Verity Group Limited

Verity HealthCare - Waltham Forest

Inspection report

Gateway Business Centre Suite 2, 3 & 4
210 Church Road
Leyton
London
E10 7JQ

Tel: 02036435295

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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 took place on 28 February and 2 March 2017 and was announced. This was the first inspection at this location.

Verity Healthcare – Waltham Forest is a domiciliary care service providing personal care to people in their own homes. They are also registered to provide Treatment for Disease, Disorder and Injury but were not delivering this at the time of our inspection. They were providing support to approximately 60 people at the time of our inspection.

The service had two registered managers, one for each regulated activity. 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.

People told us they felt safe, and received good care when they had regular care workers. However, other people told us they received care from lots of different care workers and this affected how safe they felt and the quality of their relationships with care workers.

Only one third of staff had been trained on safeguarding adults from abuse. Records showed that investigations into allegations of abuse had not been conducted in line with safeguarding best practice and local authorities told us they found the provider was very defensive during safeguarding investigations.

Risk assessments relating to risks people faced while receiving care were not complete and did not address all risks faced by people during care. Risk assessments were not completed before people started to receive a service.

People were supported to take their medicines by staff from the service. Records did not show that medicines were managed in a safe way.

The service checked that staff were suitable to work in a care setting by completing criminal records checks. Recruitment records showed the service was not always following its own recruitment practice. We have made a recommendation about recruitment.

Care plans were task focussed and did not contain details of people's preferences. They told staff where they were involved in supporting people with eating and drinking, but did not include details of people's dietary needs and preferences. We have made a recommendation about meeting people's dietary needs and preferences.

Staff gave us mixed feedback about the support and training available to them. Records of training and supervision were inconsistent and did not show staff had received the support and training they needed to

perform their roles. We have made a recommendation about staff training and support.

Records regarding people's capacity to consent to their care were not clear. People had not clearly indicated their consent to their care plans.

The service recorded people's religious beliefs and cultural backgrounds. The service provided care workers who reflected people's cultural needs where they were able. The service did not explore people's relationships or sexuality in assessments or care plans. We have made a recommendation about supporting people who identify as lesbian, gay, bisexual and transgender.

The service had responded to complaints made. The service's complaints policy was not appropriate for the service. We have made a recommendation about complaints.

People and staff gave us mixed feedback about the leadership and management of the service. While some people and staff told us management were accessible and responsive, other people and staff found them inaccessible and unresponsive.

Quality assurance and audit mechanisms had been ineffective as they had not identified or addressed issues with the quality of the service.

We have identified breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We will update this report with our regulatory response.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People did not always feel safe because they did not know when care workers would visit them.

The service did not respond to allegations of abuse and neglect in an appropriate manner.

Risks to people were not appropriately assessed or mitigated against.

The service did not consistently follow its recruitment processes. The service ensured staff recruited had completed criminal records checks before they started work.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not consistently receive the training and supervision they needed to perform their roles.

There were risks that people's nutrition and hydration needs were not met as information in care plans was insufficient.

The service was not always seeking consent in line with legislation and guidance.

Staff escalated concerns about people's health, and supported them to access healthcare services where appropriate.

Is the service caring?

Requires Improvement

The service was not always caring. Changes in care workers meant not everyone was able to build up positive, caring relationships with staff.

Care staff spoke about the people they supported with kindness and affection.

People's religious and cultural beliefs were recorded and the service provided culturally specific support where possible.

The service did not explore people's sexual orientation or

relationships and the impact they had on support preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were task focussed and did not reflect people's preferences. Care plans were not completed before people started to receive a service.

People gave us mixed feedback about whether or not they were involved in writing and reviewing their care plans.

Some people knew how to make complaints, but others did not. Records showed the service investigated and responded to complaints.

Is the service well-led?

Inadequate

The service was not well led. Quality assurance and audit systems had not identified or addressed issues with the quality of the service.

People and staff gave us mixed feedback about the leadership of the service. Although some people found management available and approachable, other said they were not available and did not respond to concerns.

Verity HealthCare - Waltham Forest

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 28 February and 2 March 2017 and was announced. We continued to speak to people and staff and received further information from the provider until 22 March 2017. The provider was given 24 hours' notice of our inspection as the location provides a service to people in their own homes and we needed to be sure someone would be in the office to work with us.

The inspection was completed by one inspector. Before the inspection we reviewed the information we already held about the service, in the form of notifications that had been submitted to us and feedback from members of the public. We sought feedback from the local authorities who commissioned the service and from the local healthwatch.

During the inspection we spoke with seven people who used the service and four relatives. We spoke with ten members of staff including the two registered managers, two coordinators, the receptionist, and five care workers. We reviewed six care files, including needs and risk assessments, care plans, medicines records and records of care delivered. We reviewed six staff files including recruitment records and records of spot checks and supervisions. We also reviewed various policies, procedures, reports and documents relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

Care workers told us they would report any concerns they had regarding possible abuse of people who used the service. One care worker said, "Straight away I'd be onto the office [if person expressed allegation of abuse.]" Another care worker said, "I'd report to the supervisor." However, records showed that 21 out of 62 staff who had direct contact with people who received services had not received training in safeguarding adults. After the inspection the provider submitted an additional training matrix which showed 14 of these staff had received training in safeguarding adults. However, this training pre-dated their employment with the service.

The registered managers told us they reported and escalated concerns about possible abuse of people who used the service. The registered managers sent us copies of 16 incident report investigations including safeguarding investigations. These records showed investigations were completed by staff from the service. However, it was not clear the investigation had been delegated to the service by the appropriate safeguarding authority. Investigations into allegations of abuse must be delegated and directed by the safeguarding authority. It was not clear from records that the safeguarding authorities had instructed the provider to complete their own investigations. In addition, where allegations had been made about care worker behaviour it was not clear that feedback had been sought from other people receiving a service from those care workers. The service had not explored whether other people were dissatisfied with their experience of care from these care workers. This meant the service had not assured itself that other people were not experiencing poor care or abusive behaviour from staff.

The registered managers sent us a copy of their safeguarding policy. The safeguarding policy did not include the contact details of the local safeguarding teams, and although it provided a lot of detail on the policy context and duties of local authorities, it did not clearly explain to staff working in the service what their role and responsibilities were in terms of raising concerns about safeguarding allegations. After the inspection the provider submitted a safeguarding policy which included local contact details and more information on the roles and responsibilities of care workers in the safeguarding adults' process.

As part of the inspection, feedback was sought from the local authority safeguarding teams involved with the service. They told us they were aware of some of the allegations made, but not because the provider had raised safeguarding alerts as required. The local authorities were aware of issues because people had raised them directly with their social services departments. This meant the service was not consistently following safeguarding adults processes and were not operating systems to respond to allegations of abuse appropriately.

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

People told us they were supported to take their medicines by staff. One person said, "She [care worker] supervises my tablets, she makes sure I take them." Records of medicines administration were not clear and did not contain the information required to ensure that people took their medicines as prescribed. For

example, one person's care plan instructed care workers to "Prompt my medication." Their needs assessment stated, "[Person] is unable to administer medication and requires her son and care workers to support medication administration." The care plan did not contain a list of the person's medicines or how care workers supported the person to take them. The provider's medicines policy stated this information should be contained within needs assessments and care plans. The provider submitted an undated copy of their prescription list. This person's medicines administration record (MAR) was reviewed. The records showed that care workers had marked some doses with an "x" and signed below. However, where there were multiple doses of the same medication at different times during the day there were not signatures for each dose. In addition, this person's medicines records showed that the afternoon doses of one medicine had no records beside them for 29 out of 31 days in January. This meant the records did not show this person was supported to take their medicines as prescribed. Other people's MAR were reviewed and contained gaps where it was not clear whether care staff or a relative was responsible for administering medicines. This meant the service was not ensuring medicines were managed in a safe way and there was a risk people did not receive their medicines as prescribed.

Care files contained risk assessments relating to the physical environment of the home and moving and handling tasks. These were thorough and included detailed instructions for care workers to follow to ensure that people were supported to use moving and handling equipment in a safe way. However, risk assessments were not complete. For example, one person's care plan referred to transferring them into a bath, and lifting them. Their moving and handling risk assessment contained details of transfers from chair to bed, and bed to chair, but did not include how to manage the risks associated with using the bath. In addition, this person's care records referred to the use of a standing frame, and the use of suctioning to remove excess fluid and identified the person was at high risk of choking. There were no risk assessments in place in relation to the use of the standing frame, choking risks or use of suctioning equipment. Care staff who supported this person told us they were shown how to mitigate these risks by the person's family.

Another person's care records included an instruction from healthcare professionals made on 31 January 2017 to use a pressure relieving cushion to reduce the risk of pressure damage to their skin. This person's skin risk assessment was dated 2 February 2017 and did not include any reference to the use of pressure relieving equipment. A third person's referral information identified they were at risk of poor nutrition and dehydration. However, their care plan contained no risk assessments in relation to nutrition and hydration and the only information provided to care workers was "Assist me prepare breakfast. I usually prefer hot drinks. Sit with me and encourage me to eat. Assist me to prepare sandwich for lunch." There were no details to tell care staff what assistance meant for this person. This meant risks associated with people's needs and care had not been appropriately assessed or mitigated against and they remained at risk of harm.

The above issues with medicines and risk assessments are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and relatives told us they felt safe. One person said, "I feel safe, they support me nicely." A relative told us, "My family member is safe with them." Another relative said, "I'm happy to leave my family member alone with the staff. I trust them." One person said they did not feel safe as they did not know the staff who were supporting them.

People and staff gave us mixed feedback about the staffing levels in the service. Some people and staff told us they thought the service had enough staff and they received a consistent service, other people told us they received an inconsistent service and frequent changes in care worker. One person said, "I always have the same care worker. She'll always stay extra if she's been running late." Another person said, "I have two

main care workers and they're on time." However, another person said, "I don't feel safe because I'm only just meeting them [care workers]. I don't know them to feel safe. I never know what time they are coming." A relative told us that staff sometimes had to rush to get to visit other people. They said, "Sometimes they are having to rush, so if the job is done it's OK for them to leave." Another person told us they had previously had a lot of missed visits. They said, "We had a lot of missed visits, though this has improved recently. Before it was atrocious."

Staff told us the rota was disorganised and they worried about whether or not visits were covered on their non-working days. One member of staff said, "There's no organised cover, I always have to check they've got my days off covered. I worry people will miss visits." Another member of staff said, "I'll get asked to cover on my days off. I don't think they have enough cover staff." A third member of staff said, "I can't say now, as I'm on a fixed rota, but before there were definitely not enough staff." However, a different member of staff said they thought the service had sufficient care staff. The registered managers told us they had recruited additional staff in specific areas to address issues of staff travel time and to ensure they had sufficient staff to meet the needs of people they supported. The service had introduced electronic call monitoring to increase its ability to monitor missed visits and to ensure cover was arranged. However, the system was not operating fully so the service relied on log book entries to monitor missed and late visits. The service had investigated allegations of missed and late visits and stated they were not missed. This contrasted the feedback from people, who told us visits were missed.

Recruitment records for six staff were reviewed. These showed the service had not consistently followed its recruitment processes. Not all interview records showed that answered had been assessed, and in some cases gaps in applicant's employment history had not been explored. The service's policy stated that references should be supplied by the applicant's most recent employer, or character references where the person had not previously been employed or had been out of work for a long period. Records showed the service had accepted references that were not from the applicant's most recent employer. The registered managers showed us an independent human resources review which included a plan that stated they would ensure their recruitment processes were followed in the future. Records showed the provider carried out criminal records checks on staff before they started work to ensure they were of suitable character to work in a care setting and had not been barred from working in care settings.

We recommend the service seeks and follows best practice guidance on recruitment practice.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest and as least restrictive as possible. We checked whether the service was working within the principle of the MCA.

Records regarding people's capacity to consent to their care and treatment were unclear. One person's care plan stated they were unable to consent to their care due to their limited English skills. This person's care plan was agreed with their relatives. Although the assessment noted the person required an interpreter to engage with the assessment and care planning process, there was no record that this had been provided, and the provider had relied upon the person's relative to consent to care. There was no record the relative had legal authority to act on their relative's behalf and no record the service had provided the help the person needed, such as an interpreter, to make their own decision. A second person's care plan stated their needs assessment and care plan had been written with their relative. Although their summary stated "I speak very little English" their assessment stated their preferred language was English and they did not require an interpreter. There was no record of measures taken to undertake assessments in this person's first language had been attempted.

Although some care plans had been signed by people to indicate their consent, most had not been signed. The provider told us this was because they faced difficulties in taking completed care plans to people's homes to get them signed. The service did not have records to show that relatives' had legal authority to act on people's behalf. This meant the service was not seeking consent from people in line with legislation and guidance. The provider's service monitoring report asserted that managers at the service "are trained and competent to conduct Mental Capacity Assessments." MCA training was not included in the training matrix submitted which meant there was no record that any staff had received training in this area. After the inspection the provider submitted records that showed managers and coordinators had received training in the MCA. There were no recorded mental capacity assessments in any of the files viewed, even where there were doubts about people's ability to make decisions about their care. The report continued to state the provider had supported one person in the community who had been subject to a Deprivation of Liberty Safeguard (DoLS). This was not possible, as DoLS apply to care homes and hospitals and do not apply in community settings. In community settings a Court of Protection order is required. The inclusion of this in the provider's end of year report shows they had not understood the application of MCA and DoLs processes.

The above issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans and needs assessments contained a high level summary of people's medical history and health needs. Where health needs were met by other health professionals involved in the person's care this was clearly recorded. For example, one person also received care from district nurses and instructions were clear

that care workers should not be involved with those aspects of the person's care. The registered managers told us that most people received support to meet their health needs from their relatives and this was confirmed by the people and relatives we spoke with. Relatives told us they were confident they would be informed and updated if there were concerns about people's health. One relative said, "They escalate concerns appropriately." Another relative told us, "They let me know if my relative is not OK." Staff told us they would report concerns about people's wellbeing to their supervisors and would escalate their concerns to management if they were not happy with the response they received. This meant people were supported to have their healthcare needs met.

One person told us how their care workers ensured they had sufficient food and drink. They said, "The care workers make me a flask of tea to last the day, and prepare my meals as I ask for them." Another person told us, "Sometimes she [care worker] makes me breakfast if she has time." The registered managers told us most people were supported by family members to have their nutrition and hydration needs met. Care plans contained limited details regarding people's dietary needs and preferences. For example, one person's assessment stated, "[Person] can feed herself but requires assistance in preparing meals." Their care plan instructed staff, "Prepare meals for me and encourage me to eat." There were no further details for staff regarding this person's preferences or how to encourage them to eat. This person had communication difficulties which meant new staff visiting this person would not be able to establish their preferences easily. This meant there was a risk that people's dietary needs and preferences were not met.

We recommend the service seeks and follows best practice guidance around meeting people's dietary needs and preferences.

People told us they thought staff were good at their jobs. One person said, "They [care workers] know what they're doing." The provider told us they were committed to providing trained staff and had a dedicated training manager. Staff were receiving training during the inspection.

Staff gave us mixed feedback about the training and support they received. Some staff were very positive about the training and support. One member of staff said, "The training is very good. I learned a lot, like all clients are not the same, it makes me treat them as individuals." Another member of staff said, "They are really training us properly. I have weekly meetings and trainings." However, other staff told us they had not received training and had not had one-to-one supervisions or checks on their performance. One member of staff said, "I was not trained. I learn for myself." Another member of staff said, "The training seems non-existent to me. They started me on a course. They gave me the questions I was supposed to be learning, you're meant to pass a test. They also give you the answers, they tell you what to write." A third member of staff said, "I've had no training since I've been in post and one-to-ones, they don't happen"

The provider sent us a copy of their training records. Training records contradicted the information provided by staff who told us they had not received training. Their entries showed they had received training in areas including person centred care, equality and diversity, dementia, end of life care and substance misuse. The records showed that all staff had completed the care certificate or were working towards it. The care certificate is a recognised qualification that provides care staff with the fundamental knowledge and skills required to work in a care setting.

The provider's policies on assessment and support planning stated these would only be completed by staff who had been trained in how to complete assessments and care plans. Assessments and care plans were completed by the registered managers and care coordinators. One of the care coordinators was not included in the training matrix submitted, and the other coordinator's record did not include training in completed needs assessments or care plans. This meant staff had not received the training they required to

perform their roles.

Records showed that spot checks were carried out by supervisory and management staff. These sought feedback from people about their experience of care, and evaluated the performance of care workers in their roles. Supervision records were also reviewed. These showed training needs and the support needs of people were discussed. The provider's policy did not state the frequency with which supervisions should be completed. However, the provider's end of year report stated they aimed to complete them on a monthly basis. The records did not show that supervisions were completed at this frequency. The registered managers told us complete supervision records were currently with an independent auditor to prepare for the completion of a quality report. This meant it was not clear all staff were receiving the support they required to perform their roles.

We recommend the service seeks and follows best practice guidance around training and supporting staff.

Requires Improvement

Is the service caring?

Our findings

People told us they had built strong relationships with regular carers who they thought cared about them. One person said, "They do it [provide support] in a nice way. I think they care." Another person said, "I get on with my carer very well, she's a friendly personality. She's got to know me as a friend." A relative told us, "They [care workers] spend time with my family member. They have got to know her. They are respectful to her." Another person told us, "I have two main carer and they're very good, excellent. I'm confident they would get anything I wanted."

However, other people told us the strength of their relationships with care staff were affected by changes to staff supporting them. For example, one person told us, "There was one girl who was always late. I didn't like her coming." Another person told us, "We've been having a lot of problems with them sending new carers, then there are irregularities in the times and they don't know what to do." They continued, "We had another new one [care worker] yesterday. We don't like new faces knocking on the door. That was causing friction." A relative told us changes in care workers had a negative impact on their family member's wellbeing and ability to engage with support provided. They said, "The care workers are always chopping and changing. When it's a new worker [my relative] panics and becomes non-cooperative. [My relative] has no quality of life. They haven't had a proper wash in months because he panics with new workers." This meant not all people were able to build caring relationships with regular care staff.

Staff told us they were able to build relationships with people where they worked with people regularly. Some staff told us the strength of the relationships had benefitted from the people they now supported regularly being people they had shadowed during their inductions. One care worker said, "The shadowing gave me a bit of an introduction. That helped us get to know each other." Care workers spoke about the people they supported with kindness and affection. One care worker described how they encouraged the person they supported to maintain their dignity. They told us, "I always ask what he wants. I don't tell him, but ask each day. It's to do with how you phrase it. So I'll say something like 'Do you fancy jumping in the shower today? Your relative might pop round and it'll be nice to be spruced up.' If I told him he needed a shower he'd never agree, you have to explain it properly."

Care plans contained details regarding people's religious faith and cultural background. The service operated in a culturally diverse area of London and records showed they supported a significant number of people who did not speak English. Where the service had staff available who were able to speak the same first language as people receiving care, they provided these staff to people. Where they were unable to provide staff who were able to communicate with people in their first language, care plans included details of people's family members who would be able to facilitate communication. Care plans included whether people preferred to be supported by male or female care workers.

Care plans contained the names and contact details of people's nearest relatives. However, they did not contain information about people's relationships and pasts. There was no information about people's sexuality contained within care plans. Care workers were asked if they supported anyone who identified as lesbian, gay, bisexual or transgender (LGBT) and whether this affected the support they wished to received.

One care worker said, "No [I don't know if anyone I support identifies as LGBT]. I don't ask those questions." Another care worker said, "No, no, no. They're straight people. It's in the care plan." This information was not contained in any of the care plans reviewed and the assessment template did not include questions regarding sexuality or relationships. This meant there was a risk that people who identified as LGBT were not supported to disclose this information and the potential impact it had on their support preferences.

We recommend the service seeks and follows best practice guidance on supporting people who identify as lesbian, gay, bisexual and transgender.

Requires Improvement

Is the service responsive?

Our findings

People and staff gave us mixed feedback about their involvement in creating care plans and their usefulness in providing staff with the information they needed to provide high quality, person centred care. Some staff told us care plans contained all the information they needed. One member of staff said, "Everything we need is in the care plan." Other staff told us the care plans were lacking in details. One member of staff said, "I'm finding I'm having to do things that aren't in the care plan. It's not always clear or written down."

Some people and relatives told us they were involved in creating their care plans and could make amendments easily. One person said, "I had a meeting and they told me what I would get." Another person said, "I have a care plan, they [care workers] know all the tasks." A relative told us, "It's no trouble to ring the office. We've done the plans and assessments over the phone." However, other people told us they did not have care plans or that care plans were not accurate. One person said, "I've got a care plan, but I don't know what it says." Another person said, "I don't know what they [care workers] are doing. There was no assessment. I've never been asked questions about what I want." A third person told us, "There is a care plan, but it's not quite accurate. It took months to get one made and even then it wasn't quite right."

Records showed there was often a significant period of time between people's needs assessments being completed and the care plans being produced. For example, one person's records showed their package started on 19 December 2016 but their care plans and risk assessments were not completed until 17 January 2017 and 7 February 2017. Another person's records showed the care package started on 15 December 2016 but their care plans and risk assessments were not completed until February 2017. A spot check on a care worker noted they had not been able to follow the care plan on the visit as it had not yet been completed. The time between the packages of care starting and care plans being produced meant that staff did not have the information they required to know how to provide care in line with people's needs and preferences. This was discussed with the registered managers. They told us that initial visits of care were completed by the coordinators who completed the assessments and care plans. They said these staff provided care until the care plans were written. The provider's policy on care plans and assessments stated that care plans should be in place "Before we start to provide a service or, in urgent cases, as soon as possible afterwards." This meant the service was not following its own policy and was not ensuring there were care plans in place to inform staff how to meet people's needs and preferences.

Care plans reviewed lacked detail and were not personalised. Care plans contained a list of tasks for care workers to complete during visits. For example, one care plan stated, "Support me to undress and remove continent pad. Hoist me on the commode. Empty and disinfect commode. Support me with oral care. Strip wash / bath me with clean flannel and dry me thoroughly with a clean towel." There were no details regarding preferences such as water temperature, clothing choices, or products to use during personal care. The registered managers told us they would update care plans to include these details. Updated care plans reviewed remained task focussed.

Records of care delivered showed staff were supporting people with tasks that were not explained in the care plan. For example, one person's care records showed care workers supported them with exercises and

massages on a daily basis. Information on how to support these exercises and provide massages were not included in the care plan. Another person's care records showed care workers used equipment and took part in activities that were not detailed in the care plan. Staff working with that person told us they followed instructions from their relative. This meant there was a risk that if a new care worker attended they would not have the information they needed to provide appropriate care as it was not recorded.

People told us they had found the service did not provide care workers at times that suited them, or that care workers were frequently late. One person said, "I don't know what time they are coming." Another person said, "It happens every time [care workers are late]. I always have to phone them." A third person said, "They are always late." A relative told us, "Sometimes they are a bit late." Records showed the service had investigated nine incidents of allegations of missed or late visits. The service had recently introduced an electronic call monitoring system to make it easier for them to monitor visit times. The system was not fully operational and levels of use were low. However, of the records available, 30% of visit times were outside the 15 minute timeframes allowed by the provider. Eight recorded visits were more than an hour earlier or later than the scheduled visit time. This meant people were not consistently receiving a personalised service as they were not receiving care at a time that suited them.

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

Care workers told us they reported to the office when they thought someone's needs had changed and their care plan needed amending. Feedback from staff was mixed regarding how effective the response from the provider was. Some staff told us the office responded quickly to their feedback and implemented changes in care packages. However, other staff told us they did not receive a response when they raised issues. One member of staff said, "We tell the office if people need support. They tell us the will raise it but they do nothing. We raise it, but I don't know what they are doing with it." Another member of staff told us, "I raised that the person needed more support. I had to really push until they did something about it." This meant there was a risk that people's support arrangements were not consistently amended to ensure they continued to meet people's needs. After the inspection the provider submitted emails showing they raised concerns about people's needs changing with local authorities."

Some people told us they knew how to make complaints, and that they had been satisfied with the outcome when they had done so. One person said, "I told [coordinator] I needed it [issue with support provided] fixed and they responded well." Another person said, "They did improve for a while when we raised issues." However, other people told us they did not know how to make complaints. One person said, "I don't know how to complain." Another person said, "I've not been told how to make a complaint."

Records showed people and relatives had made complaints about the service. The investigation reports stated these were often the result of miscommunication or disagreements between people who received the service and their relatives. Records showed the service would change allocated care workers when complaints were made.

The provider submitted a copy of their complaints policy. This referred to the guidance, regulations and duties that apply to local authorities in managing and handling complaints about health and social care services. The policy included the statement, "Independent sector social care providers are required by law to have their own complaints procedure and self-funded users of those services can access that procedure." The policy gave detailed guidance on how Adult Social Care Services within local authorities should respond to complaints. Although the procedure outlined for responding to complainants could be applied to complaints received by the service, the policy was not appropriate as it was outside the scope of the

organisation as an independent provider of health and social care services.

We recommend the service seeks and follows best practice guidance in responding to complaints.

Inadequate

Is the service well-led?

Our findings

The service had two registered managers. One was registered for the regulated activity of treatment of disease, disorder and injury. This was a regulated activity that the service was not providing at the time of the inspection. This registration is required for services that deliver nursing care. The provider told us they planned to deliver nursing care in the future and had secured a contract with 15 Clinical Commissioning Groups in London to deliver nursing care to people in their homes. This inspection did not assure us the provider was ready to expand its services to this extent. The other registered manager was registered for the regulated activity of personal care. This registered manager had submitted applications to cancel their registration as registered manager. In the provider's end of year report they stated they had not had a response from CQC regarding this application. Our records showed the provider was advised these applications had been rejected in February 2017.

People gave us mixed feedback about the leadership and management of the service. Some people gave positive feedback saying they found the registered managers approachable and responsive. One person said, "The boss has come to my house a couple of times." Another person said, "I ring [one of the registered managers] the head bloke. He finds out what's going on and tells me what's happening." However, other people were not positive about the availability and capability of the management team. One person said, "[Registered manager] is always busy." Another person said, "They [management] do listen. I feel it's all a bit beyond them really. They'll make promises and apologies [when things go wrong] but not a lot of things seem to happen."

Staff also gave us mixed feedback about the leadership of the service. One member of staff said the registered manager was supportive and approachable. They told us, "I think he's a good man." However, other staff told us the registered managers were always too busy to speak to them. One member of staff said, "[Registered manager] always tells us 'I'm busy I can't see you.'" Another member of staff said, "I don't normally talk to [registered managers]. They might be busy." A third member of staff told us, "The office is chaotic and it's not easy to raise concerns. It all feels a bit higgledy-piggledy. I'm never sure what [registered manager] means." This staff member said that some office based staff had been rude to them when they raised concerns. A further member of staff said, "Nothing seems to get done. It's like talking to a brick wall. The registered manager is either busy or in a meeting. The office doesn't feel well run or organised. I tried to raise an issue once. The registered manager raised his voice and told me if I was not happy I should go and work somewhere else."

Care workers told us they did not have meetings where they could raise concerns or discuss the service. The registered managers told us they did hold staff meetings. They sent us copies of meeting minutes. These showed the office staff met regularly but did not show meetings where all care workers were invited to attend. This meant the management of the service were not providing the opportunities for staff to be involved in developing the service, and were not developing a person centred culture across the whole staff team.

The registered managers told us they completed quality assurance checks on staff through spot checks.

They also told us they sought feedback from people who received a service through questionnaires. They sent us copies of a sample of the questionnaires completed by people and spot checks. These showed people were asked to provide feedback regarding timekeeping of care workers, the number of care workers involved in their care, care workers understanding of their needs, and the performance of the care workers. In addition, the registered managers sent us copies of detailed observations of practice they had completed in people's homes. These showed they identified when staff followed care plans, and when they needed to improve their work. They also identified when staff were not wearing their identification badges and stated staff had been advised to wear them at all times.

The registered managers sent us a copy of their end of year report. This was an evaluation of the quality of the service they provided and was produced with an independent consultant. The report evaluated the service in relation to people's engagement with the service, the quality of documentation including care plans and risk assessments, record keeping, safeguarding, the MCA, complaints, infection control, medicines management, staff recruitment and training. It also included a self-evaluation in relation to the five key questions asked on inspection. This report assessed the provider as being good or outstanding in all areas of service provision. The report had not identified the issues we found with the timeliness and quality of care plans, risk assessments, medicines, safeguarding practice, consent recording and other records. The report had not identified or addressed the issues with timekeeping of care workers that people told us about. In addition, this report made reference to out of date regulations and areas of regulation, such as Deprivation of Liberty Safeguards, that are outside the scope of the service. This meant the quality assurance mechanisms had not been effective. They had not identified or addressed issues of quality in the service or the issues identified during this inspection.

Care providers are required to notify CQC of serious incidents, injuries, safeguarding allegations and incidents being investigated by the police, as well as deaths of people while using the service. The registered managers told us they had submitted notifications but these could not be found in our systems. During the inspection the registered managers submitted 15 notifications which they stated had previously been submitted. A thorough examination of our records could not locate them. The notifications submitted contained inconsistencies. For example, in two notifications the date recorded as the date the notification form was completed was before the date at which the registered person was made aware of the concern. In addition, the wrong identification code for the service had been used for all the notifications. This meant the registered managers had not completed their duties thoroughly or as required.

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

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans had not been completed in a timely manner, were task focused and did not include details of people's preferences. People were receiving support with care tasks not included in their care plans. 9(1)(c)(3)(a)(b)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent had not been sought in line with legislation and guidance. 11(1)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not operated effectively to ensure people were safeguarding from avoidable harm and abuse. 13(3)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been assessed and measures in place to mitigate risks were insufficient. Medicines were not managed in a safe way. 12(2)(a)(b)(g)

The enforcement action we took:

We have issued warning notice.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and audit systems had been ineffective in identifying and addressing risks to people and measuring and improving the quality of the service.

The enforcement action we took:

We have issued a warning notice