Metro Homecare Ltd

Metro Homecare LTD

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 1 and 6 November 2017 and was announced. Metro Homecare is a domiciliary care service that provides care to people in their homes. The service supports people who live with mental ill health and young adults living with a learning disability. Older adults who are frail and have dementia receive care and support from care workers. At the time of the inspection, 400 people were using the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was the first inspection at this service since they registered with the Care Quality Commission (CQC) in December 2016. At this inspection, we found the service was not meeting all the regulations we inspected. Two breaches of regulations were found. The breaches were in relation to good governance and notifications. The overall rating for this service is requires improvement. You can see what action we had told the provider to take at the back of the full version of this report.

Staff did not always act in a way that demonstrated dignity and respect. People told us they found care workers were kind, compassionate and helpful to them. However staff did not always treat people respectfully. This was because some staff engaged in their own private activities and spoke in a language people did not understand while delivering care, which meant people did not receive all aspects of their care as planned.

Staff prepared meals and completed shopping tasks so people had enough food and drinks for their needs. However people told us that staff sometimes refused to prepare the food that they preferred to eat.

The registered manager provided us with a list of people using the service as requested. However, we found the information provided to us was not accurate because there were a number of incorrect contact details for people.

The registered manager had not notified CQC of significant incidents that occurred at the service. We were made aware of two safeguarding incidents by the local authority that occurred within the last year that had not been reported to us. The registered manager had told us that there had not been any safeguarding allegations at the service.

The registered provider had safeguarding processes to protect people from abuse. The registered manager and staff understood what action to take to protect people from the risk of abuse.

Assessments recorded risks to people's health and well-being and the support required. Each person had a

risk management plan that identified potential risks and the actions staff should take to mitigate those risks and keep people safe.

There were enough staff deployed to meet people's needs. The staff rota showed the names of people using the service and the allocated care worker who was scheduled to deliver their care. There were systems in place to monitor missed and late visits. Staff learnt from incidents that occurred at the service. Any incidents of missed and late calls were reviewed and the actions taken to resolve these concerns were recorded. The registered manager implemented an electronic tracking system that care workers used that identified whether people had received their planned care.

People's medicines were managed in a safe way. We found that people had their medicines as prescribed. When people required support to take their medicines this was provided to them by staff.

People were protected from the risk of infection. The registered manager supplied personal protective equipment (PPE). Gloves, aprons and foot covers were made available for staff to use. Staff used PPE to reduce the risk of infection for people.

People had an assessment of their care and support needs. Assessments were completed before they received a service. The assessments provided staff with sufficient information to enable people to receive safe and appropriate care.

Staff were supported by their line manager. Staff took part in training to increase their knowledge and support them in their role. Staff had regular supervision and an appraisal. An induction programme was in place for new staff to help them understand the organisation they worked in and people they provided care to. However, staff required further support to improve their skills to enable them to be effective in their roles.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were understood by the registered manager and staff. The registered manager and training provider organised MCA training for all care staff. People were supported to have maximum choice and control of their lives and staff provided care in the least restrictive way possible for people. The policies and systems in the service supported this practice.

Consent to care and support was provided to staff by people. Decisions about care and support needs were made by people and their relatives. Staff understood and respected people's individual needs regarding their care decisions.

Health care support was provided to people when required. Care workers reported any concerns about people's welfare and office based staff contacted health care services for support and advice on behalf of people. The service, worked in a co-ordinated manner with health and social care services to meet people's needs.

Staff supported people to maintain their privacy and dignity during care visits. People were mindful when carrying out personal care tasks to help maintain their privacy. People commented that staff supported them in a way that helped them to maintain some independence in their lives.

Care assessments and care plans were developed in accordance with people's views. People had regular reviews of their care and support needs. Care records we viewed placed people at the centre of them.

The registered manager had a system in place for people to make a complaint about the care they received. People were provided with details of how to make a complaint about the service if they chose.

Staff provided individualised care for people nearing the end of their lives. People were encouraged to discuss the care they wished to receive at the end of their lives and these were recorded in their plan of care.

The registered provider demonstrated a clear vision within the service. We observed a positive work culture and the registered manager valued staff that worked at the service. Staff were positive about working for the service and commented positively about both their line manager and the registered manager. Each member of staff had their designated role within the service. There were systems in place to monitor, review and improve the quality of care.

The registered manager gathered people's views of the service. People were encouraged to give their views on the service and staff that provided care and support to them. The service engaged with local community groups and local health and social care services to improve the quality of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People had an assessment of their health and well-being. The identified risks were recorded and staff used this guidance to manage them safely.

The management of medicines was safe. People had their medicines as prescribed.

There were sufficient staff available to support people's care needs.

Staff understood how to protect people from abuse and took actions to report suspected abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff did not always provide meals that met people's preferences. People were not always supported to make choices in the meals they enjoyed to eat.

The registered manager had systems in place so staff had training, supervisions, appraisals and an induction during their employment. However, people raised comments on staff ability to read and speak English enough to support them.

Staff supported people to access health care services when their care needs changed.

Staff understood the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not always caring. Staff did not always treat people respectfully.

People told us that staff treated people in a way that was kind and compassionate.

Is the service responsive?

Good

The service was responsive. People had an assessment of their care and support needs before receiving a service.

Staff supported people to make care choices which helped them promote their independence.

The registered provider had a complaints policy in place. This allowed people to make a complaint about the care they received.

People had support and care in place for them at the end of their lives.

Is the service well-led?

Requires Improvement

The service was well led. The registered manager understood their role and responsibilities.

Staff were complimentary about the registered manager. They described him/her as approachable and supportive.

The systems in place assessed, reviewed and monitored the quality of care provided.

There was partnership working in place with local authority departments that commissioned care for people.

Staff obtained people's views about the service they received and these were used to drive improvements.

Metro Homecare 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.

This inspection took place on 1 and 6 November 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to be sure that someone would be in. The inspection was carried out by one inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. We used this information to help us with the planning of the inspection.

We spoke with 14 people who use the service and two relatives. We also spoke with the registered manager, two care coordinators, the care manager and two members of staff from the training service. We also spoke with five care workers employed at the service.

We looked at 10 care records, 10 medicine administration records (MAR) for people, five staff records and other documents relating to the management of the service.

After the inspection, we spoke with two representatives from the local authority social care and commissioning teams.

Good

Is the service safe?

Our findings

People described the care and support they received as safe. One person said, "Yes I feel safe with my regular carer." A relative said, "Yes my [family member] has the same male carer everyday so feels safe." Another person told us, "By supporting me every day – they help me feel safe." A third person also told us, "I feel comfortable about the carer who comes into my home. It's important I know that the care worker is trustworthy."

The registered provider had systems in place to protect people from abuse. The service had a safeguarding policy in place. This provided staff with guidance on the actions to take to identify and manage an allegation of abuse. Staff also completed training in safeguarding adults, which increased their knowledge of harm and abuse. This provided staff with knowledge of the types and signs of abuse and how to report an allegation of abuse. Staff we spoke with described actions they would take to protect a person from harm and abuse. All staff told us allegations of abuse were discussed with and reported to their manager. The service had the local authority safeguarding team contact details available for staff when needed.

The registered provider had a system that monitored and reviewed missed and late calls. The system alerted staff when a care worker arrived late for their care visit. Office based staff identified the care worker who was late and contacted them for an explanation. Then office based staff would call the person using the service and inform them of the lateness. The registered manager explained that three commissioning local authorities had direct access to this system. They used the system to track and identify any patterns of lateness or missed calls. Care workers had an electronic system in which they would log their arrival and departure. The registered manager told us that at times the log in system had temporary errors which could affect the accuracy of the system.

We spoke to people and their relatives about their experiences of the timeliness of care visits. People shared mixed views and experiences of missed and late visits. One person told us, "Yes, they have let me know." Another person told us they had, "Not experienced [missed visits]", and said "No, they have never not turned up." A third person said, "Hit and miss – I have had to phone the office and I am angry as they have a tendency not to let [my family member] know the carer is not coming, usually it's the pm call. Then [my family member] has to phone lots of times and gets an answer machine." A fourth person said, "Not always – staff arrive give or take within half an hour and yes there have been times they have not turned up or let us know." The registered manager maintained records of all missed visits and shared these with the appropriate local authority.

Staff assessed risks for people to ensure these were managed safely. Each person had a risk assessment completed as a part of the assessment process. The assessment identified risks associated with people's health and well-being. Risks were recorded on people's care records. An additional risk management plan was developed. This detailed the support people required to manage those risks. For example, one person's care record detailed the support they needed from staff when walking and the need to use their walking aid. We saw another example, that recorded two members of staff were required to provide support to a person who was at risk of harm because they were unable to move and stand without support. Care records

detailed when additional equipment was required due to the identified risks. This included a specialist wheelchair, hoist and sliding sheet to help people move whilst in bed or sitting in the chair. The examples of care records we looked at demonstrated that staff identified and understood risks to people's wellbeing. This was followed by the implementation of a management plan to keep people safe.

People had their medicines administered as planned and prescribed. The registered manager explained people who required support with their medicines were supported by staff with this. We asked people whether they received appropriate support with taking medicines from staff. People shared mixed views of this aspect of their care. People shared comments with us such as, "yes from the dossette box", "They [care workers] make sure I take it", and "Yes they give it to her from the dossette box." However, a relative said, "Yes they do – but never record medication prompted/administered. My [family member] viewed the care plan [this] amounted to an A4 sheet, but no MAR sheet was present or available in the care plan. Four months ago the supervisor visited and asked mum for a list of all medications she took each day and took the pharmacist form with her, never bringing it back or telling mum why she needed it". Another person said, "Yes they prompt me to take medication but it is never recorded that they have done this." We saw completed copies of MARs for people, these were accurate and reflected that people received their medicines as prescribed. MARs that came into the service were checked and audited for their completeness.

The registered provider had a medicines administration policy in place. This provided staff with guidance on how to safely manage people's medicines. The registered provider told us that most people had their medicines dispensed in dossette boxes and staff were able to administer and support people to take their medicines as prescribed. Staff completed training in the management of medicines and we saw records that confirmed this. Following this training staff were confirmed as competent and safe before supporting people with their medicines.

There was a system implemented to review records for the administration of medicines. Each month a senior member of staff reviewed medicine administration records (MARs) for accuracy. We found the audit recorded any issues or concerns found in the MAR. For example the September 2017 audit showed staff had not always recorded the GP's name or allergy status of the person. We saw this issue was discussed at the staff team meeting and during supervision with staff. There was an improvement in this noted in the next medicine audit. The registered provider had systems in place that supported safe administration of medicines. Staff followed the registered provider's medicine management policy so people received their medicines as prescribed.

People had enough staff available to care for them. Staff were deployed to care for people safely and meet their care needs. Two members of staff were deployed to people who required this level of care to meet their needs. Staff had contacted a person's social worker to review the level of care the person received as care workers found the time allocated to provide care was no longer adequate. The care package was revised to ensure the person had sufficient time to allow care workers to support them safely. Two staff were always allocated when people required support with using a hoist to ensure this was managed safely. People shared their comments about whether there were sufficient members of staff available to support them. A relative said, "Two carers come to help [my family member] to move." Another relative said, "[My family member] uses a standing hoist. They [care workers] are trained by the agency to use it."

We reviewed a copy of the staff rota for one month. This showed that there were enough staff to provide the required amount of care for people. Office based staff had organised the staff rota to ensure that there were sufficient staff available to meet people's needs.

There was a safe recruitment process in place at the service. Newly employed staff completed the registered

provider recruitment process. This included an application form, job references, employment history gaps, interview records and criminal records checks. Office based staff completed pre-employment checks. The recruitment checks carried out on new employees were used to evaluate their suitability to work with people. The recruitment process in place reduced the risk of people being cared for by unsuitable care workers.

People were protected from the risk of infection. Training in infection control was provided for staff. Staff we spoke with understood how to provide care and support to people in a safe way. Staff understood how to reduce the risk of infection for people they cared for. Staff had access to personal protective equipment (PPE). Gloves, aprons and foot coverings were made available to staff. Supplies were held in the office and in people's homes with their permission. Staff wore these while providing care to help reduce the risk of infection.

Requires Improvement

Is the service effective?

Our findings

People did not always have meals that met their preferences and nutritional needs. We spoke with people about the meals and food care workers provided for them. People told us that care workers encouraged them to eat their meals to maintain their nutritional needs. One person said the, "Carer makes me breakfast and heats up a ready meal for me." A relative said, "Oh yes, before they leave they always make sure [my family member] has water and tea near [by]." Another relative said, "I do all the food and they [care workers] encourage [my family member] to eat." Although staff completed shopping for people when this was part of their package of care, people did not have meals that met their preferences, choices and needs. People told us that care workers did not always respect their food choices. People and their relatives told us that care workers did not always cook meals of their choice. We received comments such as, "Yes they do cook the food. But they are not allowed to touch ham or pork", "Yes staff refuse to prepare ham sandwiches for [my relative] if I leave ham for meals.", "It depends. Some don't make me ham sandwiches and have refused to touch ham, so I have to do it myself." A relative told us "A [care worker gave [my family member] a raw bacon sandwich for their meal." We discussed this feedback with care workers. All the care workers spoken with confirmed they would prepare pork based meals for people using the service. The registered manager was informed of these concerns. They told us they would discuss this feedback with staff at the next staff meeting. We did not receive a copy of the meeting minutes to confirm this concern had been addressed.

Some staff did not have English as their first language and had some difficulties with communication in English. People raised some concerns about the communication of some of the staff that cared for them. We received comments such as, "The [care worker] cannot speak English, but the [second care worker] is very friendly and fluent in English", "Some do not speak English. I have dismissed four of them" and "Depends on who comes and if they speak English." A relative told us, "[My family member] has been asked by carers what to do as the carer cannot read English or the care plan. They cannot record in the care plan of tasks done." Another person said, "Carers cannot read English so cannot write in care plan, those that have a small amount of English record in parrot English." We discussed the concerns people raised with us about care workers language skills with the provider. The registered provider had acknowledged some of these concerns and had provided basic literacy and numeracy to staff that required this additional support, however the comments made indicated still indicated that staff were not always adequately equipped with the skills to enable them to fulfil their roles effectively. We recommend that the provider seeks further advice from a reputable source to ensure that all care workers are fully able to read care documentation and complete the required records to ensure that people's needs are met effectively.

The registered manager ensured staff were supported while working for the service. Staff had their work performance assessed by their line manager. Staff had an appraisal each year that allowed staff and their manager to review their progress in their role. Appraisal meetings were used for staff to discuss their personal development needs. If they identified they needed additional training this was discussed. The manager with the member of staff put strategies in place for professional goals to be achieved.

Supervision with staff occurred on a regular basis with their line manager. Supervision meetings occurred face to face in a location near to where the member of staff worked. For example, staff that lived and worked

in west London were able to meet at an office in the west London area. Staff told us their manager was flexible and they preferred that arrangement especially when they did not work in the area of the main office. During supervision, the manager reviewed the daily practice and concerns they may have when carrying out their work. Staff supervision was used to discuss any practice changes in the service. Any areas of concern were discussed and the manager was able to offer advice and guidance to resolve any concerns. Care workers were supported by senior and experienced staff. Newly employed staff completed a period of induction to help them familiarise themselves with the service and people they would be providing care and support to. Staff had the opportunity to work with experienced members of the care staff by shadowing them. This enabled newly employed staff to have an insight into the work and support they would provide. Following the completion of the induction programme, the manager assessed the new member of staff as being competent following their induction before they were able to work independently with people.

Staff completed training to equip them in their jobs. Staff completed regular training in basic life support, medicines management and safeguarding adults from abuse. Staff discussed the training they completed. One member of staff told us "The training is very good and I learnt a lot." Another member of staff told us "I have done a lot of training before coming here, but it is always good to have refresher training, things change a lot in care services." People we spoke with felt that staff were trained which enabled them to be supported. One person said, "Yes the two I have are good." Another person said, "Oh yes they are very professional [and well trained]."

There was an external training provider that the registered provider used to provide training. We spoke with two people from the training provider. They told us that they met regularly with the registered provider and devised a training programme which met the needs of the service and individual care workers educational and training needs. There was a training matrix in place. This provided details of the training programme for staff. When staff required additional training this was provided to them.

People's needs were assessed by staff and care and support was delivered to meet those needs. The registered manager and office based staff carried out an initial needs assessment with people and their relatives. This established the level of care and support each person required to ensure the assessed needs were met in a safe way. Assessments detailed people's medical conditions, physical and mental health and social care needs. Care plans were developed with people to ensure their care needs and support were recorded. The care plan provided staff with guidance in how people preferred to have their care and support needs met. People's care plans detailed the support people required with their personal care and support needs. This also included whether they required support while going out in their local community.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. When people's ability to make a decision changed this was reported to the local authority. A representative from the local authority completed a mental capacity assessment. If specific decisions needed to be made these were discussed in a best interests meeting. Any decisions made were recorded. People were cared for in a way that protected them from risks of the unlawful deprivation of their liberty. People were supported to have maximum choice

and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

The registered manager understood their responsibilities to care for people appropriately in line with the MCA.

Staff obtained consent from people before supporting them. People we spoke with gave their consent to care and support. They told us that staff asked them for their consent before providing care. One person said the care worker asked them for their permission and consent before carrying out tasks. They added, "Yes [they ask me what I need and then they] help me with." A relative said, "I will make decisions for mum and speak to her about it. My mother is very assertive and will tell them what she wants."

Staff understood how to support people when their health care needs changed. People told us that staff supported them when they needed help in an emergency. One person told us, "Yes, [my care worker] helps me when I need it." Staff understood the process of supporting people when required, staff we spoke with understood when to contact the medical services if the person was unwell and they were concerned about this. We saw the staff contacted people's GPs and out of hours health services in an emergency. Staff supported people to attend health care appointments if this was required.

The registered manager and staff worked jointly with local health and social care services. When people's needs changed staff made contact with occupational therapists, dieticians and social workers who had been involved in people's care and support. Partnership working with health and social care professionals helped in the effective coordination of care and support for people.

Requires Improvement

Is the service caring?

Our findings

People were not always supported by staff that who were caring. We found that staff did not always care for people in a way that promoted their dignity. During the inspection we were made aware of an incident where a care worker had not respected a person's home by using their space to carry out a personal task. We discussed this incident with the registered manager. They confirmed the expectation is for care workers to respect both people and their homes. We found another example where people were not treated respectfully as care workers were sometimes speaking in their own language whilst supporting people and therefore not including the person in their conversation. A relative shared with us, "My only gripe is that they sometimes speak in their own language. They should speak in English." Another person raised a similar concern, "It's not good – I desperately need carers who can speak English."

People we spoke with shared their comments about the care workers that supported them. One person told us they had a "Very caring lady carer." Another person said, "It's good for me to have carers. They are willing to do anything that is caring work." A relative told us, "Oh yes they are very caring they give [my family member] birthday presents. We feel we have known them for years." Another relative said, "They are very caring, I couldn't survive without them. They are wonderfully friendly, they are like members of the family." People we spoke with were happy when their care worker provided regular care and support to them. One person said care workers are "Very nice, polite and caring is my regular carer."

People said staff showed them kindness and compassion when supporting them. A person said, "Yes they have a very good attitude they are happy and cheerful." A relative told us, "We all get on well. They sometimes bring in cake [for my family member]. When my [family member] died they went to [their] funeral and brought in food." A second relative said, "Very caring and gentle and laughs with [my family member]. They don't get offended when she is nasty to them. They sing and dance with [them] and [my family member] loves it."

People told us that staff respected their privacy when providing care to them. We received comments such as, "[The care worker] puts me in a bath and covers me with a towel afterwards" another person said, "Carers close the door when I'm [in the bathroom]". A relative said, "They are very good…[the care workers] cover [my family member] with a towel when doing personal care." Staff supported people in a way that promoted their privacy.

People and relatives were able to plan and make decisions about their care. Staff collected information that described people's likes, dislikes and preferences for care and support. Care records also had details of what people enjoyed doing during their day. People told us that they felt involved in their care and were able to make decisions. One relative told us, "Will make decisions for mum and speak to her about it. My mother is very assertive and will tell them what she wants."

People were supported to be as independent as they were able. People told us staff encouraged them to carry out their personal care needs as far as they could. One person said, "They encourage her to get up otherwise she would spend all day in bed." A second person said, "Yes they help me to go downstairs." A

relative said, "They let her walk on her own." Another relative told us, "They encourage [my family member]."

Staff promoted independence for people and helped them to discover their individual abilities. Staff supported people to attend health appointments and social activities. For example, one person told us staff helped them to get ready so they could go shopping. They told us, "They help me to mobilise to the day centre via the Mini Bus."

Good

Is the service responsive?

Our findings

People's care was tailored to meet their individual needs. People's needs were met after staff completed care needs assessments. The information obtained from the assessments helped staff to determine the level of care and support people needed before they received a service. People and their relatives told us that assessments took place before they received support from the registered provider. People confirmed with us that office based staff visited them to discuss their care needs and said they received a care plan which gave them details of the care and the support they needed.
Care assessments were completed with the contribution of the person or their relative.

These identified people's care needs, social activities they took part in, religious and other cultural needs. Once the assessment was completed the plan of care was provided to people and the care worker so they had sufficient information available to them in what support people needed. People told us that the provider accommodated their preferences and made changes to their care plan when requested. For example, one person said they had requested a change in the time of their care visit. The relative told us, "They are friendly. [My family member] likes to get up late at about 10.30am so they come then."

Staff reviewed people's care and support needs on a regular basis. This ensured the care and support that was provided remained relevant and suitable to meet people's individual needs. Following a review of care, the care plan was updated to ensure it reflected people's current or changed care needs. This information was then shared with people, care workers and recorded on people's care records.

Care records we looked at showed staff involved people when planning their care. For example, staff completed six monthly care reviews with people and their relatives. This meeting was arranged to discuss how the care service was going and whether any changes were needed and required since the last care assessment or review of care. In each care review it detailed people's opinions and whether they had requested any changes or adjustments in their care to meet a need. Where a change was required we found office based staff followed this request up with the relevant commissioning authority.

The registered provider had a complaints policy in place. People understood the process to make a complaint about the service and the quality of care. One person said, "Yes I have asked for changes and yes I have made a complaint." A relative told us, "Yes I have complained about carers not turning up." Both people informed us that changes were made as they requested which met their needs. They also told us that the service had handled their complaint and were satisfied with the outcome. We looked at the complaints records. We saw that the registered manager had contacted complainants and provided them with a response in line with the registered provider's complaints process.

People were supported to receive appropriate care at the end of their life. We reviewed the care records of a person who was receiving end of life care. We saw their care records detailed the care and support they received from health and social care services. Their contact details were also recorded so staff had access to these when required. Care workers were familiar with supporting people at the end of their lives and knew who to contact when people reached the end of their lives during a care visit.

Requires Improvement

Is the service well-led?

Our findings

People shared their views about the management of the service. People told us they felt the service was managed well. Their comments included, "Excellent, we used two agencies before. This one is excellent", "I would recommend the agency based on the carer I have", "[Care workers name] is the main carer – [care worker] is lovely….The agency is very good quality and caring." A relative said, "I think they are excellent. If you asked me how many I would give them out of 10, I would say 12. We have struck gold." Despite these positive comments we found that aspects of the service were not well led.

The registered manager showed their understanding of their responsibilities in delivering effective care to people. They had an understanding of their CQC registration requirements, however did not send notifications of significant incidents that occurred at the service, including safeguarding allegations as required by law. There was a system in place to capture safeguarding incidents. The local authority had informed us of one safeguarding concerns relating to the service.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

There was a risk of people not receiving visits as required because people's contact details were not kept up to date. The registered manager provided us with a list of people using the service as requested. We found when we contacted people on the list we encountered difficulties. We found that two people had ceased to use the service for some months because they no longer required it. They told us they stopped receiving support in September 2017. We contacted another person and we were told that the person had died some months before our call. Four contact numbers we were given had wrong numbers because the calls did not connect and one person identified on the contact sheet was living in a residential home. Therefore, the registered manager could not accurately assess and monitor the level of staff required to meet people's needs as this was based on an inaccurate record of people using the service. We spoke with the registered manager about the contact list. They told us that they would review and update their contact list for people using the service.

Although the provider had taken some action to address issues related to the knowledge and skills of staff this had not been effectively monitored to address the impact this was having on people using the service.

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

The registered manager carried out a system of quality assurance, internal reviews and monitoring of the quality of care and the service provided. This included the review of care records to ensure they were of good quality. Staff carried out unannounced spot checks with staff to ensure they met and maintained good standards of care and practice. Spot checks were carried out during planned home visits by care workers and were used to identify areas of good practice and areas for improvement. The manager recorded the outcomes from the spot checks, any concerns were discussed with the care worker and support given to improve the quality of the care delivery.

Staff we spoke with were complimentary about the service they worked for and the management of the service. Staff shared positive examples of how the service was supportive to them. One member of staff said, "I would not hesitate to call the office if I needed help or advice", another member of staff said "I wouldn't work for her for so many years if I wasn't happy and enjoyed my job." A third member of staff said "This is a very good place to work." Staff gave examples of raising concerns with the senior team they told us that the management team listened to them and helped resolve issues where they could. The service had a positive culture within the service. They had an ethos that advocated quality care for people. Staff understood the aims of the service and showed their commitment to providing good care and support to people.

People were asked for feedback on the quality of care and support they received. We saw the feedback people and their relatives provided. We saw that people stated they were happy and satisfied with the level of care they received. People said they had received questionnaires or were contacted via the telephone by office based staff for their views of the service. People told us, "Yes they send in forms for me to fill in." A relative said, "Yes I think they have phoned up about 3 times to find out." People felt able to raise concerns they had with the service if they were unhappy with their care.

The service and staff worked closely with external organisations. The service was involved with local community groups and charities. We were informed that Metro Homecare limited had developed links and increased their activity in local communities. The service had sponsored four local football teams and supported them in purchasing football kits for the players. The service had additional links with community groups and encouraged more than 50 local children to take part in local activities and held various events for parents, trainers, and children to get together in order to promote and encourage community cohesion. The service had also developed partnership working with local health and social care services as well as voluntary organisations such as UK Sickle Cell (based in Southwark), and a local service for people who were experiencing homelessness.

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 did not send notifications of incidents that occurred at the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager did not ensure service users contact details were accurate and updated.