits being too close together had not been recorded and acted on appropriately to prevent possible harm. We informed the local authority safeguarding team about our concerns.
An effective system was not in place to assess, monitor, record and reduce the risks associated with very late or missed visits in line with the registered provider's policy. The registered manager did not accurately record or monitor incidents to reduce the risk of further missed or very late calls to people who were vulnerable.
Staff competency checks, in respect of medicines, had not been carried out in line with National Institute for Clinical Excellence (NICE) guidelines.

At our last inspection a robust system of recruitment was not in place. At this inspection we found there was

a continued risk that staff employed by the service had not been appropriately vetted to work with people that might be vulnerable.

There were mixed responses from people about having a regular staff team that came at the scheduled time and stayed for the allocated time.
Care staff had an understanding of what to do if they saw or suspected abuse during their visits.

People were not supported to have maximum choice and control of their lives because mental capacity assessments and best interest processes had not been completed in line with legislation. We saw evidence some people had given their consent to the care and support they were receiving.

Most staff told us they felt supported and received some supervision and training, although only half of the staff training records were available to review. This meant we could not be assured all staff had been trained, supervised, appraised and had their competency checked in line with nationally recognised guidance e.g. NICE

Most people and their relatives we spoke with told us they were treated with consideration and respect by care staff during their visits.
Care plans did not always contain sufficient up to date and relevant information to provide direction for staff. Most staff we spoke with told us they were familiar with people's individual needs, although information was not always shared with staff about a persons needs prior to commencing care delivery.

Complaints and concerns were not always acted upon. There was a mixed response from people and their relatives to confirm when they raised any issues with managers that their concerns were listened to.

The registered manager and registered provider failed to monitor and improve the quality and safety of the service and had not taken action following our last inspection to meet the continuing breaches of the regulations in line with their action plan.

People were not protected against the risks associated with missed visits or medicines management because the registered provider did not have an effective system in place to monitor, assess and mitigate the risk. An effective system of oversight was not in place to reduce risks and demonstrate learning from incidents.
Accurate and up to date records were not kept and an effective quality monitoring systems was not in place.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not

enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Full information about CQC's regulatory response to any concerns found during inspections is added to the 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?

Inadequate

The service was not safe.

Some people's risk assessment records did not contain measures to reduce risks and medicines were not always managed in a safe way for people.

People were not protected by an effective system to reduce the risks associated with very late or missed visits.

Recruitment procedures were not robust.

There were sufficient staff to provide a regular team of care staff, but people and relatives provided a mixed response that staff came at the identified time and stayed for the correct amount of time.

Is the service effective?

Requires Improvement

Mental capacity assessments and best interest decisions were not always completed in line with legislation.

Staff told us they felt supported and they had received training to enable them to provide support to people who used the service. Staff supervision, observation and training records were not all available to demonstrate this.

People were supported to have sufficient to eat and drink and access healthcare professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

Care was not always organised in a way that supported staff to deliver compassionate person centred care.

Most people told us staff were caring.

Staff spoke in a professional and caring manner about their job and the people they supported.

The service took account of people's preferences regarding the carers who supported them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all people were involved in the development and the review of their care plans.

Care plans did not all contain sufficient and relevant information to support staff to deliver effective care.

There was a mixed response on how the service dealt with complaints or concerns from people and their relatives.

Is the service well-led?

Inadequate

The service was not well-led.

An effective system was not in place to assess monitor and reduce risk to people from missed or very late visits, medicines management and unsafe recruitment practices.

Accurate and up to date records were not kept.

Audits had not been completed and the proposed system of audit was ineffective and did not identify or address the concerns found during this inspection.

The registered manager and registered provider had not taken sufficient action to address the concerns we found at our last two inspections and meet the regulations.

Quality Homecare (Barnsley) 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 13 and 14 February 2018 and was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure someone would be available to meet with us. The inspection continued on 16, 19 and 28 February 2018 when two adult social care inspectors made telephone calls to staff. The inspection team consisted of two adult social care inspectors and an assistant inspector. An expert by experience made telephone calls to people using the service and their relatives to gain feedback about the service provided. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was with older people.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider and feedback from the local authority and health service commissioners. We also received information of concern regarding an alleged incident, which was currently being investigated. At the time of the inspection a Provider Information Return (PIR) was available for this service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people using the service and their relatives during visits to their home on 13 February 2018 and reviewed the care records in their homes. We visited the office location on 14 February 2018 to see the manager and office staff; and to review care records and policies and procedures. During our visit we reviewed seven people's care records. We also looked at four records relating to staff recruitment, 25 records relating to staff training and seven supervision records, and various documents relating to the management

of the service. We spoke with the registered manager, a care coordinator and the training officer. Following the inspection we spoke with six members of care staff on the telephone on 16, 19 and 28 February. We also spoke on the telephone with four people using the service and seven of their relatives and friends. We conducted a further office visit on 20 March 2018 to view requested information that had not been received.

Inadequate

Is the service safe?

Our findings

Most people we spoke with told us they felt safe with staff from Quality Home Care. One person said, "I feel safe yes. No problems." A second person said, "Yeah, sometimes they haven't turned up, something is wrong like somebody's ill, they usually send somebody else."

One relative said, "They are great, really great. Never had any problem at all. They keep themselves safe and [my relative] safe." A second relative said, "They use gloves but not aprons despite a big box of aprons being here. I've also found soiled gloves thrown on the floor that haven't been put in the bin."

At our last inspection on 12 July 2017 we found the service was not meeting the regulations related to safe care and treatment because risk assessments did not contain sufficient accurate and up to date information to provide guidance to staff. At this inspection we found this regulation was still not being met.

Some action had been taken to seek advice regarding bed rail risk assessments following our last inspection and we saw bed rails for one person had been checked by a competent person to ensure they were safe for use. We found a generalised bed rail risk assessment was in place including general advice and pictures of entrapment (becoming trapped in the space between the bed rail bars leading to harm). However the risk assessments were not specific to the individual and the risk posed by their condition or presentation, which staff should be aware of to minimise the risk of harm.

We saw in one person's file a moving and handling risk assessment, which listed the equipment required by the person which staff would need to utilize, including a bath board, wheelchair, commode and walking frame. This contained a list of tasks, with no information about how to reduce the risks and no information about how to use the bath board for transfers. A further person's risk assessment contained a list of tasks to be completed, with no measures recorded regarding how to reduce or mitigate the risks. This meant care and support was not always planned and delivered in a way that reduced risks to people's safety and welfare.

We asked people if they felt the service had enough staff to deliver their care. One relative said, "[Name of manager] is taking on too many visits, so no I don't think there is enough staff. Sometimes they do seem rushed." A second relative said, "They usually come on time. They are a bit pushed for staff."

Most staff told us there were enough staff to complete visits and the training manager showed us no staff members working hours were excessive. One staff member said there were not enough staff. "There are never enough staff, but it's up to me if I want to do extra." The registered manager told us there were enough staff to cover shifts, however they were always recruiting for staff.

We asked people if their care visits were ever missed or late. Three out of the five people or their relatives we visited told us they had care visits that had been missed since our last inspection in July 2017. One person said, "They always tell me when they will be early like today. No missed visits. Only after hospital when the manager didn't give the carers the message." A second person said, "They are late very often, they're never

on time but there's 45 minutes flexibility. I did have a missed visit the other day because [name of registered manager] missed me off the rota. It's happened three times I think and twice last week they missed my tea time visit. I rang up and they sent someone but I had to wait. They did turn up eventually though. It shouldn't happen though I had to call them. I missed my medication on the day they missed my tea time visit and two weeks before that I missed medication in the afternoon."

One further person's relative said, "A tea time visit was missed once when [my relative] had come back from the hospital, we rang the office to tell them to come but we didn't get anyone. It's happened twice once in November and once in October (2017)."

We asked the registered manager how missed visits were recorded and analysed to prevent future incidents. The registered manager told us when there had been a missed visit an incident report was completed and they would let social services know, however the above missed visits were not recorded in line with the registered provider's policy. This meant they were not keeping accurate records of late or very missed calls to keep an overview of the safety of the service and reduce risks to people.

We asked the registered manager about the missed visit one person had told us about. We found information relating to the missed or very late visit was inconsistent and poorly recorded. The registered manager did not evidence appropriate action had been taken to ensure future risks to the person were assessed, mitigated and monitored. We saw in the person's care records brief information about a further missed visit in January 2018, which stated the visit was attended three hours after the planned time at 7pm by the registered manager. No incident report or safeguarding investigation was recorded. The staff log in system recorded the call time received as planned between 15.50pm and 16.05pm.

The training manager showed us staff often didn't use the electronic log in device which would indicate a missed call and they relied on service users, staff or relatives to contact the office if a call had been missed. The registered manager told us the log in system was not checked on a daily basis for any missed or very late calls. This meant records were inconsistent and not always accurate and demonstrated an effective system was not in place to record, assess, monitor, and respond to the risk of missed or very late calls and prevent future risks.

At our last inspection the registered provider was not meeting the regulations related to managing risk because, for some people, sufficient time had not been left between care visits to administer medicines at the correct time in line with the prescription. At this inspection we found improvements had not been made.

We asked the registered manager how they ensured this concern did not recur. The registered manager gave us an example of a staff member who had called in within the last week regarding insufficient gaps between medicines administration for one person and how the registered manager had changed the care schedule. We asked the registered manager for evidence of the action they had taken to keep the person safe or seek medical advice and there were no records relating to this. This meant accurate records of incidents were not kept to ensure risk could be assessed, monitored and mitigated.

Following our inspection we requested further information and found there was a three hour and 31 minute gap between two visits where Paracetamol was administered for the person. We alerted the registered manager to this concern so they could take appropriate action to keep the person safe. Following our inspection we saw from daily records for a different person there was insufficient gap between medicines administration recorded to safely meet the requirements of the prescription. We informed the registered manager of this and they said they would address it to ensure the person was kept safe. This meant the registered provider did not have an effective system in place to assess, monitor and reduce risks to people

and they were failing to keep an overview of the service to prevent future incidents. We shared the concerns with the local authority safeguarding team.

The registered manager told us there had been no medicines errors at the service since our last inspection and if there had been they would retrain the staff member. The registered manager later showed us a written record of an incident where medicines had been missed that they had addressed in supervision in January 2018. A staff discussion was the only record of action taken regarding this incident and there was no incident report, safeguarding notification or records of actions by the registered manager. The record stated the incident had been reported to safeguarding by the registered manager. We asked to see the training record for the staff member, however this file was missing. This meant there was no evidence the staff member had received training since the incident. We concluded a safe system of managing medicines errors to reduce risk to people was not in place.

There was no record of medicines competence assessments for staff administering medicines. Following our inspection the registered manager sent us two undated staff observation records as evidence medicines competence was assessed, which briefly referred to the staff members administering medicines. We concluded the service was not following NICE guidelines related to the safe management of medicines, which states staff competence to administer medicines should be assessed annually. This meant medicines may have been administered by staff without the competence to do so.

The registered manager told us there had been no incidents or accidents since the last inspection and so no incidents or accidents had been recorded, although we saw evidence of missed visits and medicines errors that had occurred since our last inspection that had not been recorded as incidents. This meant an effective system of recording and learning from incidents was not in place.

The above issues demonstrated effective systems were not in place to reduce risks to people. We concluded this was a continuing breach of Regulation 12 (1) and (2) (a) (b) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because care was not always provided in a safe way for people.

The above issues contributed to a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because effective systems were not established to assess, monitor and mitigate risks to the health, safety and welfare of people who used the service.

There were some detailed 'Safer Moving and Handling Plans' included in care plans, which were completed by the local authority, which included clear instructions on how to hoist the person and the use of slide sheets. One moving and handling plan where a person required the use of a hoist for all transfers, detailed the type of hoist and which sling and loops should be used. A series of risk assessments were in place related to the environment. This meant some risks to the health and safety of people using the services had been assessed and mitigated.

At our last inspection in July 2017 we found the registered provider was not meeting the regulations related to fit and proper person employed because recruitment processes were not robust. At this inspection we found improvements had not been made.

We looked at the recruitment process for four staff members and found the process was not robust. In two staff files we looked at a full set of information and documents required as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, were not in place. A Disclosure and Barring Service (DBS) check provides information about any criminal convictions a person may have.

However, we noted one staff member, who had recently commenced employment, Initial DBS check showed past offences; however there was no assessment in place to assess the risk to people who used the service. The registered manager told us there was a risk assessment, which had been mislaid, and this staff member did not work alone, however we saw from staff rota's week beginning 12 February 2018 and confirmed with the care coordinator that the staff member had attended three care visits alone that week.

The staff member had one reference on file, which was not from their most recent employer and did not include the company name. Following our inspection the registered manager told us they had attempted on several, occasions to get a reference, but been unsuccessful. They did not provide evidence of the attempts. A second staff member did not have references from their most recent employer. This meant the registered provider failed to ensure systems were robust to ensure fit and proper persons were employed to work with people who may be vulnerable.

We concluded this was a continuing breach of regulation 19 (1), fit and proper persons employed, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because robust recruitment procedures were not in place to ensure people employed were suitable to work with people who may be vulnerable.

At our last inspection we found the registered provider was not meeting the regulations related to safeguarding service users from the risk of potential financial abuse, because an effective system was not in place to reimburse people if they did not receive their allocated care hours. We saw from daily records there was still evidence people had been charged for time they had not received. For example; We saw for one person in one week in December 2017 that 50 per cent of 15 minute visits were five or more minutes short and only one visit was one minute over the 15 minutes allocated.

We disused short visit times with the registered manager and registered provider and they said they did not use 'minute billing' and charged for care in 15 minute blocks. They said some call times were longer than the allocated time, although there was very limited evidence of this occurring. We discussed this with the local authority safeguarding team and they confirmed the local authority charged for care in 15 minute blocks and they were not concerned about this practice. The registered manager told us if visits were consistently short they had discussed changing the length of the allocated visit times with the person and the person's assessor, to better suit the times required.

Care staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and they understood the procedures to follow to report any concerns or allegations. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected.

Most people and relatives we spoke with told us staff took steps to reduce the spread of infection, saying staff wore protective clothing, such as gloves and aprons when completing personal care tasks. Staff members we spoke with said aprons and gloves were kept at the office and all staff were able to collect what they needed when they visited the office. This showed the service had taken steps to ensure the people and staff were protected from the risk of infection.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For this type of service any applications to deprive a person of their liberty must be made to the Court of Protection.

We checked whether the service was working within the principles of the MCA. The provider had a policy in place; however some of the staff we spoke with did not have an understanding of the principles to follow. One staff member told us they did not know what the Mental Capacity Act was.

The registered manager was not aware of the requirements of the MCA (2005) and how this should be applied in practice. They were unable to tell us how they would complete a mental capacity assessment or what types of decision might require a metal capacity assessment and best interest decision to be recorded. This meant they may not have the skills and knowledge to ensure people's rights were protected.

Care plans for three people whose mental capacity was in doubt did not contain decision specific mental capacity assessments and best interest decisions regarding consent to the care plan. For example; one of the care records we sampled, where the person may lack mental capacity to consent to their care plan, was signed by the person's relative, who did not hold legal authority to make decisions about care on their behalf. No mental capacity and best interest decision was recorded regarding medication or use of bed rails. This meant the service had not ensured all the correct processes were followed to protect the rights of the people they supported.

The registered manager could not always evidence people had consented to their care plans, for example, one person's care plan was signed by a senior carer and not the person or their representative. We saw two of the five people we visited had signed their own care plans.

The above issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent, because the service was not always provided with the consent of the relevant person.

We looked at how new staff were supported in their role. One person said, "There was a new [staff member] last Thursday, so she watched the others using the hoist. There were three of them. We've got a good team." In the staff records available we saw staff completed induction training including safeguarding, health and safety, equality and diversity, mental capacity, fluid and nutrition and moving and handling. Staff were supported to complete further training which followed the same key modules as the Care Certificate. The

aim of the Care Certificate is to provide evidence that health and social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

Staff told us they shadowed more experienced staff for three shifts. Staff received some on-going refresher training in a variety of topics as well as practical training in the use of equipment such as the safe use of hoists. We found medicines administration competence was not always assessed regularly in line with NICE guidelines which meant some staff may not always have the appropriate knowledge and skills to perform their job roles effectively.

Staff told us they felt supported by senior care workers in the field, who also did occasional spot checks. Three staff who had been employed by the service for over a year out of six staff we spoke with told us they did not receive supervision. One staff member said about spot checks or observations, "I virtually rarely have them, because I am very experienced." A second staff member said, "They have done spot checks in the past. I don't have supervision." The registered manager told us supervision was completed in the field in the form of observation followed by a written discussion.

We found that two out of four staff supervision records were not up to date. When we returned to the service to look at the records in more detail two of the four supervision records we requested were not available to view. The registered manager told us the staff files were with senior care workers who were completing checks at the time. No supervision or appraisal rota was in place and the staff training matrix was not up to date. Half of the staff training files were missing. This meant we could not be assured all staff had been trained, supervised, appraised and had their competency checked in line with nationally recognised guidance e.g. NICE.

The above issues were a breach of regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing, because staff did not always receive sufficient supervision, appraisal and training to carry out their roles effectively.

People were supported with their choices if support with meals was required. Staff told us if people were assessed as requiring support with preparing food or drinks, staff would prepare a meal of the person's choice. Care plans recorded where people needed support with eating and drinking and details of their preferences and requirements.

One staff member said, "You pick things up about health if you chat with people." They gave us an example of how a person had changed in their presentation and they contacted the office to seek medical attention. Each of the care plans we looked at recorded the contact details for the person's GP and other relevant health professionals. Staff we spoke with explained if they thought someone's health needs had changed they would prompt them to visit the doctor or would contact the person's family and pass on their concerns to them if appropriate. We saw from records, concerns about a person's health had been passed on to the relevant health professional or family member when people were not able to do this for themselves. This showed people using the service received additional support when required for meeting their care and treatment needs.

Requires Improvement

Is the service caring?

Our findings

Despite concerns regarding the running of the service, feedback about individual care staff was positive. Most people we spoke with told us staff were caring and they had a good relationship with the staff who supported them. One person said, "It's different staff for day and night visits, it depends which shift they're on. I do prefer female carers not males and I've never had any trouble with that." A second person said, "Very good. I can't fault any of them. They are very good with everything. Nothing is a bother. They are very caring. Good girls." A third person said, "I think they are nice."

One relative said, "The carers are amazing. They are very person centred. They use the time nicely and go at [my relatives] pace. They are not rushed. I wouldn't let them in if they weren't caring. We had one bad one. I complained and they were removed." A second relative said, "Yes they do [protect their dignity] now, but we did have an incident a while ago where carer's weren't covering [my relative] when they were seeing to personal care. A text message was sent to the carers then reminding them to make sure [my relative] is covered."

Staff told us they enjoyed working with people who used the service. One staff member said, "I do enjoy meeting people, looking after them." Another said, "I like putting a smile on people's faces. I've helped someone today." A third staff member said, "I love it."

The service did not always give staff the time they needed to provide care and support in a compassionate and personal way. We found there were concerns from people about care visits being short and not planned in line with their preferences. Some people told us they were not actively involved in decision making and we saw evidence this was the case.

Staff told us they usually supported a regular small group of people and people told us this was usually the case. This meant most of the time people were supported and cared for by staff who knew them well, however staff told us they were sometimes expected to deliver care without prior knowledge about the person they were supporting.

We saw care files and profiles contained information about the tastes and preferences of people who used the service, including a short personal profile. Care staff spoke about the people they supported in a caring and professional manner. They expressed knowledge of people's needs and demonstrated an understanding of the need to treat people as individuals.

Staff we spoke with told us they showed people who had communication impairments a choice of clothes or food to enable them to communicate their preference. One staff member said, "I don't rush them. I ask them what they want and let them make decisions." Most care plans informed staff how to communicate in the most effective way with people. This meant staff supported people with their communication needs.

Staff told us they respected people's diverse needs by ensuring they understood the person through their care plan, talking with them and their families and supporting their lifestyle choices. Care plans recorded

any religious or cultural needs. Each of the care records noted if people had a preference for the gender of the care worker who supported them. The registered manager gave us examples of people from different religious backgrounds they had supported and told us they treated people equally and tried to match people and care staff with specific interests. This indicated the service took note of people's individual preferences.

We asked people if staff maintained their privacy and dignity; they told us they did and daily records reflected this. This demonstrated privacy and dignity was respected by staff.

People told us they were supported to remain as independent as possible in their daily lives and we saw from records they were encouraged to do what they could for themselves. Care plans detailed what people could do for themselves and areas where they might need support. One staff member said, "I let them do as much as they can do. If they are struggling I give them a hand." Staff were aware of how to access advocacy services for people if the need arose.

Requires Improvement

Is the service responsive?

Our findings

We received a mixed response from people regarding involvement in their care plans. People told us they had a care plan in their homes, but not all people were aware of what it contained. One person said, "I'm quite happy with the care plan. I'm happy with the amount of times I'm seen per day. I don't need any changes."

We asked relatives if the care plan had been reviewed. One relative said, "I don't think so. The supervisor [name] came out, but they didn't go through [my relatives] care plan. They just shuffled some paperwork around and removed some documents; They took them with them when they left."

The registered manager told us when they accepted a care package for a new person a senior member of staff went to meet the person to discuss their needs and to see how they wanted to be supported. They said the care file was developed from there and a copy of the care file was put in the person's home and a copy retained in the office.

Most staff told us there were care plans in people's homes and any changes in people's needs or concerns were passed on to the office. Two staff members told us they did not have chance to read people's care plans before delivering care, although the senior carer usually gave them some information verbally prior to commencing care. One staff member said, "We don't have a chance to read the care plan before a new client starts. We get a text with the person's name and address. It has happened a few times. We read the care plan when it goes in the house."

One relative said, "We were surprised to see the carers when they arrived on the first morning as we didn't know the care was starting that day. They arrived just before [name of care coordinator]."

We reviewed seven care plans in the office and five care plans in people's homes, some for the same people. Each care plan recorded the individual's details as well as a summary table of the visit times and the support care staff were to provide at each allocated care visit. In two of the care files we viewed care visit times were not being scheduled or delivered in line with the requested times. For example in one person's daily records we saw all night visits were an hour earlier than planned, 8 pm not 9 pm, week beginning 1 January 2018.

Care plans included personal information, such as details of people's preferences and hobbies, for example, "I like to walk, listen to the radio, sport, talking about travel." And for another person, "I like my meals served at my table." These details helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care.

Care plans contained information in areas such as health, nutrition, hygiene and Infection control, Interests, financial, practical support, service provided and risk assessments. We saw some detailed moving and handling plans, with instructions on how to support people with mobility needs, what equipment was required and how to use this, which were completed by the local authority.

A brief care plan summary was recorded every month in some of the care plans we reviewed briefly noting any significant events or stating there were no changes. Although one person's summary stated, "No problems with [person] to date," each month since 2016, despite significant changes to the person's circumstances, which affected the type of support provided by Quality Home Care. Not all care plans we sampled had been reviewed in the last year, were up to date or signed by the relevant person. For example one person's medicines care plan had not been reviewed as planned in 2017.

We found some information in care plans was contradictory, for example one person's care plan stated, "Memory problems, needs support with food stocks, making meals and drinks." And in another part of the care plan, regarding making meals stated the person did this themselves. A second persons care plan stated the person and [spouse] are clients and [spouse] is living with dementia. The same care plan later stated the person lived alone. This person's care plan had been reviewed in May 2017. This meant care plans were not always accurate and up to date to provide information and direction for staff and demonstrated a breach in Regulation 17, good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was unaware of the requirements of the Accessible Information Standard. This requires them to ask, record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. We found information regarding people's communication needs and the communication needs of their carers was recorded in care plans, for example information about people's hearing, vision, communication and memory, although some of this information was contradictory. For example one care plan stated the person had no hearing problems and later stated they were, "hard of hearing." This meant their communication needs were not accurately recorded, to support good communication.

We saw a 'comments sheet' was completed by staff on each visit. This recorded the date and times of visits and a record of the care and support provided. This meant there was record of the care provided.

People told us they would feel comfortable raising issues and concerns with any of the staff, although not all concerns had been acted on by the registered manager. One relative said, "[Name of coordinator] said if not happy ring the office. Anything at all is addressed straight away. Highly professional." A second relative said, "It's running well. No complaints. I would put them in the picture and it would get sorted out. "

The service had a complaints procedure which was included in each person's contract agreement when they started using the service and people we spoke with and staff were aware of this and the procedure to follow for making a complaint. Some of the people we spoke with told us they had raised concerns regarding late or missed visits or changes they wished to make regarding visit times being unsuitable, and these had not been addressed satisfactorily. The concerns or issues people told us they had raised were not recorded as complaints and there was limited evidence these issues had been acted on. The registered manager told us there had been no complaints since our last inspection in July 2017. There was therefore no evidence concerns were dealt with appropriately and any learning implemented to improve the service. This demonstrated people's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.

In the care plans we sampled people and their relatives had not discussed preferences and choices for their end of life care. Whilst no one was receiving end of life care, some people were living with potentially life limiting conditions. The registered manager said they would discuss this with people to record preferences for the future, to ensure people's wishes were respected.

Inadequate

Is the service well-led?

Our findings

We asked people and their relatives if the service was well-led and received a mixed response. One person said, "[Name of manager] doesn't listen, I've filled a questionnaire in but it's the first time I've been asked to do it." When asked what the service could do better the person said, "I can't think of anything no. Some staff are better than others. They're not bad." One person told us, "The manager has not been out since the early days. No one from the office has. [Name of senior carer] is in charge and rings the office." Although the person's relative told us a care coordinator had visited since our last inspection to check on a specific issue.

One relative said, "They aren't professional enough for me. No we wouldn't recommend at all." A second persons relative said, "They are a consistent team of carers. I don't have much to do with the managers." A second relative said, "The office are very considerate, usually speak to a young man. No complaints. Excellent set up." We asked people what improvements could be made to the service. One relative said, "I wish [name of manager] would get more staff to support [the care staff]. Carers care and are professional. When there is a change [name of senior] is straight on it, but it doesn't always follow through at the office. Despite ratings, they are the best we have had."

We asked staff if the service was well led. One staff member said, "Sometimes yes. There is some lack of communication. They are doing the best they can." Another staff member said, "If there is a problem they sort it out. They have been very good to me. Nothing can improve." A third staff member said they would recommend the company to their relative, they definitely felt supported and the service was like a family. They told us the registered manager was, "Brilliant, approachable and good at her job." Another said the staff team was good and they supported each other.

At our last inspection on 12 July 2017 the service was not meeting the regulations related to good governance. Following the last inspection the registered provider told us the improvements they would make to comply with the regulations. At this inspection we checked and found the registered provider had failed to make improvements and the service was still in breach of the same regulations, with two additional breaches.

People were not protected against the risks of inappropriate or unsafe care because the provider did not have effective systems in place to monitor and improve the quality and safety of the service provided.

We asked the registered manager to show us the visits received week beginning 5th February 2018 by five people. The registered manager told us they did not know how to use the system and the training manager showed us the visits that were recorded. They said they were unable to print these out or send them to us as this was managed by a staff member who came into the office one day a week. Where some planned visits were blank there was no record of whether this visit had been missed, cancelled or the staff member had failed to log in.

We asked how the registered manager knew from the system whether visits had been late or missed or if the correct amount of time was being spent on the visit to meet the persons assessed needs. The registered

manager said they relied on care staff ringing them to say they had missed a visit or the person using the service ringing them to inform them the visit was late or had been missed. They told us sometimes staff did not use the electronic log in system and sometimes they forgot to log in and out of the visit. The registered manager said they did not monitor the system for very late or missed visits. This meant people were at risk of harm because an effective monitoring system and oversight of this was not in place to ensure visits were completed in line with people's assessed needs.

Following our inspection on 20 March the registered manager told us the system was not effective and they had ordered a new visit monitoring system to record if visits were missed, short or late, which would be implemented in April 2018.

The training officer told us people were billed according to the number of hours of care they had received and not the number of hours stated in their care plans. When we looked at the care free log in records these were not up to date and some visits, which were no longer required, had not been removed from the system. There were some gaps in the visit records where visits should have been completed and it was not possible to calculate how many hours each person had received from these records. This meant accurate and up to date records were not kept.

The registered manager told us if staff found gaps in medication administration records (MAR's) or daily records they asked care staff to log this and the staff member would go back and sign them. The registered manager told us that they completed quality checks on MARs returned to the office, but they had not recorded these checks and they intended to check these three monthly going forward. No checks on MARs were recorded since our last inspection in July 2017. They said there had not been many gaps in MARs signatures in the last 6 months as this had improved. We saw for one person no daily records or MARs had been returned to the office for auditing since they started using the service in April 2017. This meant the registered manager did not have a system in place to ensure the safe administration of medicines.

Improved audits of care files were planned, however in the one example we were shown dated February 2018, no action to address the deficits found in the care plan was recorded. Other care files contained blank audit forms. Care plans were not always up to date and regularly reviewed, for example for one person their MARs did not correspond to the medication recorded on the medication care plan, although the MARs indicated there had been changes to the persons medication prior to July 2017. There was no evidence MARs had been audited since our last inspection in July 2017. This demonstrated the registered provider and registered manager did not have an effective system of audit in place.

We reviewed twenty five training records out of fifty four staff who were employed by the service. We asked the training coordinator for the remaining twenty nine staff training files, however they were not available and could not be located by the registered provider. This meant we could not be assured staff had received training to be able to perform in their roles. Systems for supervision, spot checks and appraisals were not in line with nationally recognised guidance.

The system for monitoring late and missed calls was ineffective. As no incident reports had been recorded at the service regarding very late or missed visits or medicines errors there was no evidence of learning from incidents to reduce future risks. This demonstrated the registered provider was not keeping an overview of the safety of the service.

The system for recording complaints or concerns was ineffective. No complaints had been recorded at the service, but people told us they had expressed concerns and we saw evidence of very late and missed visits. This meant we could not be sure people's views were taken into account or that concerns or complaints

were acted on by the registered provider in line with their policies.

All the above issues demonstrated a breach of regulation 17 (1) and (2)(a)(b)(c)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because effective systems were not in place to assess, monitor and improve the quality and safety of the service.

The registered manager explained the aims and values of the service, "We are trying to revamp and improve the service. Our values are to treat people as though they are your own parents, as you would want to be treated."

The registered manager told us they had completed a registered manager award and had been managing a care business for eighteen years. The registered manager was not aware of the requirements of the MCA (2005) and how this should be applied in practice. They were unable to evidence they kept up to date with good practice and developments in health and social care. This meant there were gaps in their understanding of key aspects of care delivery at the service and the associated regulatory requirements.

We saw feedback was sought from people when individual care staff were being observed in people's homes by senior staff and when people's reviews were held. A questionnaire had been sent to people in one area due to a specific concern raised to the service and the responses were mostly positive, with one concern to follow up. The registered manager had not recorded they had followed up this concern with the relevant authority, however, following the inspection, it was confirmed by the authority that they had.

Regular staff meetings were held to share information with staff. Topics of included rotas, confidentiality, safeguarding, uniform, MCA, whistleblowing, length of visits, record keeping and training and supervision. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service, although our findings indicated they were not always effective in sharing the required information.

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 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments and best interest decisions were not completed in line with legislation. The consent of the relevant person was not always evidenced. (1) and (2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Evidence was not provided that all staff had been trained, supervised, appraised and had their competency checks to enable them to carry out their role effectively. (2) (a)