

Agincare Live In Care Services Limited

Agincare Live-in Care Services

Inspection report

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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Inadequate



Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was announced 48 hours before we visited.

Agincare Live In Care Services provides care to people in their own homes. They provide live in care staff to support people with personal care needs throughout England. At the time of our inspection there were 170 packages of care being provided to people in their own homes. This number changes weekly. The provider is registered to provide personal care.

At the time of our inspection there had been no registered manager in post since July 2013. The current manager had been managing the service since January

Summary of findings

2014. They had submitted an application to become the registered manager in April 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People's experience of their care was mixed. While most people and their relatives were very happy, others were not. Most people's concerns related to times when their regular, or permanent, staff member was on a break.

People's safety was being compromised in a number of areas. This included how they were protected from the risks of abuse and how possible abuses were identified and responded to. The provider had not notified the Commission about some allegations of abuse in a timely fashion.

Medicines were also not managed in an appropriate way. There were gaps in records and some records did not accurately reflect the medicines that staff were giving people.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. The staff responsible for assessing people's ability to consent had not received training in the Mental Capacity Act 2005 and were not able to describe how capacity should be assessed.

We found that people's care needs were assessed, but their care was not always delivered consistently. In some cases, this either put people at risk or meant they were not having their individual care needs met. For example one person wasn't able to go out for three weeks because the staff weren't confident to support them with their mobility. Sometimes risks to people's welfare were not identified as part of their care plan.

Staff were not always trained and supported to provide the care people needed. We found that staff had received induction training but staff did not always get the specialised training they needed around people's particular needs. This meant they were not always able to provide appropriate care. We found examples of this when people had specialist health care needs and also in end of life care.

Systems in place to monitor the quality of the service were not effective. Staff who undertook assessments, quality monitoring and staff support in the community did not have adequate training to undertake this role effectively and safely.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe. People who used the service were being put at risk because abuse was not being identified or responded to appropriately.

Risks to people's health and safety were not always identified and as a result they were not managed effectively. This meant people remained at risk of harm.

Medicines were not managed safely. This put people at risk of receiving their medicines in ways that were inappropriate or unsafe.

Where people did not have capacity to make decisions about their care or measures had been put in place to keep them safe, the Mental Capacity Act 2005 was not being followed.

Inadequate



Is the service effective?

People did not receive effective care. Staff did not always receive support and training to undertake their roles safely and appropriately.

Most people were supported to use health services however we found that sometimes problems were not followed up because staff were not clear on their role responsibilities. This meant people might not get the right health equipment quickly enough.

People were mostly happy with the support they received from staff regarding food preparation.

Risks associated with eating and drinking were not always identified and managed effectively. This meant that people might not be supported appropriately to eat and drink safely.

Inadequate



Is the service caring?

Most people told us they were happy with the care they received and felt respected by the staff. They told us they had built up positive relationships with their permanent care staff. This was not always the case when their permanent staff were not available.

People at the end of their lives were not always supported by trained staff. Records did not clearly outline their wishes.

Requires Improvement



Summary of findings

Is the service responsive?

Most people told us that the service was responsive to their needs. However, care plans did not always show the most up-to-date information relating to people's needs and risks. This meant there was a risk that their care would not be provided appropriately.

The service had responded to complaints that had been raised. However where complaints related to care practice these did not lead to checks on care quality. This meant that people's care might not be improved by the complaints process.

Requires Improvement



Is the service well-led?

The service was not well led because the systems to check on quality and gather people's views were not effective, because there was no system that catered for people who could not use a telephone and had no person to speak on their behalf. Checks made in people's homes didn't always pick up issues with care delivery or risks. This put people at risk of inappropriate care.

Most staff were confident in raising concerns but some said they might be reluctant to because they were not sure who to speak with or were worried about the outcome. Staff were not clear how learning from concerns and mistakes was used to improve the quality of the service.

Inadequate



Agincare Live-in Care Services

Detailed findings

Background to this inspection

We visited the office of the service on 9 and 14 July 2014 where we spoke with three staff who coordinate care and provide telephone support to people and staff, two senior staff, and the manager. We visited six people using the service in their homes with their permission on the 10 and 11 July 2014, and spoke with a further 20 people and eight relatives by telephone. We also spoke with twelve staff who were providing care in people's homes, and four assessors. The assessors assessed people's needs, completed care planning documents, carried out staff supervision and monitored the quality of care. We also spoke with eight health and social care professionals.

The inspection team consisted of a lead inspector, one other inspector and an expert by experience, who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We observed interactions between staff and people in people's homes. We reviewed a range of records about people's care and how the service was managed that included eleven people's care records, six staff files that included their supervision and recruitment records, the complaints folder, and a selection of quality assurance audits that the service had completed.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information included in the PIR along with information we held about the service and notifications they had sent us since their last inspection. A notification is information about important events which the service is required to send us by law.

We last inspected this service in October 2013 and found them to be compliant with the regulations we inspected.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Is the service safe?

Our findings

Most people told us they felt safe; however feedback from people and their relatives regarding six people's care indicated that they did not always feel safe. Four people told us they did not always feel safe with staff. Relatives told us they did not feel their relative was always safe with the staff provided. Three of the people who told us they did not always feel safe said, that due to their disability or fear of complaining about staff whilst they were placed with them, they would not be able to tell the service they felt unsafe over the telephone or in writing until their permanent care staff returned from their break. Permanent care staff work for varying amounts of time with people and then have a break during which another member of care staff come and stay with the person. The breaks also vary in length but can be a number of weeks.

The service had a clear policy on how to safeguard vulnerable adults, however there were examples of when this had not been put into practice. When concerns about welfare, that could indicate abuse, or allegations of abuse were raised, visits were not made to check on people's welfare and safeguarding alerts were not always made. A safeguarding alert should have been made by the service making the relevant local authority aware of the concern so that they could investigate and take appropriate action if necessary. For example, one person made allegations of emotional abuse by a member of staff in February 2014. The service did not raise a safeguarding alert in line with their policy. This meant the Local Authority had not been alerted to this and had not been able to investigate and determine if the person needed protecting. We also saw that a relative had made two allegations of physical abuse in June 2014 and the service did not raise a safeguarding alert. The member of staff was removed from the person's home after the second allegation. This meant the person may have been supported by someone they were at risk from for longer than was necessary.

The way care was delivered sometimes put people at risk of harm. For example we found that one person's money was accessed by the member of staff in a way that did not protect them from financial abuse. We spoke with the manager about this and they told us it was not reflective of their procedures and they would ensure that correct procedures which reduced the risk of financial abuse were put in place.

We saw from the records that care staff had received safeguarding training. We spoke with staff about their safeguarding training and most staff providing care were able to tell us about their role with confidence. However, two of the care staff could not describe their role in identifying abuse or reporting safeguarding concerns and one of them told us: "Oh I'm not sure about that now." This meant some staff would not always know how to identify abuse or report it appropriately.

Bed rails were used by one person who may not have capacity to consent to this potential restriction due to dementia. No capacity assessment had been completed and no best interest decision had been recorded. This person also could not leave the house without a member of staff. There was no best interest decision relating to this potential restriction. The service had a behaviour management and restraint policy that described the use of bed rails as a physical restraint and detailed that the Mental Capacity Act 2005 guidance must be followed. Staff had not followed this policy. This meant that breaches of people's human rights may not be recognised and acted on appropriately.

All of the above evidence meant that people were not protected from harm, or unsafe care practice or abuse that may breach their human rights. This is a breach of regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with four staff who undertook assessments and wrote care plans. They told us they had not received training on the Mental Capacity Act 2005. We asked them how they assessed capacity. Two of the four assessors gave examples of how they would assess a person's capacity to consent to care but these were not in line with the Mental Capacity Act 2005 or its codes of practice. We also spoke with them about best interest decisions. Best interest decisions are made within the framework of the Mental Capacity Act 2005 and ensure that when a person does not have capacity to consent to care that the least restrictive option is chosen and the appropriate people and factors are considered. None of the assessors were able to describe when a best interest decision should be taken. This meant that people may be subject to care that was not in their best interests and breached their human rights. This is a breach of regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service safe?

When risks were identified these were managed in ways that protected people's freedom. For example we saw that where someone's lifestyle may have posed risks to their wellbeing this was discussed and documented appropriately. However because risks were not always identified they were not managed safely. For example we saw that one person who was registered blind did not have any risk assessments referring to this and their care records stated that their sight was satisfactory. The person and their relative told us that they needed extra support from staff when crossing roads due to their poor eyesight.

We spoke with the manager about how risks were planned for at a national level. In particular we discussed how the service ensured they could provide care if a member of staff needed to leave people's homes in a hurry. We also discussed this with two of the staff who coordinated care from the office. The manager told us they had staff on standby to provide cover if necessary. This was usually two or three care staff available to travel to any part of the country and assessors were also available. Records showed there were occasions when this had worked successfully, and a relative and a family member told us staff had been replaced on the same day when necessary. However, there were examples where this had not worked and people had been left with inappropriate care as a result. For example in one instance another agency undertook the care without a prior agreement in place, and in another situation a member of staff who said they weren't coping was left in the person's home.

Staff travelled across the country and sometimes from other countries to arrive at people's homes. Handovers were scheduled between the staff leaving and the staff arriving to ensure that the new staff member understood the care needs of the person and could be trained in specialist skills if necessary. People, relatives and staff told us staff sometimes turned up late for hand overs and could at times be tired after long journeys making it difficult for them to take in all the information they needed to look after the person during the handovers. One relative described a member of staff arriving for a hand over: "She was extremely tired and incapable of taking in any information that evening." Another relative described the staff arrival and departure times at the last handover. They said: "The handover should be for two hours but it was only half an hour." Both these relatives described how they then stepped in to ensure the care their relative received was appropriate. We spoke with six staff about travel and being

ready to work and take part in handovers. Four told us that this was not a problem for them; however we spoke with two members of staff who told us handovers could be difficult due to problems with travel. One said the organisation did: "Nothing at all to make sure you are ready for work. You are actually worn out." We also saw a supervision record that detailed the concerns of a member of staff who was moved from waking nights to an emergency day placement without an opportunity to sleep. This meant that care was not planned for in a way that ensured staff had the knowledge and skills they required, or were rested and fit, to ensure the welfare of the person.

The above evidence meant that people were not always protected from risks and care was not planned and delivered in a way that ensured people's welfare and safety. This is a breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations.

We read eight staff files and found staff were usually recruited in a safe manner. However, we saw that gaps in the records showed that the service had not followed its own recruitment policy in four of these files. For example, three of these staff had been working prior to the organisation seeing the full checks made by the Disclosure and Barring Service (DBS). It is legal to work after the first check is back but the person receiving care must be told that the full checks are not back and consent to them providing care. However this practice was not in line with the organisation's recruitment policy that said that any convictions identified by the criminal records check would be risk assessed. We also saw that one person only had one reference on their file and no risk assessment regarding this. This was also not in line with the recruitment policy and meant there was a risk that they could not evidence satisfactory conduct from previous employment.

Medicines were not administered, stored and recorded appropriately. We looked at one person's medicine records kept in the office. The information detailing when and why they should take as required medicines was clear. However, when we looked at the medicines and medicines records of four people we found errors and omissions in three instances. For example, we found that one person's medicines were not stored in their pharmacy boxes and a loose tablet was lying near the boxes. This meant that there was an increased risk that the wrong medicines could be given or the dosage be incorrect as the medicines were not

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linked to the pharmacy label detailing the dosage. Medicine records for three people were not completed accurately. One had not been signed for over one week and it was not clear from the amounts left in the packaging if they had been administered correctly during that time. Another person had stopped receiving a medicine on the instruction of a visiting nurse and this had not been recorded in their medicines or care notes. There was a risk that this medicine could be started again in error if the staff changed suddenly. Another person was taking varying doses of medicines covered by the Misuse of Drugs Act

1971 and the records did not reflect what dose the person was taking. There was a risk that these medicines could not be accounted for and that a true picture of their usage could not be provided to health professionals. We also spoke with a relative who told us that the medicines were not signed for regularly by the staff giving them. They told us this happened whilst the last member of staff had been providing care, and they had made the service aware of this. They were not aware that this had led to any action. This is a breach of regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service effective?

Our findings

People were at risk of not receiving effective care because staff were not always appropriately skilled and experienced. The manager told us they worked to match people with the staff with the right skills. However, we heard from people, relatives and staff that sometimes the staff who arrange this were struggling to find cover. One member of staff said: “It is like the emergency room, whoever appears goes to whoever needs someone.” Another member of staff told us they found palliative care stressful and they are very anxious about how they would cope if someone died. They told the staff that coordinated care this but they were still being allocated palliative care work. An assessor also commented that they did not feel that some staff had the experience and training necessary to provide end of life care.

Most people told us that their permanent staff had all the skills they needed them to have. Some people also told us that when they did not have this permanent staff member the replacement staff did not always have the skills to provide their care effectively. One person told us that they had been unable to go out for three weeks because the staff sent was not confident to use their wheelchair. They told us: “Next time I will go into a home to be safe. I haven’t had very much luck with the others.” A relative detailed how they had been called on to undertake care tasks for their relative when the member of staff did not feel comfortable doing it. They told us they did not like showing new staff how to do specialist procedures and had asked that this be done by trained staff or medical professionals as per the organisation’s procedure, but this did not always happen. Another relative told us they did not feel the staff who covered their relative’s permanent care staff understood dementia: “They just don’t know how to distract or deflect when necessary.”

The organisation had a policy that stipulated staff will receive four supervisory type sessions throughout the year two of which should be face to face. These could include spot checks, supervision, and appraisal. We reviewed eight staff files; spoke with nine staff and four assessors. Most staff had received a supervision session or spot check but others had gone long periods of time without face to face support. For example, two members of staff who had worked for the organisation for more than nine months had not received any spot checks, supervision or appraisal in

that time. This meant that these staff had been working in people’s homes without any face to face opportunities to develop their working practice informed by observation or detailed care practice discussion. There was a risk that poor care practice would go unrecognised, for a long time, as a result of this.

Staff also received a weekly welfare call from the organisation providing an opportunity for them to raise practice issues but this was not part of their professional development or recorded as such. We spoke with four assessors who undertook spot checks, supervision and appraisals. They had not been supervised themselves and three were not sure who their supervisor would be. They told us that when they went to do a supervision, appraisal or spot check they were not provided with any information about the member of staff including previous training requests, practice issues or complaints. This meant they were not able to follow staff support issues up effectively. For example, we saw in one staff member’s supervision notes from March 2014 “X finds it difficult when clients judge her and they cannot form a relationship.” This indicated the staff member required support around this area. It was recorded as a statement but there was no record of it being explored or followed up with the member of staff at a later date. We also saw an example where the manager had spoken with a member of staff about their practice following a complaint and this was not discussed at their next formal supervision as part of their professional development. We discussed this with the manager and found there was no system in place to provide assessors with information about the staff they were supervising.

Staff did not always receive appropriate support when they faced difficulties in people’s homes. We heard a coordinator talking with a member of staff on 9 July. The member of staff was unhappy providing care to a vulnerable person and felt unable to cope. They asked to be replaced as soon as possible. They were replaced on 16 July 2014. We spoke with the member of staff and asked them if they had been visited by the organisation during this time. They told us that no one had visited them to check on their welfare or ability to undertake the role during this time. There was a risk that the person’s care could have been adversely affected by the stress the member of staff felt under during this time. Some staff told us they felt supported by the organisation, one member of staff told us: “I feel they care about my welfare.” another said: “Placements can be stressful, they are happy to talk

Is the service effective?

with me.” However, another member of staff said: “I have no support. They have only called back when I have asked them to. Here there is not enough support for the carer. It is difficult.”

Staff had not always received appropriate training. Staff were assessed whilst in people’s homes for competence in manual handling, medicines, safeguarding and infection control by the assessors. We spoke with four assessors and found that they did not have current training in these areas themselves. There was a risk they would not recognise problems with care practice due to their own lack of training and knowledge. All the new care staff had undertaken a comprehensive induction aligned to national acknowledged induction standards and this was followed up annually with work books covering areas such as safeguarding.

Specialised training was undertaken in people’s homes or by distance learning. We spoke with a member of staff who was working with someone who used oxygen. This was described by the service as a technique requiring specialist training. The member of staff did not feel they had received this, and told us they had been “told a bit about it” by the district nurse. We were told by a senior member of staff this specialised training would be arranged by the staff who coordinate care. A coordinator told us this training was the responsibility of the member of staff to arrange for themselves. This lack of clarity in responsibility meant that training in specialist techniques might be missed and this would affect their ability to provide appropriate care and treatment.

The evidence above meant that staff were not supported appropriately in relation to their responsibilities. This is a breach of regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with people about the help they received with food and drink. The amount of help people received was dependent on their assessed needs. For example we spoke with one person who prepared their own food and another person who had all their meals cooked for them by their care staff. A person told us they had complained about the standard of cooking provided by one staff member and the staff had been replaced. Staff told us they had received training in nutrition and food hygiene as part of their induction and they told us they felt confident in cooking for people. However, the risks associated with food and drink were not always appropriately managed. A person had

previously been identified as at risk of choking by a speech and language therapist and whilst this was recorded in their care plan there was no clear guidance in place around this for the staff to follow. We spoke to a member of staff and a relative and looked at care delivery records relating to diet and found that there were differing views about how these risks should be managed. Two assessors had visited this person and they had not identified that risks associated with eating and drinking were not being managed as described in the care plan, nor had they identified a need to seek the input of a speech and language therapist to determine the current risks. We also spoke with a person who was at risk of choking and who should have a member of staff with them when they ate. They told us this did not always happen and sometimes the staff did not prepare appropriate meals for them. We looked at their care delivery notes and saw that they were not always clear about whether this part of the care plan was followed.

We saw in one person’s records that health intervention had been sought when they became unwell. We also saw that a member of staff who provided regular care to one person had established good links with local health professionals. We saw examples in their care notes of quick responses when mobility equipment was broken and GP visits when the person was unwell. The member of staff described how they had established these relationships and felt confident they could get the person health support whenever it was necessary. However we also found that staff were not always clear what parts of health coordination they were responsible for and this resulted in appropriate action not being taken. For example, we saw that another person was struggling to get the mobility equipment they needed. The staff member told us they had told the office about the broken equipment and thought the staff there would chase it up. We saw the equipment was not safe to use and the person and the member of staff told us it had been that way for months. We also saw in another person’s care records that the hoist they used some of the time was broken. The member of staff based in the office responsible for coordinating this person’s care was not aware of this and did not know who had responsibility for ensuring this was resolved. This meant that people’s access to appropriate healthcare was hampered by a lack of clarity around responsibility and this put them at risk of delayed input from appropriate health professionals.

Is the service effective?

The above evidence meant that some people did not receive effective support to maintain good health and

some people were not protected from risks associated with eating and drinking. This is a breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service caring?

Our findings

Most people told us that they were happy with the care they received and described their staff as caring and compassionate. One person told us: “I’m only alive and well because I am looked after so well.” Another person said: “Agincare have been perfect. The care provided has always been very good.” And a relative told us: “The main carer is excellent.” Another person said: “I’m happy with (permanent care staff) but I worry about who I will get.” This emphasis on the “main” or “permanent” care staff being good was a common theme and the concerns relating to staff practice identified at this inspection were largely associated with care provided when the permanent staff were on their break. We spoke with the manager about how many people received care from permanent staff and they told us that 78% of people had staff they were familiar with going back to them.

People and their relatives told us they had been involved in planning their care. One person told us they were: “Very satisfied with the service. I get choice about everything.” We asked people how they were involved in their care and they said they were asked what help they wanted. Relatives told us they were also asked to contribute and were able to share what they felt was important. Care plans provided personalised detail which was gathered through these discussions and individuals’ preferences were highlighted. For example, we saw that people’s food and clothing preferences were recorded when they were unable to express these consistently due to their illness or disability.

People told us they had positive relationships with their permanent staff. We visited six people and observed gentle and caring interactions between staff and people during five visits. In the sixth home the person did not have permanent care staff and described feeling uncared for. People were treated with respect and afforded the space and privacy to talk with us in confidence. For example, one member of staff got on with tasks around the home but returned frequently checking before coming in that it was appropriate and offering their support. The person told us they appreciated this and the other things the staff did that they felt respected them. They told us other staff had not respected them and this was hard.

We spoke with staff about the people they were caring for and they mostly spoke with affection. One member of staff described the motivation they got from work because: “I see them smiling.” Other members of staff spoke with understanding and respect about the challenges faced by the person they were providing care for.

Care records for a person receiving palliative care was personalised about some aspects of their care, but there were no details recorded about how they wished to be cared for at the end of their life. This meant we were unable to tell from the care plan whether they wished to go to the hospital or stay at home. There was a risk that if they were cared for by someone who didn’t know them well, or if they became unable to communicate, they may receive inappropriate care. This person was making choices about the care and treatment they received on a day to day basis and they told us: “I’m happy with the whole service.”

The organisation had a Death, Dying and Palliative care policy written in April 2014 that outlined a commitment to ensure that staff have appropriate support to deal with the death of a person receiving a service from them. It also stated that there was an expectation that staff were familiar with the principles of end of life care as detailed in their training programme and that records about decisions around resuscitation would be contained in care plans. We spoke with a staff member who was caring for someone who was receiving end of life care. They told us they did not feel confident about their role and did not have end of life care knowledge. They also told us they were not sure if the person had made a decision as to whether or not they wished to be resuscitated. They were uncertain because they had not seen a record of this in the person’s care records but they had seen one in the records kept by the district nurse. They had not followed this up with the service to agree any necessary action. There was a risk that people may be resuscitated against their wishes if the staff working with them are not clear of their wishes. This is a breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service responsive?

Our findings

Although most people told us they received personalised care that met their needs, we found people were at risk of not receiving care that was responsive to their needs. One person told us: “(the person’s permanent care staff) does just what I need.” Another person said: “With (the person’s permanent care staff) we decide on the day together. They know how to look after me.” We were also given an example of a care worker sourcing an iPad application that enabled the person to communicate. However, there were examples where the care given to people was not detailed in the care plan or the care plan was no longer relevant to the person’s needs. For example, we spoke with a social care professional, visiting a person at home, who told us the staff member had supported a person to mobilise in a way which was not detailed in the person’s care plan. This meant that there was a risk that this support was not appropriate. We also found errors and omissions that impacted on care in five of the six care plans of people we visited. For example, one care plan included out of date moving and handling plans, another did not detail important health information about the person that could have affected their care and impacted on their safety. There was a risk that people would receive inappropriate or unsafe care if these care plans were followed. This is a breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two care plans were detailed in how to support the person and had been updated regularly. These care plans included detailed personalised information about the person. Most members of staff commented the care plans in people’s homes were useful. One member of staff told us: “The care plan is helpful. It tells me what his needs are. What he likes and enjoys.” This member of staff was confident discussing the detail of the person’s preferences and daily routines. However, one relative told us care plans had not been updated in the person’s home after a review had taken place in May 2014. A member of staff also commented about the care plan in the home of the person they were supporting: “The care plan is wrong. It is out of date and no one has reported how it is.” This view was supported by a social worker involved in this person’s care. We spoke with the manager and they told us that one of the challenges for the service was ensuring that staff made the office aware when there was a change in care needs. They told us that they reinforced this with staff during phone calls and in

supervisions because they were aware it did not always happen for a variety of reasons. Care notes made by staff were an alternative means of checking care delivery against care plans. These were recorded as submitted to the office when they were sent in from people’s homes. Some care notes had not been sent in to the office and those that had been received were not routinely reviewed against the person’s current care plan. This meant there was a risk that people might receive inappropriate care because changes in care, or care not described in the care plan, were not identified and addressed appropriately.

People told us that they were listened to and the service made changes. For example, one person explained they had been unhappy with a staff member’s ability to cook and they told the service. They had not had the same problem since they raised this. A relative explained that: “One person didn’t shave him, but once I pointed that out it was dealt with.” Most people also told us that they received regular calls from the office and were able to discuss their care. Some people told us that they could not talk on the telephone and this method of seeking their views was therefore not appropriate for them. Where the service had identified this they tried to speak with a representative for example a relative who had regular contact with the person. Two people identified by the service as being able to talk with us on the phone were in fact not able to do this. This meant the information the service had about people’s communication needs was not accurate and this might impact on whether the need for an alternative to the weekly phone call was identified.

We reviewed the complaints received by the service for the period February until June 2014. There were seven complaints recorded during that time and they had all been addressed. We reviewed three of these complaints in more detail including talking with the complainants. We found that the information the complainant received did not always match the records kept. For example one complainant had received a letter stating that the worker concerned had received “a disciplinary”. The workers record relating to this stated this was “not a disciplinary”. We also saw a letter was referred to as being needed in one complaint record. It was a letter detailing further action that would be taken by the service as the initial response to the complaint had not worked. The letter was not with the other documents in the complaints folder but it was printed for us when we asked for it. We looked at the paperwork which related to this complaint at the person’s

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home and discussed it with them. They did not have this letter and told us they had not received any further communication at this stage of their complaint. There was a risk that the letter had not been sent to the complainant as it had not been printed off for the file either.

We were also told by a relative that they had complained to the staff that coordinated their relative's care about a number of care issues in May 2014. We did not see a record of this complaint in the complaints folder. There was a risk that not all complaints were dealt with through the complaints process which meant they would not be subject to the processes which were designed to ensure they were handled appropriately.

Where complaints related to care practice we looked at the records of the staff members concerned and found it did not lead to checks on their practice, nor was it followed up

through supervision. There was a risk that people would be at risk of receiving unsatisfactory care if related staff development issues were not identified or addressed. We found three examples where allegations of poor practice or abuse were not followed up as part of the supervisory and monitoring process. This meant that the practice of the staff was not checked in people's homes and that any professional development was not undertaken. We also saw that people making complaints were not routinely spoken with and where their views were contradicted by the member of staff no further investigation or discussion with the person took place. There was a risk that the information necessary to form a judgement was not gathered and that people's care was not improved by the complaints process. This is a breach of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service well-led?

Our findings

People had mixed opinions as to whether the service was open to hearing their views. Some people were clear that they spoke with the office most weeks; others told us that they had their relatives make contact with the office for them. One person said: “My son sorts it all out.” Another person told us: “They call every week and check I’m happy with the service.” We spoke with the manager about these calls and they explained they were a means by which the service checked on the welfare of people and staff and afforded an opportunity to gather people’s views. We noted that care records did not identify people who found talking on the phone or reporting concerns, difficult and if they had no relative or other representative who spoke for them. There were no alternative arrangements in place for these people. One person told us: “I’ve no idea how they know I’m happy. I presume they work on the principle that if I’m not I will tell (staff member) and she will tell them.”

This telephone method of gathering people’s views was excluding many of the people who used the service. Four people told us that due to their disability, or anxiety, they would not be able to tell the service over the phone if they did not feel safe or were unhappy with their care. As a result, we saw that the weekly calls had happened for two of these people at times when they told us they were unhappy with their care but the calls had not picked this up. The systems excluded some people and therefore important information was lost and the provider was unable to assess and monitor the quality of the service for these people. The service also sought to gather people’s views by means of an annual survey. The most recent survey had been undertaken in 2013 showed feedback around the quality of care was positive.

Most of the staff worked on their own in people’s homes and had the majority of their contact with the service by telephone. Most of the staff said they felt confident to contact the office and raise concerns or to report mistakes. One member of staff said: “I can always call. They are polite and listen.” However five members of staff highlighted difficulties with this process including not receiving calls back, not being sure who they should speak to, anxiety about the outcome and not having time to call the office due to caring duties.

We spoke with the manager about how learning was shared amongst care staff and they gave us an example of

how lessons learned had led to a change in process when working with people at hospital discharge. However, the care staff we spoke with were not aware that learning was used in this way and did not have the opportunity to learn from this.

We noted that an audit of staffing records in May 2014 had picked up omissions from two staff files relating to the support and supervision they had received. These had not been rectified at the time of our inspection, and this meant that the manager had not supported staff to check and improve their care practice through supervision.

The provider also checked on, and aimed to raise, the quality of care people received through home visits by assessors. These visits were not always effective in promoting quality. For example, we saw that medicines had been checked, in the week before our inspection, by an assessor in two people’s homes we visited. We found concerns in both cases and the assessor had not identified these concerns. We also saw that an assessor had visited a person in their home in April 2014 and not identified financial procedures as contravening the service policy and putting the person at risk of financial abuse. This meant that the systems in place were not addressing situations where improvement was necessary.

The evidence above meant that the provider had systems in place to monitor the quality of the service and to promote high quality care but these were not effective and did not involve people consistently. This is a breach of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had an understanding of the purpose of the service which was to provide an alternative for people who needed care and did not want to go into a care home. One member of staff said: “It lets people stay at home. That is a good thing.” They were able to speak about the beliefs that underpinned this goal. For example, one member of staff told us: “It is important that (the person) keeps their place in their community.”

We spoke with the manager about how staff worked together. We saw that within the office staff had shared diaries and this ensured that there was an understanding of the work staff were undertaking within the team. We were shown minutes of the regular office staff meeting and saw these happened on a weekly or fortnightly basis. These meetings followed a regular agenda which included

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general business, business development, operations and compliance. Organisational issues and new practice issues were shared at these meetings and there was a clear focus on organisational growth and improvement. For example we saw that new paperwork was shared with office staff at this meeting.

The provider has an obligation to submit statutory notifications to the Care Quality Commission (CQC) detailing any allegations of abuse. We looked at our records and saw that the manager had not submitted notifications about allegations of abuse in a timely manner. We also saw the CQC had not been notified of allegations of abuse identified during this inspection. This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff were working with a wide range of organisations and professionals nationally. We spoke with eight health and social care professionals. Five of these professionals identified communication with the service as a difficulty. For example one social worker told us: “They don’t return calls.” A further social worker explained how they had been given different information than to a relative and this had

caused difficulties and a third described delays in receiving information requested. Three other social care professionals told us that they were happy with the service and its interactions with them.

We saw evidence that planning care for people took place alongside appropriate health and social care professionals in assessment and review records, for example we saw that one person’s care plan included input from a district nurse, occupational therapist, another social care professional working with the person and the service. During our inspection we saw the manager was involved with meetings with other health and social care professionals to ensure people were receiving an appropriate service. We have however noted in this report that the service was not always effective in contacting health professionals, and a social care professional with expertise in safeguarding told us that they were concerned that the service did not provide enough detail of investigations they undertook into safeguarding concerns. They also told us that they had not received safeguarding alerts from the service in line with agreements in place.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 9 (1) (a) (b) (i) (ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>There were no suitable arrangements in place to ensure that people were protected against the risks of receiving care that was inappropriate or unsafe by means of an assessment of needs when needs changed, and planning and delivery of care in such a way that meets assessed needs.</p>

Regulated activity	Regulation
Personal care	<p>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines</p> <p>Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>People who used the service were not protected from the risks associated with unsafe use or management of medicines.</p>

Regulated activity	Regulation
Personal care	<p>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff</p> <p>Regulation 23 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010</p> <p>There were not suitable arrangements in place to ensure that persons employed for the purpose of carrying out the regulated activity were appropriately supported in relation to their responsibilities.</p>

Regulated activity	Regulation
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This section is primarily information for the provider

Action we have told the provider to take

Personal care

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

Regulation 18 (1) (a) (b) (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no suitable arrangements in place for determining mental capacity, obtaining consent or establishing a person's best interests in line with the Mental Capacity Act 2005

Regulated activity

Regulation

Personal care

Regulation 18 CQC (Registration) Regulations 2009
Notification of other incidents

Regulation 18 (1) (2) (e) of the Care Quality commission (Registration) Regulations 2009.

The service had not informed the Care Quality Commission of allegations of abuse in a timely manner.

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	<p>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse</p> <p>Regulation 11(1) (a) (b) (2) (a) (b) (3) (a) (b) (c) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>People who use services and others were not protected from the risk of abuse because appropriate steps were not taken to identify the possibility of abuse and to prevent it before it occurs.</p>

The enforcement action we took:

We served a warning notice and told the provider to make the necessary changes by 30 September 2014.

Regulated activity	Regulation
Personal care	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p> <p>Regulation 10 (1) (a) (b) (2) (b) (i) (iii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>People were not protected because there was not an effective system in place to monitor service quality and identify and manage risk.</p>

The enforcement action we took:

We served a warning notice and told the provider to make the necessary changes by 30 September 2014.