First Choice Homecare & Employment Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19, 20, 21 and 26 July 2016 and was unannounced. At our previous inspection on 6 November 2013 we found the provider was meeting the regulations we inspected.

First Choice Home Care and Employment Services Limited is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our visit the service was providing support to 332 people in the London Boroughs of Newham, Waltham Forest and Redbridge. Support provided to people in Redbridge was usually a six week re-ablement service when they were discharged from hospital or if their health needs suddenly changed. The majority of the people using the service were either funded by the local authority or the NHS.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (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 2008 and associated Regulations about how the service is run.

People who lived with specific health conditions did not always have the risks associated with these conditions assessed and care plans were not always developed from these to ensure their safety and welfare. Risk assessments lacked detail and did not always provide staff with guidance on how to minimise risk. There was no guidance around the provider's rating of risk and it was difficult to see how risks to people had been calculated.

Appropriate policies and procedures were not in place to ensure that people received their medicines safely and effectively. The registered manager told us that they were implementing a new process to check all medicines records on a monthly basis however this was not in place at the time of the inspection.

Where issues had been raised previously relating to late and missed visits, there was evidence that enhanced monitoring and risk alert notifications had been put in place to make sure people had their visits on time. However there were still inaccuracies between scheduled visits and actual visits where without daily log records or time sheets, we could not be fully assured certain visits had taken place.

The provider had a robust staff recruitment process and the provider completed the necessary checks to ensure staff were suitable to work with people using the service.

The provider had a good understanding of the policies and procedures in place to safeguard people from abuse and avoidable harm. Incidents were reported and followed up and we saw evidence that disciplinary procedures were followed.

Requirements of the Mental Capacity Act 2005 (MCA) were not followed. The provider did not have a clear understanding of the need to demonstrate that people had consented to their care and that there should be

an assessment of their capacity if they were unable to do this.

People were supported to have sufficient food and drink however people's preferences were not always recorded and care plans did not always identify risks or nutritional needs.

There were gaps in staff training which was acknowledged by the registered manager. A refresher training programme had just started for all care workers within the service. Care workers received regular supervision where they were able to discuss issues relating to their role, including any issues or concerns they had for the people they supported

People and their relatives told us that their regular care workers were kind and caring and knew how to support them. People felt that they were given choices in their care and staff understood the importance respecting people's privacy and treating people with dignity and respect.

Care plans for people lacked detailed information, were incomplete and not always specific to people's needs. We could not always be assured they reflected people's wishes and how they wanted to be cared for.

People and their relatives knew how to make a complaint and were able to share their views and opinions about the service they received. There were quality monitoring visits and phone calls in place to allow people and their relatives the opportunity to feedback about the care and treatment they received however it was not consistent. There was a lack of evidence to show that concerns were always followed up.

The provider did not meet the CQC registration requirements regarding the submission of notifications about serious incidents, for which they have a legal obligation to do so.

Quality assurance and management systems were not consistent throughout the service to monitor the care provided to people who used the service.

We found five breaches of regulations relating to person centred care, consent, safety, good governance and notifiable incidents. You can see what action we told the provider to take at the end of the full version of this report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

Appropriate policies and procedures were not in place to ensure people received their medicines safely and effectively.

Risk assessments were in place but lacked detail and action needed to reduce the likelihood of people coming to harm.

People were protected from the risk of potential abuse because the provider followed their disciplinary procedures and staff had a good understanding of how to recognise and report signs of abuse.

Robust staff recruitment procedures were followed to minimise the risk of unsuitable staff being employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have a clear understanding of the principles of the Mental Capacity Act 2005 and people's consent to care and support was not always recorded accurately.

People's nutritional needs and preferences were not always documented or managed appropriately and care plans did not always record important medical information, such as diabetes.

There were gaps in staff training which had just started to be addressed by the provider. Staff spoke positively about the training they received.

Staff received regular supervision to monitor their capability and understanding of the tasks they were required to undertake.

Is the service caring?

Good

The service was caring.

People spoke positively about their regular care workers and were generally happy with the care they received.

People felt involved in decisions about their care. They were given a choice and were encouraged to be independent.

Care workers respected people's dignity and maintained their privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans for people lacked detail, were incomplete and were not person centred. We were not always assured they reflected people's wishes.

There was a system in place to deal with people's complaints. We saw concerns raised were followed up however this was not consistent throughout the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not meet the Care Quality Commission registration requirements regarding the submission of notifications regarding safeguarding incidents and incidents involving the police, for which they have a legal obligation to do so.

There was an inconsistent approach to quality assurance and record and data management systems varied in quality and detail.

Staff felt supported by management to carry out their roles and responsibilities.

First Choice Homecare and Employment Services Ltd

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 the 19, 20, 21 and 26 July 2016 and the first day of the inspection was unannounced. We told the provider we would be coming back on the following days.

The inspection team consisted of five inspectors, with one present on all four days of the inspection, two on the 19 July and two on the 21 July. It also included two experts by experience who were responsible for contacting people during and after the inspection to find out about their experiences of using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The experts by experience had experiences as a family carer of people who have severe learning disabilities and/or behaviour that is considered to be challenging, and older people who use regulated services.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC and the report for the last inspection that took place on 6 November 2013, which showed the service was meeting all the regulations we checked during the inspection. We also contacted the local authority safeguarding adults team, the quality monitoring team and commissioning team and used their comments to support our planning of the inspection.

We called 60 people using the service and managed to speak with 25. We also spoke with 14 relatives and 26 staff members. This included the registered manager, a branch manager, six care coordinators, three field care supervisors, the office administrator, the trainer and two system administrators. We called 19 care

workers and spoke with 11. We looked at 28 people's care plans, 16 staff recruitment files, training files and audits and records related to the management of the service.

Following the inspection we contacted nine health and social care professionals who had worked with people using the service for their views and heard back from four of them.

Requires Improvement

Is the service safe?

Our findings

At the time of the inspection there were no assurances that people who were supported with their medicines received them safely. The registered manager was aware of how many people required support with medicines but there was no system in place for auditing the medicines records. We were only able to look through five people's daily log records and we saw no evidence of medicine administration record (MAR) sheets being filled in. In one person's records we saw the care workers had recorded in the daily contact sheets when the person refused their medicines but there was no entry in the MAR sheet or any follow up information within the log books to highlight if anybody had been notified about it. We spoke with the registered manager about this who confirmed it was within their policy for care workers to record people's medicines at each visit but acknowledged that this was not being done. They told us that the organisation was just starting to audit people's logs books and people being supported with medicines would have their log books checked on a monthly basis. We saw correspondence that showed senior management were planning to implement monthly audits of people's log books, including MAR sheets, by August at the latest and were updating the recording forms that were currently in use.

Medicines risk assessments were in place which documented people's medicines, their administration, record keeping and people's compliance with taking medicines. We saw a number of files where the forms were not filled out accurately or lacked detailed information. In one person's care file, the risk assessment highlighted that assistance was required but there was no information about the level of support required. The level of support was listed as 'none', 'prompt', 'assist' and 'administer' however this was left blank and no action was identified. It also stated a MAR chart was to be used but this was not in place. Another person's risk assessment highlighted they needed prompting with their medicines, however the local authority assessment had highlighted they needed assistance due to other health issues. It later highlighted care workers should administer medicines but the final part of the assessment highlighted care workers to prompt so we could not be sure what support was needed. One other person who required support with their medicines did not have a medicines risk assessment in place.

Medicines were not managed in a way which ensured people received them in a safe and effective manner with regard for the risks associated with them. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments that were completed upon the commencement of care being authorised. We could see that risk assessments were reviewed regularly, generally on an annual basis, however the level of detail within these assessments was not consistent throughout the care files we looked at.

One person was assessed as having poor mobility and at risk of falls. This person's records contained information about what actions to take to reduce the risk, with guidance of specific support that was needed, highlighting the location and use of mobility aids to support the person to remain as independent as possible. However another person had been assessed by the local authority as being at risk of falls and needed support using stairways. Their risk assessment had no record they were at risk of falls and the risk on stairway assessment box stated 'non applicable'. We also saw records where people required support with

transfers. There was limited information and guidance about how people would like to be supported in this way.

The risk assessments recorded possible identified hazards, guidance, a risk rating and whether the risk was acceptable. Each area was given a risk rating. However we found there was no guidance around the scale of the scores given or the threshold for identifying what was an acceptable and unacceptable risk. A risk management strategy was also in place for areas deemed high risk. However we found these were inconsistent in files and not always effective in mitigating the risk. These had an identified risk, an initial risk rating, the control measures in place to manage the risk and a revised risk rating. In many of the examples we saw the initial and the revised risk rating was the same even with the control measure in place. We also saw that one risk management review and action plan to address hazards had not been filled in. This meant that risks were not always effectively managed to keep people safe.

The above indicated that the provider was not doing all that was possible to mitigate risks to people using the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that they felt safe when receiving care. One person said, "I feel safe with them in my home. I am happy to have them in my home." Another person said that they felt safe with all the care workers that visited them. A relative told us that they felt their [family member] was safe. They added, "The care workers report to us if something happens. If they find any scrapes or sores they do communicate with us."

During the inspection 16 care workers attended training in safeguarding and a further 20 were booked onto the same course for the following week. Care workers we spoke with had a good understanding about safeguarding adults and were able to explain what kinds of abuse people could be at risk of, potential signs of abuse and what they would do if they thought somebody was at risk. Staff were confident that concerns would be dealt with appropriately. One member of staff said, "I'm comfortable raising concerns and I like how they are followed up." We saw records that showed when safeguarding concerns had been raised, they had been recorded, followed up and disciplinary action taken if necessary.

The staff files that we looked through were consistent and showed that the provider had robust recruitment procedures in place. We saw evidence of criminal records checks and photographic proof of identity. Records contained details of people's Disclosure and Barring Service (DBS) reference number and the date of the disclosure. However not all files had an annual DBS disclosure declaration where staff had signed to say they had no convictions in the past year which was the provider's policy. We spoke with the registered manager about this who showed us that a DBS matrix was being completed by the office administrator so they would be aware when DBS checks were due to be reviewed.

The provider asked for two references and people could not start work until they had been verified. References gave the referee opportunity to comment about competence, reliability, honesty and integrity and we saw positive responses from the files viewed. The interview assessment form covered areas such as moving and handling, pressure area care, personal care and medicines. We spoke with a new starter who spoke positively about the interview experience. They added, "It was very detailed and I was impressed with the questions they asked."

At the time of the inspection there were 86 care workers covering the Newham area and 26 care workers covering the Waltham Forest and Redbridge area. New office staff had recently been recruited and there was sufficient office staff in place to manage care worker schedules. Care workers we spoke with felt that they

were given enough time between visits to make sure that they were not late for calls. People and relatives we spoke with confirmed that late and missed visits had been a problem in the past however there had been significant improvement in this recently. One person said, "There had been occasions where carers had not turned up however this has not happened for a while."

We had received some information of concern prior to the inspection about missed visits which had a negative impact on people using the service.

One person, who lived alone and was assessed as high risk, had 10 missed visits over a four month period and the allegations had been substantiated at a recent safeguarding strategy meeting. We spoke to the registered manager about this who acknowledged the issue and the impact that it had had for the person. We were told that it was due to scheduling errors by a care coordinator who was no longer working for the company. We saw that risk alert notifications had since been set up on the electronic monitoring system so office staff would be alerted if care workers had not arrived for a scheduled visit. We looked at the electronic monitoring records for this person over an 8 week period. We saw that one care worker failed to log in and out half of the time so calls were logged manually. Of 80 calls, 31 were early, on time or within ten minutes of the visit time. 12 calls were 30-60 minutes late, seven were 61-120 minutes late and 10 visits were over two hours late. On three occasions, there was nothing logged at all. We also saw anomalies in the scheduling. The care plan stated that there are three visits per day of 30 minutes each, however it did not specify a set time. On some days there were four visits scheduled with significant differences in time. For example, on one day, there were two visits scheduled for 3.45pm and 8pm, but the actual visits took place at 4.53pm and 5.28pm, with the care workers missing each other by just five minutes. We also saw three visits that were scheduled for 8pm but the care worker arrived around 5.30pm.

We looked at a sample of staff rotas over a two week period from May to July that covered 100 calls. The majority of calls had no significant scheduling errors and only two calls would have resulted in a care worker being 40 minutes late or more. We also found occasions where care workers had overlapping calls. This occurs when two calls are scheduled simultaneously. We found one care worker had 75 clashes over a two week period in May. We spoke with the registered manager about this and highlighted that it would have been impossible for all these calls to have been made. They acknowledged that there had been issues with the electronic monitoring system and that they had not had sufficient training using the system. We saw that the system had been updated and it was no longer possible to schedule calls that clashed. We asked a member of the office team to demonstrate this and confirmed it was not possible, which reduced the chance of scheduling issues arising. The provider had also recruited two system administrators who were responsible for monitoring care workers and confirming when calls had been made if they were unable to log in at people's homes.

We requested to see the daily logs for people receiving care from this care worker to confirm what calls had been made. We saw a number of inaccurate recordings within the logs we looked at. For example, one electronic record showed the care worker logged in at 11.05am and was manually logged out at 11.35am by a member of the office staff, however the log book had the visit recorded from 1.20pm to 1.50pm. Another record showed the care worker had signed in and out of two visits at the same time. We also saw one care worker sign in at 5.45pm and sign out at 6.15pm however another care worker had also signed in the log book at 6pm, recorded they gave the person food and drink then signed out at 6.30pm, despite the previous record saying they had already eaten.

Time sheets were not available for these visits and the registered manager agreed that we could not be reassured that these calls took place when they said they did.

The electronic monitoring system was not being used effectively to monitor if people received their calls when they should have and therefore people may not have received the care and support they required. Records relating to the care and treatment of people were not accurate and at times not available. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

The majority of people we spoke with told us that they were happy with the care they received and care workers had the necessary skills and knowledge to meet their needs. Comments from people included, "They're good at their jobs and seem to be well trained", "When they come in, I can trust them. They know what they are doing. They have to earn my trust. If they don't I would complain" and "[The care worker] supports me correctly to get in and out of the bath and [they] help me go up and down the stairs." One relative told us they felt the care worker had the experience to support their [family member]. They added, "The carer has built up the skills because they have been with my [family member] for three years." The negative comments we received related to cover workers where people felt they did not receive the same level of care as their regular care worker. One person said, "My regular carer is OK. She knows what I would want. The weekend carers don't seem to know what you are saying to them. They might wear big shoes and have no manners and walk in and see it as a care home." A relative highlighted similar issues when regular care workers were being covered. They added, "The regulars know what to do, the fill ins don't seem to be that well trained."

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 we spoke with told us that they felt involved in decisions and that staff asked for their consent before carrying out any activities. One person said, "They always ask me if I'm ready for what needs to be done." One relative told us that the care workers were very patient and had an understanding of their [family member}, and always involved them and sought consent despite their fluctuating capacity. Care workers we spoke with understood the importance of asking people for their consent, especially when it involved carrying out personal care. Care coordinators had an understanding of when they would need to assess people's capacity and the importance of other people being involved in making decisions. However records we saw were not consistent with this level of understanding.

There were no consent forms on file and no evidence of best interests decisions or mental capacity assessments highlighting that people did not have capacity to sign their care plan. We saw in some files that had been audited a new form was being used for people's assessment which had a section highlighting whether a mental capacity assessment was required. However in all the records we saw, this had not been filled in. We also saw inconsistencies with people signing care plans. One person had their care plan signed by a family member with no documentation to evidence that they were legally able to do so. However the person had then signed their risk management strategy plan despite it stating the person was confused and had dementia. Another person had their care plan signed by a support worker from a housing association and their care plan review signed by a scheme manager. Not only was there no evidence of a best interests meeting being carried out, it would not be appropriate for people in this position to act as a representative. We also saw care plans being signed by relatives but then the person signing telephone monitoring forms.

We spoke to the registered manager about these issues and they told us that it was not their role to carry out mental capacity assessments. However it is integral to their role to ensure that people have consented to their care plans.

The provider did not have a clear understanding that there should be signed consent forms in place, that care plans should be signed by the person to show their agreement to the care and support provided and that there should be a clear indication of an assessment of their capacity if they are unable to do this.

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

When people started their employment with the service they had an induction and we saw induction checklists in staff files. This was a one day programme that covered a wide range of topics and policies and procedures, including a 'Getting Started' workbook, safeguarding, medicines, home visits and lone working and was signed off once completed. Shadowing checklists were in place to show that staff had the opportunity to shadow senior staff before starting work on their own and care workers we spoke with confirmed this. We saw shadowing experiences differed between care workers but the majority of files we looked at showed care workers had at least four opportunities and covered more than one person and a number of tasks, including personal care, supporting with medicines and carrying out moving and handling procedures. We also saw staff had a medicines and moving and handling competency assessment in place that was completed during their induction. If care workers wanted to be put through the Care Certificate, there was a cost to the care worker of £125. The provider did support staff to enrol on vocational qualification courses in health and social care and at the time of the inspection six care workers had signed up.

At the time of the inspection, the registered manager told us that their training programme was just starting again due to the organisation not having a trainer since October 2015. Due to this they admitted that there would be gaps within staff training but were now working to carry out training for all staff. They told us that care workers whose training had been out of date the longest would be a priority for receiving refresher training. We saw minutes of two care worker meetings held on 17 June 2016 stating that the training process was to begin now a trainer has been recruited and highlighted the importance of attending training sessions. Training was taking place during the inspection and we spoke with the trainer who showed us their training schedule. During the first week of the inspection, 15 care workers attended medicines training, 16 attended safeguarding training and 17 attended moving and handling training. The provider had also recently purchased a hoist to support staff with practical moving and handling training, along with theory based training. We saw similar numbers of care workers booked onto training for the following week. The trainer said, "I was aware of the gaps in training and am working to get all training refreshed for all care workers." They added that they hoped to have completed all the refresher training by the end of August 2016. Care workers spoke positively about having training again. One care worker said, "It's really good, and refreshing. It is explained well and easy to learn. We have to take a test afterwards."

We saw records that showed care workers had regular supervision and spot checks. An annual appraisal system was also in place. We looked at records of supervision sessions which showed care workers were able to discuss key areas of their employment. It included discussion topics on safeguarding, timekeeping, protocol for double up visits and training needs. One care coordinator said, "It is important to meet with care workers, to communicate with them, support and encourage them. If training needs are identified, we need to speak with the trainer to get it booked."

Assessments covered the level of support people required to prepare and eat food. One person said, "They

get my breakfast and make sure I have a bottle of water before they go." Another person said, "They make my meals and make sure I have enough to drink." Care plans made reference to people's preferences and diagnosis. For example, one person's care plan stated it was important to ask what meal the person wanted on a day to day basis then prepare the meal for them. Another person was a diabetic and it highlighted that a low sugar diet was required, with reminders for care workers when supporting them with meals. However, it was not consistent in all the files we reviewed as there was limited information available about what support people needed with these conditions. One person required support with all their meals but there was no information or preferences within their care plan. For two other people who were diabetic, this was either not recorded in their care plan or was not reflected accurately so we could not be assured that care workers would be aware of their dietary needs.

People told us that they felt they were supported to maintain good health. One person said, "My carer always asks if I'm OK and if I feel I need to see my doctor." Another person was confident that if any health issues arose his care workers would call for an ambulance. One relative said, "If the care workers are concerned, then they talk to us and let us know." One person who was less positive told us that if their family member was unwell, the care workers would not know what to do as they were not trained in relation to the person's condition, but would call an ambulance.

As we were unable to see a large sample of people's daily records it was difficult to determine whether people were supported to maintain their health and access healthcare services. We saw some evidence in the out of hours records where care workers had called ambulances. We also saw where office staff had followed up concerns raised in the out of hours report and liaised with GPs and other healthcare professionals, such as district nurses and social workers. Contact details for health and social care professionals were held in people's files so the provider knew who to call if people's healthcare needs changed.

Good

Is the service caring?

Our findings

The majority of people we spoke with told us they felt well cared for by the service and thought the staff were kind and respectful. Comments from people included, "They are very kind, friendly and pleasant", "The staff are excellent and treat me properly and with respect" and "The first thing she does is sit down and have a chat with me and ask me how I am. She's very kind." One relative said, "The carer really helps. Without her, my [family member] wouldn't have a life." Comments we received that were of a negative tone generally related to care workers who covered shifts and did not know the people as well as their regular care worker. One person said, "Most of them are kind and helpful, but some of them just do the tasks without engaging with me."

People were assigned regular care workers depending on their needs and then had cover care workers when their regular staff were away or off sick. A care coordinator told us that they looked at care workers skills, experiences and geographical location when matching them to people. Care workers we spoke with told us they generally worked in their local area which minimised the risk of them running late. People commented positively on their regular care workers and they felt it was very important to have consistency in their care. One person added, "I get the same ones all the time, they are very nice and always talk to me." One relative said, "I know the regular carer very well and talk to her, she listens to me." We saw records that showed when a relative commented on the impact that irregular care workers had on their family member, the provider tried to be as consistent as possible, including sending weekly rotas to them to make sure they were happy with the upcoming schedule. Care workers we spoke with knew the people they were caring for and understood the importance of their work and caring for people in the right way. One care worker said, "It is important to be caring and look after the people we are responsible for."

People and their relatives told us that they had been involved in the planning of their care from the initial assessment and start of the care package. People received a visit from a manager or care coordinator to complete an assessment of their needs and arrange for the care and support to be set up appropriately. The registered manager told us that they would always ensure people had a relative with them if they wanted one. One relative told us how their family member's health had deteriorated and there had been regular reviews to check their needs were met. They added, "If I could not be present I was always able to be involved over the phone."

Care workers we spoke with told us how important it was that people were given the opportunity to be as independent as possible and that they had their own choice. We saw comments in monitoring forms highlighting that people were happy with being given a choice when they received their care. One comment from a supervisor who carried out an observation on a care worker stated that the person's choices were always taken into account and comments from the person highlighted they were happy with the care they received. One person said, "She knows my capabilities. She won't force help on me when there's things I can do myself. She is very encouraging. She might say 'can you manage to cream and dress yourself or shall I take over." One relative said, "They do listen to my [family member] and change things if they can." We did hear from one relative who felt that there were times when their [family member] was not given as much choice as they would have liked.

People told us staff respected their privacy and dignity. We received many positive comments about how respectful care workers were when they worked with people. One person told us that they felt respected when they were receiving personal care. They added, "They pull the shower curtain across for me and respect my privacy." Another person told us that if they received a call from their family member during a visit, the care worker would always leave the room. Care workers had a good understanding of the need to ensure they respected people's privacy and dignity. One care worker told us that they always made sure they respected people's privacy and that it was discussed during training sessions. We saw evidence in one person's care plan where it was highlighted how important it was to allow them to use the commode in private and this wish must be respected. We also saw that this topic was discussed during the interview assessment process and candidates had to describe their understanding of treating people with dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

The majority of people we spoke with felt their care was personalised and met their needs. One person told us they were happy with the care they received as their care worker knew how they liked things done in certain ways, such as how they liked having their hair done. One relative was happy with the level of care and said, "Everything the carer does is aimed at what my [family member] needs." However we also received comments stating that after the initial assessment had been completed, there was minimal contact with the office. One relative said, "I expect it to be higher and better quality. It would be nice if the carers did do what my [family member] wanted them to do. I don't want shouting so I just bear it."

Each person had an individual care folder which included an initial assessment from the local authority with an overview of people's care and support needs. The provider was then responsible for carrying out their own assessment before drafting people's individual care plans. Their assessment covered a wide range of needs, including mobility, personal care, communication, nutrition, community access and inclusion, medicines and health and wellbeing. One person's plan had detailed information within the assessment which highlighted the level of support needed, how their emotional needs could be met and information about the person's capacity. However this level of detail was not consistent throughout the files we reviewed. We found care documents which lacked person centred information, were inaccurate or did not contain any important medical information about the person so we could not be assured people were receiving the care they required as their needs had not been identified in sufficient detail.

One person's care plan, who had limited mobility, highlighted the importance of their personal hygiene and that they needed support to be wheeled into the bathroom to be assisted to have a full shower. When we looked through the risk assessment the information was not consistent and stated that they required a strip wash. Daily log records were not available so we could not see if the person's wishes were being carried out. Another person's care plan and assessment lacked detail and did not match the assessment from the local authority. The person was a diabetic however their diet was recorded as 'normal' with no information about food preferences or importance of visit times. The assessment did not highlight the person's other physical health issues, including arthritis and being at risk of falls. Under the 'personal care and incontinence' field, there was no information about what was required. We used this care plan as an example when we raised the issue with the registered manager. They acknowledged that it had not been checked and the information within the plan was not acceptable. They said the care coordinator would be supported in carrying out future assessments. As the provider was not able to make available logs of care and support provided, we had no evidence as to whether people's needs were being met.

We saw information that showed the provider listened to people and tried to support their cultural and religious needs however it was not consistent throughout the records we reviewed. We saw records that one person had requested earlier visits than normal due to Ramadan and care workers were contacted and able to meet the request. We saw information detailed in another person's care plan that going to church was important to them and visits needed to be factored around this activity. However we saw a number of care records where cultural and religious needs were not completed. For example, one person was described as Orthodox Jewish, but there was no information about their cultural needs, including dietary needs, the

requirement to keep kosher and religious festivals and practices, which staff could not be expected to be familiar with. We also saw that people's choice about gender specific care was not recorded accurately. We followed up on a complaint from a relative that we received prior to the inspection where this was highlighted as an issue. Despite the person requesting a specific gender of care worker, this was not recorded within their care plan.

The lack of detailed and effective person centred plans in place to meet the individual needs of people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service and their relatives told us that they were aware of the complaints process and knew they could talk to their care worker or contact the office. We received a mixture of comments from people about how well the service listened to their complaints and concerns and if they were acted upon. One person said, "I'm happy with the care and have never had any reason to make a complaint. Another person told us they knew who to speak to and would phone the office. They added, "I had to make a few complaints at the beginning as there was a bit of a problem getting things straightened out, but the last few months have been better." The majority of people who had made a complaint told us that they were happy with how it was dealt with however two relatives did not think the issue had been resolved. One of them added, "It improves things but three or four days later they fall back."

A care coordinator told us that they always encouraged people to let them know if they had any concerns during their reviews or spot checks. A member of the office staff told us that one of the best things about the service was that they liked how they followed up concerns that had been brought to their attention. Another care coordinator explained that if any concerns were raised, they would carry out a spot check. Some samples of spot checks that had been carried out highlighted the issue and what action needed to be taken. We saw evidence of investigations being carried out and followed up to resolve the issue. However there were inconsistencies within the forms as we could not see that all concerns had been followed up. In one person's file, where comments had highlighted concerns about time keeping and care workers staying for the full duration of a visit, the action plan to address the issue was blank so we could not be assured it was followed up.

The provider had an accessible complaints procedure which was given to people when they started using the service. A copy was kept within people's daily log books. We looked through their log of complaints for the past 12 months. We could see complaint forms had been completed appropriately which gave an overview of the complaint, who was responsible for dealing with it and when it would be completed by. Each complaint included information evidencing action that had been followed up. For example, one complaint involving a medicines error had been investigated and recorded. We saw statements from the care worker involved and a disciplinary letter from the provider. The provider also kept a record of compliments that they received from people and their relatives thanking them for the care they had received.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place who had been registered since September 2014. They were present throughout each day of the inspection.

The registered provider is required by law to notify the Care Quality Commission (CQC) of important events which occur within the service. We saw records and received information prior to our inspection about three incidents that were not reported to us in a timely manner. They included safeguarding incidents involving the police and allegations of neglect. One incident occurred in March 2015, one in September 2015 and one in November 2015 and we were not notified about them until June 2016. The registered manager told us that it was due to a previous manager who was responsible for sending in notifications, who no longer worked for the company.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have requested that in future all notifications are sent to us in a timely fashion so that, where needed, action can be taken.

At the time of the inspection the registered provider was carrying out an audit of all care files. There was a comprehensive audit sheet attached to the files that had been checked highlighting which assessments and plans were in place, along with financial transaction forms, MAR sheets, quality assurance visits and an annual survey. These correctly identified when care plans or risk assessments needed to be updated, but there had not been sufficient time to see if these resulted in actions being carried out. We were unable to see any audits for people's daily logs, MAR sheets and financial transaction forms as there was no system in place and these records were either in people's homes or had been archived to a storage unit. We were only able to look through five people's daily log books that were made available to us.

In one person's daily log book we saw three entries when a care worker went shopping for them and recorded they gave the person change. There was no record of this in the financial transaction form. The registered manager told us that if care workers went shopping for people they had to record the transaction in the log book. Another person's daily log book had the front cover missing, no name or contact details were available and the times for care visits was empty. We had to ask the registered manager which person this book belonged to. From the sample of logs we were able to look through, there were inconsistencies in the quality of recording. There were records where it was difficult to tell the times care workers had signed in or out of a visit and in some records the recording was ineligible. The registered manager told us that a monthly and quarterly cycle of auditing people's logs books was due to start by August.

We saw that the provider carried out regular quality assurance checks, both by phone and in person, to get feedback about people's experiences of care they received. We saw examples when concerns had been raised and enhanced monitoring had been put in place to check the quality of the service. For example, one family member had raised concerns and we saw monthly visits by a field care supervisor, along with telephone monitoring to address the issue. We saw positive comments within the monitoring forms that service delivery had improved. One relative said, "In the past I've had many complaints however the last few

weeks the service has been going well. After having a discussion with the manager things have improved." We also saw correspondence between the registered manager and the local authority seeking advice about medicines, after this had been brought up in a contract monitoring report.

However we found that this was not the case for all files and there was an inconsistent approach to quality assurance as we saw records highlighting issues and there was no evidence that any action had been taken. For one person, there was a required action for the staff responsible to speak with the care workers about medicines and log books, and a space for the manager to sign to confirm it had been done, but it had not taken place. We found six other examples were none of the spot checks had been signed by the registered manager or another senior staff member to confirm the reports had been read and addressed any concerns. We also saw one example where a person raised a concern about the timekeeping of care workers on 15 March 2016 and there was no evidence that any action had been taken until 26 May 2016.

This showed there was a lack of effective governance and quality assurance systems in place which was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with commented on how well supported they felt in their work and praised the environment in which they worked. One member of staff, who had just started working for the service said, "The support has been great and I feel confident talking with the manager. People get along so I enjoy working here." Another member of staff added that there was a sense of teamwork in the office and people worked well together. One care worker said, "I've never felt let down and am supported well." One of the senior members of staff felt that people were comfortable talking with the registered manager as they had an open door policy, which created a good team spirit.

We received a few negative comments from people and their relatives about how well managed they thought the service was however the majority of comments we received were positive and people were happy with the care they received. One person said, "Everything has been beyond my expectations. From the visits I had I was given all the information I needed about my care. Overall I have been very pleased with the care that I have received. One hundred percent happy." One relative told us that when they had raised a concern it had been acted upon and commented that the service had improved since the beginning of the year.

We saw minutes for managers meetings that were held in March and June 2016 and saw topics such as safeguarding, complaints, staffing and departmental performance were discussed. Issues that the registered manager had told us about regarding the electronic monitoring system had been discussed and raised to senior management. We also saw records that showed care workers had attended a group meeting to discuss issues that had been brought up from the results of the last annual survey. The survey for 2016 had only just been sent out to people so we looked at the results from July 2015. The outcome of the report was largely positive and showed that 93% rated the service as good. We saw minutes of a care workers meeting where the issue of time keeping was discussed due to results from the survey. It highlighted the importance of care workers informing the office if they are running late, especially calls that required two care workers. One care worker told us that they felt listened to during meetings and were confident that issues would be dealt with.

However the survey did not show all the actions taken to resolve the concerns people had. For example, 8% of people said they would change their care provider if they could and 12% of people said that they were not happy with the outcome of a complaint. We asked the registered manager about this and they confirmed that they did not have all the information about the outcomes of the survey. Additionally, the outcome of the survey did not indicate how many people the questionnaire was sent too or how many surveys had been

returned. The member of staff responsible for sending them out no longer worked for the company.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18 (1), (2) (a) (ii) (iii) (b) (e) (f)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was failing to ensure that care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (a), (b), (c), (3) (a), (b)

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that risks to the

health and safety of service users were regularly assessed and did not do all that was practicable to mitigate any such risks. Regulation 12(1)(2)(a),(b)

The provider did not ensure that care and treatment was provided in a safe way as systems for the proper and safe management of medicines were not operated effectively. Regulation 12(1),(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems to monitor and improve the quality and safety of the services provided, to monitor and mitigate the risks relating to health safety and welfare of service users, and did not maintain complete records in relation to people's care and treatment. Regulation 17(1),(2)(a),(b),(c)