

Lalis Direct Care Ltd

# Lalis Direct Care Ltd

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

# Summary of findings

## Overall summary

This inspection took place on 20 March 2017 and was announced.

Lalis Direct Care Limited is a domiciliary care agency that provides personal care for people in their own homes. At the time of our inspection, the agency provided approximately 900 hours of support on a weekly basis to 81 people. These included people with learning and physical disabilities, sensory impairments, older people and people who lived with dementia.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission 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.

The registered manager was supported by the provider, the branch manager, two senior care coordinators, two payroll officers and 22 care workers.

The service was last inspected on 03 February 2016. At that time, we found the agency was not meeting all the required Regulations. We observed that people were not always safe as the agency did not have detailed plans in place for management of identified risks to people's health and wellbeing. Additionally, the agency's quality audits were not effective in highlighting concerns and mitigating risks to people.

At the inspection on 20 March 2017, we found some improvements had been made and further improvements were needed in other areas.

The agency did not always ensure that people were safe from harm and abuse. People and their relatives gave us mixed feedback about care they received from care workers who supported them.

Care workers received safeguarding training, however, not all of them had a good understanding of the principles of safeguarding vulnerable adults.

The agency did not always manage medicines administration safely and there was a risk that people would not receive their medicines as prescribed.

The agency did not always work within the principles of the Mental Capacity Act 2005 (MCA) and there was a risk that decisions related to people's everyday care were not made in their best interest or with their consent.

The agency did not always involve people in planning of their care and did not always take into consideration people's personal wishes and preferences.

People told us they were not always satisfied with how the agency dealt with their complaints.

The agency had systems in place to assess and monitor the quality of the service however they were not always effective.

The agency did not follow their legal duty to submit statutory notifications and did not display their most recent performance rating on their website as required by the Regulations.

Care workers had guidelines on how to manage risk to people's health and wellbeing, however, some care documents had inconsistent information on what these risks were.

The agency had a process in place for reporting of incidents and accidents and care workers followed it.

The agency had robust recruitment procedures in place to ensure only suitable care workers were appointed to work with people who used the service.

The agency had a rota system in place to ensure that all calls were covered and care workers knew who they were assigned to visit that week.

The agency worked closely with the local authority and other health care professionals to make sure people were supported to maintain good health and have access to healthcare services.

New care workers undertook an induction that consisted of the training the provider considered mandatory and shadowing of more experienced colleagues.

Care workers received regular training, supervision and appraisal of their work.

People's care plans consisted of clear and practical instructions on how to support people they cared for.

People we spoke with told us care workers respected their dignity and privacy when providing personal care.

The agency sought regular feedback from people and their relatives about the service provided.

Care workers told us they felt supported by the registered manager and the office staff and that there was a fair and open culture of communication within the agency.

External stakeholders had mixed feedback about their experience of the quality of the service provided by the agency.

We have made two recommendations relating to the review of risk assessment documents and gathering information about nutritional needs of people who used the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate** ●

The agency was not always safe.

The agency did not always ensure that people were safe from harm and abuse.

The agency did not always manage medicines administration in a safe way.

The agency had made some improvement in its' management of risk to ensure people were kept safe and well.

The agency had robust recruitment procedures in place.

The agency had a rota system in place and care workers knew who they were assigned to visit each week.

### Is the service effective?

**Requires Improvement** ●

The agency was not always effective.

The agency did not always work within the principles of the Mental Capacity Act 2005 (MCA).

People's care plans did not always consist of information on their dietary needs and requirements.

The agency supported people with prompt access to external health professionals.

Care workers received regular training, supervision and a yearly appraisal of their work.

### Is the service caring?

**Requires Improvement** ●

The agency was not always caring.

People using the service told us not all care workers were always kind and compassionate.

People felt care workers respected their dignity and privacy when providing personal care.

The agency regularly asked people who used the service and their relatives about their experience of the care and support received.

### Is the service responsive?

The agency was not always responsive.

The agency did not always handle complaints to the satisfaction of people who used the service.

The agency had not always involved people in the planning of their care.

People's care plans did not always reflect their cultural and religious needs and preferences.

Care workers knew about people's care plans and they said they had read them regularly.

**Requires Improvement** ●

### Is the service well-led?

The agency was not always well led.

Some audit systems carried out by the agency were not effective in assessing and monitoring the quality of the service provided.

Care workers felt supported by the registered manager and the office staff.

The agency had systems in place to communicate with care workers about different aspects of their role.

The agency maintained an audit trail of communication with external stakeholders.

**Requires Improvement** ●

# Lalis Direct Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 March 2017 and was announced. We gave the agency 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure someone was available to talk to us.

This inspection was carried out by two inspectors and an Expert 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, we carried out telephone interviews with nine people who use the service and seven relatives who gave feedback on behalf of those who were unable to speak on the telephone due to their complex needs. We also contacted four external professionals to ask about their experience of working with the service.

Additionally, we gathered information from 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 also reviewed other information about the service such as notifications the service is required to submit to the Care Quality Commission.

During our visit, we spoke with the provider, who was also a director and the owner of the agency, and with the registered manager.

We looked at records which included seven people's care records, recruitment records for six care workers, training and supervision records, and the service quality audits relating to the management of the service.

Following the inspection, we contacted six care workers and two external professionals all of whom gave us their feedback on their experiences of the service.

# Is the service safe?

## Our findings

At our inspection on 3 February 2016, we identified a breach in relation to assessment and management of risks to the health and wellbeing of people who used the service. At this inspection, we found that some improvements had been made but further improvements were still needed.

Following our inspection in February 2016 the provider had introduced a new risk assessment document. The document consisted of information on people's ability to perform daily activities as well as on specific risks identified for each person who used the service. The document gave guidelines to care workers on how to manage each identified risk.

However, we saw that some information about risk to people's health and wellbeing was confusing and did not always match other risk assessment documents in people's files. For example, one person's risk and needs assessment stated they were moving independently and they needed the support of one care worker. However, their risk assessment document stated they were bed bound and they needed the support of two carers.

We recommend that the provider reviews all risk assessment documents to ensure information about risk to people's health and wellbeing is clear and consistent.

People and their relatives gave us mixed feedback about care workers who supported them. Comments included, "I'm very satisfied with them. I wouldn't like to change. I've got no complaints whatsoever.", "They are alright. They are ok with me", "Sometimes (care workers are) nice sometimes not.", "At the moment they seem absolutely fine."

Some people we spoke with told us, they did not feel safe and comfortable in the presence of care workers. We were made aware of three specific incidents of abuse of people by their care workers. People told us they reported their concerns to the agency but the carers came back to intimidate the people. We reported these incidents to the local authority. We looked at the agency's safeguarding file and we did not see any records of these incidents.

Records showed that care workers received safeguarding training, however, not all of them had a good understanding of the principles of safeguarding vulnerable adults from abuse. Comments included, "(safeguarding is) being safe for myself and clients. You assess situations, how you manoeuvre chair to bed safely", "Lack of food, hygiene", "Need to be aware of the client and that the environment is safe enough". One care worker said safeguarding meant protecting people from abuse. All of the care workers we spoke with said they would report any concerns to the agency, however, they did not mention the safeguarding role of the local authority.

The evidence we saw showed that the agency had not always acted on concerns promptly to ensure people were safe. A daily telephone call record from January 2017 consisted of a record where a care worker informed the agency that a person was not opening their door and had not answered their phone. The note

on the record indicated that the call recipient intended to contact the person later, however, they had not raised the alarm immediately with appropriate services to ensure the person was safe. A second record from March 2017 stated that a person had developed an advanced pressure sore, however, it appeared care workers supporting the person had not made appropriate referrals to address it.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that the agency had made one safeguarding concern to the local authority. The information was recorded appropriately, however, the agency had not informed the Commission about it, which they should have done. This meant the provider had not followed the agency's own safeguarding policy and their legal duty to submit statutory notifications as required by the Regulations.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The agency used a daily medication log book to record medicines administration. The log book consisted of information on the date and time care workers administered medicines a record of whether the person had taken their medicine(s) and the care worker's comments and signature. However, the log book did not contain the list of medicines and the dosage that people had been prescribed to take. The provider explained the agency used this system as all medicines were administered from pre-prepared blister packs and all medicines were listed on these packs. However, this practice was not in line with the agency's own medicines policy that stated all medicines should have their name and the dose recorded on people's medicines administration sheets.

We saw that daily medicines log books were not always fully completed. On the log for one person, a care worker stated that they had administered medicines, however, they did not record if the person had taken it. A log for a second person did not have any entry recorded on one of the days. The provider explained the person had an appointment and not all calls had taken place, however, daily care records for this person indicated that care workers had completed their visits on that day.

People's care documents consisted of unclear information as to who was responsible for people receiving their medicines. One person's care documents stated their family was managing their medicines, however, a different document for the same person indicated that it was a task for visiting care workers. Care records for another person stated that they were self-medicating, however, a different document in their file said that care workers were to administer and record all medicines administration.

Records for another person showed that care workers had administered their medicines although they were not supposed to do it. An initial assessment for this person conducted by the local authority stated that care workers were not to administer medicines to the person. The person's social worker had only formally agreed medicines administration by the agency two weeks after the support for the person had begun. However, the person's care plan formulated on the first day of receiving the support instructed care workers to administer their medicines. Daily care records for this person confirmed that care workers had been administering the person's medicines before they were authorised to do it.

The registered manager provided us with medicines administration training certificates for all care workers employed by the agency. Care workers confirmed they received the training, however, their understanding of medicines administration and the required recording procedures varied. Comments included, "Yes I give medication - I write in the book and record how many and what times.", "(Medicines are) mostly in blister packs - so I don't have to do anything but record on a medication log sheet", "We write in the log book what

type of tablet, the name of the medication, how many times and what tablets." One care worker told us, "If (medicines are) in blister pack we give and record in the book. If there is a lot we get confused and don't give it".

The above evidence showed that the provider had not always ensured the proper and safe management of medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The agency had reviewed the risk to people's health and wellbeing yearly or earlier if the risk had changed. We saw a risk assessment review chart that the provider used to track whose risk assessments were due to be reviewed.

We looked at how the agency managed accidents and incidents. Following our inspection in February 2016 the agency introduced a new accidents and incidents recording form. We saw three examples of completed forms. Records included information about the incident or accident, who was involved and what actions were taken. We saw that all incidents and accidents were investigated immediately after they took place. Care workers were asked to give a written statement about what happened and all relevant parties were informed about the outcomes of the investigation. However, the agency did not have a central accidents and incidents register which would allow it to analyse and identify any possible trends in the types of incidents and accidents recorded.

The agency had robust recruitment procedures in place to ensure only suitable care workers were appointed to work with people who used the service. The agency had a three stage application process. Candidates were asked to complete a pre-application form which captured basic information about them and their availability to work. Suitable candidates were then invited to complete an application form and attend a formal interview. We looked in the files of four care workers and saw that all the required paperwork was in place.

The agency had a rota system in place to ensure that all calls were covered and care workers knew who they were assigned to visit that week. The agency had contingency plans in place to ensure that care workers' absences were covered and people received their care as planned.

People and their relatives gave us mixed feedback on time keeping and the length of time spent on calls by care workers. Comments included, "Yes (care workers) spend one hour (here)". "(Care workers) are more or less on time. They do try to be on time". There were also comments that indicated that care workers were often late. One person told us they frequently had to wait up to 45 minutes for carers to arrive. The person told us, "Unfortunately they don't (come on time). They said they would be here by 9 o'clock they were here at 9.35am. Sunday evening (they should be) at 6 o'clock, they had arrived at 6.45pm". Another person stated, "I'm finding it a bit frustrating at the moment – I can't book appointments. If it's a hospital visit I get my (relative) to come (to help me to get ready) as I can't be late. One family member told us, "If two (care workers) come they don't coordinate (time of their arrival). About half an hour late – (my relative) gets frustrated". The agency's daily telephone call records showed a number of calls from people who used the service or their family members stating that carers were late. We spoke with the agency's director and the registered manager about carers' lateness on the day of our visit. They informed us the agency had allowed up to one-hour leeway for all calls and all people using the service and their relatives were informed about this. However, this rule had not been mentioned to us by any of the people and their relatives we spoke with.

The registered manager informed us that the agency was currently in the process of implementing a new electronic system to help the agency efficiently plan all care visits and to monitor in real -time daily service delivery. The register manager stated that the system would be implemented not later than April 2017.

## Is the service effective?

### Our findings

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

The information about peoples' mental capacity and ability to make decisions was included in the referral documents sent by the local authority. However, this information was not always clearly recorded in peoples' care files. Therefore, care workers did not have complete information on people's mental capacity and their ability to make decisions. For example, one person's care file stated that the person had "difficulty with decisions regarding activities", however, it was not clear if the person had the capacity to make other decisions. A second person's care plan stated, "Family to be included in any decisions that require clarification", however it was not clear if the family of the person had the legal right to make decisions on behalf of this individual. Consequently, there was a risk that decisions related to people's everyday care were not made in their best interest and by the people who were legally appointed to do so.

We checked how the service sought people's consent to their care and treatment. A consent document for one person stated that they were unable to sign it, however, there was no explanation on why they could not do it. The provider explained that this person experienced mental ill health, therefore, was not able to sign the document. We looked at other care records for the person and we saw that they were described as being able to make their own decisions and they were able to fully participate in planning of their care. The records also showed that the person had been refusing some elements of care and support provided by the agency. This indicated that the person may have been receiving care that they periodically were unable to consent to due to the possibility of their capacity to make decisions fluctuating when they became mentally unwell.

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

We also looked at consent documents for other people who used the service. We saw a note on consent forms for two persons, stating that they were unable to sign due to having a visual impairment. Following our inspection, we contacted the registered manager to discuss this matter further. They explained that for these individuals the agency sought their verbal consent and they agreed that this should have been clearly recorded in people's files. The registered manager assured us they would amend the information.

Records showed that care workers completed training in the MCA. Care workers we spoke with confirmed they received the training, however, their understanding of the principles of the Act varied. One care worker told us, "We have to think about what they (people) want." Other care workers' comments included, "Mental capacity is for someone who has got mental health issues" and "Like someone with a mental issue- good

mood or bad mood " One care worker told us they had the training but they did not know the principles of the MCA.

The majority of people and their relatives told us care workers asked for their permission when providing personal care. Comments included, ""Yes, (care workers) asking if it's ok to do things" and "I've heard them – they always ask him. They don't make him feel like he's lost his dignity." However, one person said, "No – its automatic. Usually one (care worker) takes the lead."

People's care plans did not always consist of information on their nutritional needs and preferences. For example, care plans for two people using the service stated they did not have any special dietary requirements. However, other records for both individuals identified that they needed prompting with eating and drinking as they were prone to forgetting to eat or not feeling hunger. Another person's records said they had diabetes but their care plan stated they did not have any dietary requirements. We spoke about this with the provider on the day of our visit. They explained that the majority of people who used the service did not need the agency's support with regards to food and fluid intake as they had other arrangements in place to ensure regular meals had been provided. Some people required care workers' support at mealtimes, such as warming up already prepared food of their choice. The lack of information on people's dietary needs meant there was a risk that care workers would serve food or drink that was not suitable for people or which could cause harm to their health and wellbeing.

We recommend that the provider has accessible and comprehensive notes for people regarding their nutritional needs so care workers have an awareness of any issues regarding people's food and fluid intake.

People and their relatives told us care workers supported them when their health needs changed and they needed to see a health professional. Comments included, "There was one time when (my relative) had to go to hospital. The care workers contacted the doctors." and "I know they are there if (my relative) needs them. I don't have to worry."

Records showed that the agency worked closely with the local authority and other health care professionals to make sure people were supported to maintain good health and have access to healthcare services. We saw evidence of communication between the agency and relevant professionals such a district nurse, social services and GP surgeries.

The provider told us, and care workers confirmed, they received a detailed induction prior to starting their role as a care worker. The induction consisted of classroom training that included such courses as safeguarding, personal hygiene, health and safety, manual handling, infection control and food hygiene. Additionally, new care workers were required to complete an induction workbook and up to five days of shadowing of their more experienced colleagues. We looked at files for six care workers and we saw records of completed training and shadowing hours.

All care workers were required to complete yearly refresher training that the agency considered mandatory. Additionally,13 out of 22 care workers employed by the agency had completed or were in the process of completing their National Vocational Qualification (NVQ) Level 3 in Health and Social Care.

Care workers told us and records confirmed that they had received regular supervision and a yearly appraisal of their work. Additionally, the agency completed quarterly spot checks of care workers' work in people's homes. The information was used to inform the supervision process, and to identify any training and development needs for individual care workers.

## Is the service caring?

### Our findings

The majority of people we spoke with told us care workers treated them with kindness and respect. Comments included, "(Care workers) are always caring, always polite", "(My relative) has improved so much over the year as a result of the care from the family and the carers.", "I find them very kind." However, we were also made aware of care workers' practice that was not kind and compassionate. One person told us, "They sit on the side of the bed chatting away to each other in their own language. You feel uncomfortable in your own home." A second person told us, "Sometimes (care workers are) nice, sometimes not." Three other people told us they felt intimidated by care workers after the people raised concerns about their care practice. One person told us they asked a care worker for additional help with their personal care and encouragement to do exercises, however the care worker refused.

The provider told us the agency ensured they matched a care worker to a person, based on certain criteria, such as care workers' skills, a person's culture and gender preferences. We looked at the rotas and we saw that the majority of care workers regularly supported the same people using the service. However, one care worker told us that they only had some regular visits and mostly they supported different people. One person using the service told us that they felt the agency was "fitting them in with other calls" and different care workers had been visiting them for over three months.

People we spoke with told us care workers respected their dignity and privacy when providing personal care. Comments included, "They save my dignity. They make sure that the door is closed. When I am using a toilet, they step outside for me", "Care workers treating me as normal – not as an invalid". One family member told us, "They always ask (my relative). They bring them into the conversation and make sure it's what my relative wants".

Care workers told us respecting people's dignity and privacy when providing personal care was important to them. One care worker said, "I have to protect dignity and privacy at all times, for example, I close the door to the room if people are getting dressed or go to the bathroom". A second care worker said, "I have to respect everybody's right to privacy, if they need the toilet I would give them privacy and ask them to let me know when they need my help."

People's care files showed that the agency made regular monthly phone calls to people to ask about their experience of the care and support they received from the agency. We looked at 13 examples of completed "service users' monthly telephone audit" forms. We saw that the general feedback from the phone calls was positive and people were happy with the performance of the care worker and the service which they had received.

## Is the service responsive?

### Our findings

During our inspection on 3 February 2016, people told us that the agency had not involved them in the planning of their care. Therefore, we recommended that the agency sought guidance with regards to the planning and reviewing of people's care and support. □

At this inspection, two people also told us that their care had been planned with the local authority but not the agency. Two other people said the agency had been involved at the beginning, however the care was never re-evaluated. One person said they could not remember if the agency was involved in the planning of their care. We looked at six care plans for people who used the service and we saw that people, or where appropriate, their legal representatives had not signed them.

We looked at people's care plans and we saw that they were holistic and contained information on people's key care needs such as what assistance they needed with personal care, medicines and mobility levels. However, people's care plans consisted of incomplete information in relation to their cultural and religious needs and preferences. We looked at care plans for six people using the service and we saw that these sections of their care plans were often lacking in any details or the information was unclear. For example, one person's care plan stated care workers should respect the person's religion and culture, however, it did not say what the person's religion and culture were. One person using the service told us the agency had asked them about their cultural and religious needs at the beginning of their care package, however, a second person told us they were never asked about it.

Not all of the care plans we looked at reflected care needs of people who used the service. For example, one person's risk assessment documents identified that the person needed two carers to assist them with personal care; however, this information was not recorded in the person's care plan.

The above evidence showed that the agency did not always involve people in the planning of their care and did not always take into consideration people's personal wishes and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw good examples of care planning where care workers were given clear and practical instructions on how to support people they cared for. All of the care plans we looked at had clear information on people's preferences with regards to male or female worker when receiving personal care. People told us that although the agency had not consulted them about their preferences, they were happy with the care they received.

Care workers told us they were aware of people's care plans and they read them regularly. All of the care workers we spoke with said they would inform the office if they observed people's needs had change and if they needed additional care and support. They also confirmed that the office had contacted them about any changes to people's care needs. Care workers comments included, "I read care plans every day, some

(care plans) I know and unless there has been a change, then the office would let us know." and "I read care plans all the time before I start the service and I speak to the office." We looked at a variety of records related to people's care and support and we saw regular and timely communication between the agency and care workers relating to people and their changing care needs.

The provider told us all care plans were reviewed annually or earlier if a person's needs changed. We saw that all care plans had a next review date recorded.

The majority of people we spoke with told us they were happy with the service they received and they had not made any complaints to the agency. However, three people who we spoke with told us they had made a complaint and they were not satisfied with how the agency dealt with their complaints.

The provider informed us the agency received two complaints from January 2017. We looked in the complaints folder and we saw no records of the three complaints mentioned to us by people and relatives we spoke with. Additionally, a daily telephone call record given to us by the provider indicated there were another nine calls received by the agency between January and March 2017 where people, their relatives or external professionals expressed their discontent with various aspects of the service delivery.

We spoke with the registered manager about the agency's complaint process. They told us if a person wanted to make a complaint, they would be encouraged to discuss it with their respective social worker who would then pass the complaint to the agency. The agency did not view verbal complaints as formal complaints but as a misunderstanding about the service delivery. The registered manager informed us any such misunderstandings were clarified by the agency in a phone conversation with a person or their relative. The registered manager confirmed the agency did not have a central register of these conversations, therefore, there was no clear audit trail of what actions had been taken to respond to individuals who raised verbal complaints. This practice was not in line with the agency's own complaints policy and procedure.

The above evidence shows that the agency did not have effective systems for identifying, receiving, recording, handling and responding to verbal complaints by people using the service and other persons involved in their care.

This was a breach of Regulation 16 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

A copy of the complaints procedures was made available to people using the service and their relatives in people's care files in their homes.

We looked at examples of three complaints that had been handled by the agency. We saw that the agency had dealt with them in good time and had informed the complainant of the outcome.

The agency sought regular feedback about the service provided from people and their relatives. We saw evidence of quarterly quality questionnaires and monthly telephone call surveys completed by people and their family members. The questions related to how people were being cared for, if their care needs were being met and if the carers were reliable and punctual. The general feedback from the questioners was positive. Comments included, "very good, all carers are wonderful", "The service is fine, my relative feels happy".

# Is the service well-led?

## Our findings

During our inspection on 3 February 2016, we found that the agency had not undertaken effective audits relating to the care and welfare of people using the service. During this inspection, we found further improvements were still needed.

Records showed the agency had carried out regular, monthly audits of each person's care file, however, the audits had not identified the discrepancy between information about different aspects of people's care in various parts of their care files.

We looked at the agency's quarterly medicines audits and we saw that they did not identify gaps in recording in medicines administration log books.

We asked the provider for an up to date training matrix for all care workers working at the agency. The provider showed us two documents, a general training matrix, and a separate spreadsheet listing care workers who had completed a National Vocational Qualification (NVQ) level 3 in Health and Social Care. The training matrix consisted of information on Care Certificate Standards completed by care workers between May and June 2016 as part of their mandatory training. We saw that it did not include those care workers who started their employment with the agency after June 2016. Additionally, the document did not specify if care workers received other training than in the Care Certificates, such as moving and handling, medicines administration or other specialist courses needed to provide safe and effective care. This meant the matrix was not effective in assessing and monitoring if all care workers employed by the agency received relevant and up to date training.

This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw good example of audits carried out by the agency. Documents viewed indicated the agency completed quarterly comprehensive spot checks on personnel files for care workers employed by the agency.

The Care Quality Commission (CQC) awards rating for the performance of registered services. The law requires providers to display this rating conspicuously and legibly at each location delivering a regulated service and on their website. The provider had not displayed their most recent performance rating on their website.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers we spoke with told us they felt supported by the registered manager and the office staff. They said they could contact the office and they would be supported in dealing with any issues related to their work. One care worker told us, "The office staff is very good, cooperative, they encourage calling them in

case of any concerns, and then they give advice", "It's a good company, the manager he is so kind. If something is wrong they explain it to us"

Care workers thought there was a fair and open culture of communication within the agency and felt involved in the in the development of the service. Care workers comments included "I've been asked what would I like to change and how can we work as a team.", "they (the office staff) are always happy to negotiate, any problems I speak to them directly."

The agency had a variety of systems to communicate with care workers about different aspects of their work. These included telephone contact and text messages to inform care workers about any changes to their weekly rota and any updates on care provision. The agency also carried out quarterly team meetings for all care workers and monthly meetings for the office staff. Records we viewed confirmed that the meetings took place. Topics discussed included safeguarding, risk assessment, training and management of incidents and accidents.

The agency had systems in place to record communication with people who used the service, their relatives and external professionals. We saw that incoming telephone calls and emails were recorded on daily telephone call records and proof of email documents. The information was stored electronically, and the management and the office staff had easy access to it. This meant there was an audit trail of the communication between the agency and external stakeholders.

We received mixed feedback from external professionals who worked with the agency. Two professionals told us that they were happy with how the service communicated with them and they did not have any concerns. However, two other professionals told us that they had contacted the agency about the care provided to people who used the service, however, their queries were never responded to.

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	<p>Regulation 18 Registration Regulations 2009 Notifications of other incidents</p> <p>The registered person did not notify the Commission without delay of any allegation of abuse in relation to a service user.</p> <p>Regulation 18 (1) (2) (e)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The registered person had not ensured that care and treatment to service users met their needs and reflected their preferences.</p> <p>Regulation 9 (1) (3) (c)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The registered person had not always ensured that care and treatment was provided with the consent of the relevant person.</p> <p>The registered person had not always acted in accordance with the Mental Capacity Act 2005.</p> <p>Regulation 11 (1) (3)</p>
Regulated activity	Regulation

Personal care

Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Safe Care and Treatment

They had not ensured the safe and proper management of medicines.

Regulation 12 (2) (g)

## Regulated activity

## Regulation

Personal care

Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

Safeguarding service users from abuse and improper treatment

The registered person did not ensure service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

Regulation 13 (1) (2) (3)

## Regulated activity

## Regulation

Personal care

Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

Receiving and acting on complaints

The registered person had not ensured that people knew how to complain.

Regulation 16 (1) (2)

## Regulated activity

## Regulation

Personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The registered person did not operate effective systems to:

Assess, monitor and improve the quality of the service.

Regulation 17(2)(a)

## Regulated activity

Personal care

## Regulation

Regulation 20A HSCA RA Regulations 2014  
Requirement as to display of performance  
assessments

The registered person had not displayed the  
rating of their most recent inspection report on  
their public website.

Regulation 20A