Agincare Live In Care Services Limited

Agincare Live-in Care Services

Inspection report

Agincare House, Admiralty Buildings
Castletown
Portland
Dorset
DT5 1BB

Tel: 01258489480

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**

Is the service well-led?

Requires Improvement

Summary of findings

Overall summary

This announced inspection took place between the 22 June 2017 and 27 July 2017. It was carried out by two inspectors and two specialist advisors. Agincare Live- In Care Service is registered to provide personal care to people living in their own homes. At the start of our inspection the service provided personal care and support for 236 people living all over the country.

There was 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.

We carried out an announced comprehensive inspection of this service in November 2015. After that inspection we received concerns in relation to how people were being protected from abuse and neglect. As a result we undertook a focused inspection to look into those concerns. This was extended to a comprehensive inspection as additional risks were identified.

Staff skills were not appropriately checked and this meant the provider and people could not be assured that staff had the skills and knowledge to care for the safely.

People were supported by staff who had been trained in how to respond to abuse, but the staff in the office had not received this training and safeguarding concerns were not always identified and addressed appropriately. Notifications that the service was legally required to make to the CQC had not always been made when abuse had been alleged.

People told us they received their medicines safely, however the systems were not always operated effectively to support the safe administration of medicines and staff competency was not sufficiently assessed. □

Care staff had received training in the Mental Capacity Act 2005 (MCA). However staff did not all understand and implement the principles of the MCA and this meant people were at risk of not having their human rights respected.

People mostly had their privacy and dignity maintained although systems to return records to the office did not protect people's confidential information.

People had been involved in developing individual care plans which took into account their likes, dislikes and preferences. These care plans and records covered people's social, emotional and health needs including access to health care. These were not always updated effectively and this put people at risk of receiving inappropriate care.

There was a clear management team and staff had defined roles and responsibilities that supported providing person centred care. There was not sufficient capacity in this team to ensure the efficacy of the oversight systems and issues identified during our inspection had not been picked up by internal quality assurance.

People knew how to make a complaint and where they had made complaints these had usually been responded to appropriately. We found examples of learning opportunities from complaints.

People were comfortable with most staff and, where they had regular care staff, had formed positive relationships. They told us they were usually cared for by staff who treated them kindly and with respect.

CQC has taken action to vary the provider's conditions of registration. The provider is required to submit a report to CQC on a monthly basis, setting out the action take to address shortfalls in risk management, protecting people from abuse, staff competency and deployment and quality assurance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were supported by staff who had been trained in how to respond to abuse, but staff in the office had not received this training and safeguarding concerns were not always addressed appropriately.

People's risks were assessed and plans put in place to reduce these risks. We found an example of a mobility risk assessment not being reviewed and the person had a fall.

People told us they received their medicines safely. However, systems were not always operated effectively to support the safe administration of medicines,

There were enough care staff employed by the service to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective. People were provided care by staff whose skills were not adequately assessed. Office and field workers had not been provided with appropriate inductions to ensure they could undertake their roles safely.

Staff did not all understand and implement the principles of the Mental Capacity Act and this meant people were at risk of not having their human rights respected.

People were supported to access healthcare and with their diets where this was appropriate.

Is the service caring?

Requires Improvement

The service was mostly caring some people described experiences where they had not felt cared for.

People were usually cared for by staff who treated them kindly and with respect.

People were usually comfortable with staff and, where they had regular care staff, had formed positive relationships.

People mostly had their privacy and dignity maintained.

People told us their independence was promoted and valued by the staff.

Is the service responsive?

Requires Improvement

The service was not always responsive. People had been involved in developing individual care plans which took into account their likes, dislikes and preferences. These were not always updated effectively.

People knew how to make a complaint and where they had made complaints these had usually been responded to appropriately. We found examples of learning opportunities from complaints being missed.

Is the service well-led?

Requires Improvement

The service was not always well led. There was a clear management team and staff had defined roles and responsibilities, however there was not capacity within the team to ensure effective oversight.

The service that people received was not effectively monitored and their confidential records were not kept secure.

Statutory notifications to the CQC had not always been submitted when allegations of abuse were made.

The registered manager and other senior staff were involved in developing innovative care provisions in partnership with other agencies.

Agincare Live-in Care Services

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.

We visited the office on the 22 and 23 of June 2017 and the 11, 18 and 19 of July 2017. We visited people in their homes and made calls to staff, professionals and people throughout our inspection up to 27 July 2017. The provider was given notice of our inspection because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be at the office to assist us to arrange home visits. The inspection was carried out by two inspectors and two specialist advisors. Both specialist advisors had expertise in safeguarding, the Mental Capacity Act 2005 and risk management in community settings.

Before the inspection we reviewed information we had about the service. This included notifications from the provider; a notification is the way providers tell us important information that affects the care people receive. Before the inspection, we asked the provider to complete 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 reviewed this information before we visited the service.

We spoke with four people in their own homes and observed interactions with four members of staff. We also spoke with people who used the service or their relatives by telephone. In total we spoke with 15 people and six relatives. We spoke with 14 care staff, 15 staff responsible for organising, setting up care and supporting people and care staff. We also spoke with the registered manager, operational director and the director of customer services. We also spoke with two social care professionals and two health

professionals. We reviewed records relating to 33 people's care and support. We also looked at records related to the management of the service. This included 10 staff files, training and supervision records, accident and incident records and audit documentation.

Requires Improvement

Our findings

Systems designed to identify and respond to abuse were not operated in a way that was sufficient to keep people safe. Care staff had been trained to protect people from abuse and to report any concerns they had to their regional care manager or care coordinators in the office. They were able to describe signs of abuse and told us they would be confident to make reports to the appropriate agencies. This training had not however been effective in ensuring potentially abusive situations were identified and responded to appropriately.

Where allegations of abuse had been received senior staff had acted appropriately to reduce the immediate risk of harm to people. The registered manager told us: "The vast majority of people have a good service and we are much more responsive at the frontline when things go wrong."

Allegations of abuse were not always identified and followed up appropriately. We identified two complaints which contained allegations of abuse. One complaint related to an allegation of sexually inappropriate language and another that the person was neglected by and scared of a staff member. These complaints were addressed through the complaints procedure, however, the failure to identify these safeguarding concerns meant that the staff involved continued to work with vulnerable people after the allegations were made. The registered manager was not aware of these incidents.

There was an allegation of neglect in June 2016 regarding the care of a person who was admitted to hospital with dehydration and sores on their skin. Disciplinary procedures were followed. The person's needs had changed substantially during the time the service was provided and for 20 days they had been cared for on the sofa. The care staff had raised concerns about the care needed with a care coordinator at the start of this time period and internal procedures about checking the care plan remained effective were not followed. The person was not protected from improper treatment.

One safeguarding investigation carried out by the provider had failed to fully consider the risks posed to the person. This person had been assessed as having capacity to make decisions about their care and had an adjustable bed with rails in place. During a safeguarding investigation in March 2017 it was identified that the person had been hitting their bed rails to try and get out of bed and that the care staff did not assist them to get out of bed but told them they would take away the torch they were using to try drop the bed rails. There was no care plan or assessment indicating that their movement could be restricted in this way. The safeguarding investigation had not picked up that the person was being threatened with removal of their property and not being supported to a position of their choice.

This was a breach of regulation 13 of the Health and social care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the risks they faced were responded to appropriately. One person described how their regular staff understood how to use their equipment safely and another person described the support they received remembering to take medicines and manage risks associated with their mental health. The risks people faced were assessed prior to them using the service. This included detailed and personalised information about a wide range of risks such as how to manage risks associated with mobility, isolation, eating and drinking and health conditions. There were personalised plans in place to reduce these risks that included input from the person and their relatives when appropriate. For example, one person described how they were supported to take risks of their choosing. However we found that risk assessments were not always updated as needed. The care records for one person stated that they required a further assessment of their mobility two weeks after their care started in May 2017. This assessment did not take place and a month later in June 2017 they had a fall, whilst being supported to move, The registered manager was not aware of the incident or the missed reassessment.

People were at risk of not receiving their medicines as prescribed because medicine management required improvement. Three people had not received their medicine as prescribed. In two instances medicines remained in the person's blister pack and in another case emergency epilepsy medicine had not been put on the person's medicine administration record (MAR) when they joined the service although it had been prescribed at this time. As a result of this omission they did not receive the medicine when they had a seizure and care staff had to call for an ambulance. This put the person at risk of harm. At the time of our inspection their care plan had been updated to include their emergency epilepsy medicine. However, the regional care manager could not tell us if care staff currently working with this person had received the necessary training to give this specific medicine safely. They checked and the staff had not received the training on the planned date. This had resulted in the staff giving the medicine before being trained and authorised to do so by the relevant health care professional. This put the person at risk of harm and the regional care manager was not aware of this.

The information available to staff did not support safe administration of medicines for two people. Another person was prescribed a medicine by the GP that had not been added to a MAR which meant there was a risk that it was not given as prescribed. Another person had a medicine that was applied as a patch. The guidance for staff did not identify where this should be placed on the person's skin and they did not keep a record of this. This meant the person was at risk because the patch could have been applied to the same area of skin which could cause harm.

This was a breach of regulation 12 of the Health and social care Act 2008 (Regulated Activities) Regulations 2014.

Action was taken to monitor the safety of medicines administration and where medicines errors were identified staff received support and their competency was checked. People told us their medicines were managed safely. One person told us: "Yes they reminded me to take my medicines and made me drink lots of water which I was required to do and was important." Another person told us: "They always remember to give me my tablets from my blister pack."

Environmental and fire risk assessments were undertaken by assessors when setting up care for people. The operations director told us that this policy was being amended to include evacuation advice and this new procedure was scheduled to be reviewed by the Policy Review Committee in August/September 2017. In order that health and safety at work requirements are met; it is important that care staff know how to

support people to evacuate safely and are able to keep themselves safe in the event of an emergency.

People told us that care staff were provided to meet their care needs. Two people told us that these staff did not always meet all their preferred criteria such as being a driver. When this happened these staff were replaced as soon as staff became available who did. There were enough safely recruited care staff to meet people's day to day needs. The recruitment process included making appropriate documentation checks to reduce the chances of employing staff who were not suitable to work with vulnerable people. Following an interview the recruitment process was extended into the classroom based induction training where candidate suitability continued to be assessed.

Requires Improvement

Our findings

We received mixed feedback from people about whether they felt the staff had the skills they needed to do their jobs. A person told us: "Most of them understand how to communicate… and have the right knowledge and skills." One relative told us: "If these carers are indicative they are fantastic." and: "They most definitely have the skills they need. They are just wonderful." However, we also heard examples of care staff not having the confidence or training necessary to provide people with appropriate support. One person told us: "They just didn't communicate with my relative." Another person commented that care workers had not been able to put on a medical aid correctly.

New staff did not all receive adequate support and training to support people to move safely. Staff induction training did not include an assessment of their competence to use moving and handling equipment safely in a timely way. We saw from records three members of staff were identified at induction in February, March and July 2017 as needing: "an early competency check re medication and moving and handling". These staff had been in placement with people needing this support without further training or assessment of their skills. This put people at risk of receiving unsafe support from staff who did not have the skills to support them. Information received from the provider identified that more than half of their 407 staff had been employed in the year prior to the submission of the provider information return in February 2017. The proportion of new care staff, and the nature of their work out of line of sight, meant that the importance of the registered manager and provider being assured that they had the skills and competence to meet people's needs was heightened. The systems in place did not provide them with this assurance. Care staff were shown how to use equipment by other care staff who had not had always their competency checked and staff were not checked as competent before they supported people with equipment on their own. This meant people were at risk of receiving support from staff who had not been shown how to support them to move safely.

Staff did not receive on going adequate support and training to ensure they were competent in moving people safely. People told us this had an impact on the care they received. For example, one person described how they needed to direct staff in how to use their equipment as they had not seen it before and a relative commented that not all care staff were confident with mobility equipment. Another person told us: "I had a carer who said 'I don't know how to use your hoist'. They didn't want anyone to know." The person told us they struggled without using this equipment. A social care professional told us, they observed a care worker not confident in supporting someone to move safely and had set up equipment in an unsafe manner. We saw a care worker did not receive appropriate support and guidance in response to a reported change in support a person needed with their mobility. We also found two examples of people who had

been injured during accidents that occurred whilst they were being supported to move by staff whose manual handling competency had not been assessed.

The system in place to ensure that staff had the skills and experience they needed to carry out their role was not adequate. Staff responsible for assessing care workers' competence in moving and handling had not always had their moving and handling skills assessed. We raised our concerns with the registered manager and operations director. They acknowledged this omission and told us that all assessors and regional care managers would be trained to 'train the trainer' standard in moving and handling in September 2017.

Care coordination staff had not always received core induction training for their roles. The registered manager confirmed that the majority of care co-ordinators had not attended core induction training, but this had now been arranged. This included safeguarding adults, moving and handling and the Mental Capacity Act 2005. This was important because these staff had responsibility for using their knowledge to identify key information and share it appropriately. We found examples of staff not taking appropriate actions. For example information about an accident had not been passed on to a regional care manager. This was important information because a care needs review might have been necessary to ensure the safety of the person and their care staff. The care coordinator who did not pass this on had not completed the health and safety training deemed mandatory by the provider. For another person, a potential change in their capacity had had not been relayed to regional care manager by a care coordinator who had not undertaken Mental Capacity Act training. This meant the potential impacts on the provision of care associated with a change in capacity had not been reviewed.

We were told by the registered manager after our inspection that "External safeguarding training in addition to the internal training for the office team has been scheduled between November and February with Dorset County Council".

Care staff did not all receive the support they needed to carry out their roles. We spoke with the registered manager about the risks of staff working under strain and in isolation. They told us these risks were mitigated by staff support systems including weekly calls from regional care managers or care coordinators. We reviewed calls made to four care staff during June 2017: Three had received one call and one had been left a message. When regional care managers were off work due to annual leave or ill health their calls were not always covered. There were examples of people not getting the support they needed after care staff had remained under self-identified strain or without adequate sleep for sustained periods of time. Two staff who were getting woken regularly at night did not receive weekly calls to check on their well-being and ability to work safely. One of these care staff had recorded: "I woke up all night long every 20/30 minutes." and "This situation has to change soon as I won't be able to take care of (name) anymore." We discussed this with the registered manager who told us that when a worker was not getting enough sleep this was flagged to them. They had not, however, heard about this situation. We spoke with a member staff who knew the support provided for this person and they told us that the person's sleep had been bad since the beginning of June 2017. The member of staff and the person were put at risk because the systems in place to ensure appropriate support were not effective.

Staff feedback about support was mixed. Care workers told us they did not always get their weekly calls but they usually felt supported and organisational expectations regarding face to face supervision and appraisal were met. One member of staff told us: "The co-ordinator calls and check in and see if everything is fine. They support me." Another member of staff said: "I feel supported. My regional manager calls me." We also heard that sometimes they felt that concerns about people's wellbeing and behaviour were not heard. One member of staff told us that they did not feel able to take their full break because they worried the person they were living with was not safe. They did not feel supported. We heard from three staff who commented

that they felt there was less care for their welfare in the organisation for staff over recent months. They felt this was due to a lot of staff changes.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Care plans reflected where a mental capacity assessment had taken place and where appropriate a decision to provide care had been made in the person's best interests. Care staff, regional care managers and assessors had completed induction and annual refresher training covering the principles of the MCA.

Staff told us they found their classroom based induction useful. This was designed to give care staff the underpinning knowledge required by the Care Certificate. The Care Certificate is a nationally recognised qualification designed to provide staff new to care work with the knowledge and skills they require. The first three days were carried out by the training department and covered all the key areas of the care standards certificate. A fourth day was then undertaken within the live in service with issues specific to the live in role such as professional boundaries and service specific processes covered. Care staff told us this was useful as the role was specialised. They also told us that a lot of information was covered and they used it as a resource to refer back to whilst in people's homes. Staff also commented positively on their on going training. One member of staff told us: "I have had training in dementia; they ring me and email me about updates for training which we do online." The service had identified training that they required to be updated on an annual basis and had a robust system in place to ensure this took place. Some staff identified as requiring further training were also offered the opportunity to work in one of the provider's associated care homes . At the time of our inspection all the care staff in placement had completed the training the organisation had deemed necessary for their role. A new training programme was also being introduced to support staff working with people living with dementia. This programme was developed in conjunction with university researchers to promote evidence based care practice.

People were supported to have enough to eat and drink. People who had help with food and drink commented that this was usually done to a satisfactory standard. One person told us: "They are able to prepare the food I like." Another person's care records described the choices of food offered and how the person's preferences were reflected in the food cooked. Care staff were made aware when people were at risk of not eating or drinking enough, or had difficulty swallowing safely. They explained this information was in people's care plans and described the records they kept to monitor nutritional intake when appropriate.

People were supported to maintain good health and access to healthcare services. People's care plans detailed information about medical conditions and included how these conditions impacted on people individually. This included reference to physical and mental well-being. For example one care worker described the issues related to person's medical conditions and another described how they liaised with local health professionals to ensure the person they supported received essential care and treatment. One

person explained how they had recently been to see their GP and their care worker had supported them with a short course of treatment following this appointment.

Requires Improvement

Our findings

We received mixed feedback from people regarding their experience of how caring the staff were. People and relatives commented on the caring nature of the majority of care staff. This was specifically the case where they had regular care staff supporting them. We heard comments like: "(Name) loves my relative. They really care.", "(name) is so kind and helpful" and "They are all kind – they will give me a hug sometimes if I am upset." We saw and heard that people were relaxed and comfortable with staff. On the telephone we heard care staff ensuring that the person they were supporting understood the call and in visits to people's homes we saw warm and familiar interactions. One person told us: "there has been no nastiness they have all been respectful." Another person said: "They are respectful. They are in my home."

We also heard examples of people experiencing a lack of care. People described this as being the result of staff not been considerate of their personal situation. Two people told us that a member of care staff had been rude to them and a relative told us about a member of care staff who had been very demanding and had a disrespectful demeanour. Two people and a relative referred to staff who only undertook tasks and did not chat with them.

People who were able to make decisions about their care told us that the majority of staff listened to them and provided care in line with the choices they made. One person said: "I am able to direct what I want." However, we also heard examples of care staff making decisions on behalf of people based on their own views. One person told us: They thought I would do as I was told." And another said: "On the whole they have been respectful but I have had to put my foot down." Where people struggled to exert their authority we found examples of staff not following their direction or making restrictive decisions on their behalf. One person told us that staff were dismissive about the activities they wished to do and did not enable them to carry them out. We spoke with regional care managers about this and they told us they worked to support people to direct their own care. We saw examples of this being discussed with care workers who had been overly protective.

People told us their privacy and dignity was respected although one person commented that a care worker supervised them in the bathroom and this was neither their wish nor in their care plan. They had not felt able to raise this with the member of staff and wanted a staff member back who had been respectful of their privacy.

Privacy and dignity were reflected in initial competency checks made on staff and were commented on by care workers when they described people's care. They also reinforced the importance of promoting

independence and people reflected this in their descriptions of the support they received. One person said "(they are) very thoughtful as I am quite obstinate… (they) encourage me to keep moving". Another person told us: "(Name) likes me to do things for myself. It makes me more assertive and independent." The member of care staff supporting this person explained how they did this and also gave examples of when it had been appropriate for them to advocate for the person to ensure they received support they needed from other services.

Care staff told us they enjoyed their work and spoke with warmth about people. They demonstrated they knew people well through their conversations referring to family and significant events. This understanding supported the development of relationships and was appreciated by people and relatives. One relative told us: "They are professional but also one of the family." This observation reflected the complexity of the live in care workers role requiring them to navigate individual relationships and situations respectfully whilst following organisational policy. We also heard examples of this not being successful with observations about care staff staying in their room when not needed for tasks and not wanting to establish rapport. One care worker reflected on this saying it could be difficult to live in people's homes.

Where people had been using the service for a sustained period and had regular care staff the regional care managers knew them well. They were able to identify what mattered to people and plan their support role accordingly. For example one regional care manager described how they would be visiting a person soon because they did not like change and a new staff member had just gone into their home.

Requires Improvement

Our findings

We spoke with people about how their care had been planned. People, or relatives when appropriate, felt they had been involved in determining how their care would be provided. One person told us: "Nurses in hospital and friends told me about Agincare……a man came and went through what I might need and asked lots of information about myself and my interests."

However, once care started people described a range of experiences in relation to the responses they received from staff at all levels of the organisation. There was mixed satisfaction with the responsiveness of the staff based in the office. One person told us: "There seems to be quite a high turnover of office staff but they do always respond and within the timescales they identify – i.e. will ring back within an hour." Another person told us: "The level of communication could be better as I am constantly pushing and reminding them but they don't call me." And another person said: "They haven't rung me or reviewed the support – they used to email me the profiles of the relief staff but don't do that now either." Where people felt the office did not respond this caused frustration and anxiety especially when it related to the next member of care staff who would be arriving: "It can be worrying til you know… Get told I will get a call but it doesn't happen."

After the inspection the registered manager detailed improvement work that was beginning focussed on an improvement in customer service.

The importance of how well care staff were matched with their needs was evident in discussions. The feedback from people was mixed about the success of this process. One person described this: "Someone came and discussed with me before the support started. They told me I would have someone for six to eight weeks and then another person when they had a two week break…but I have had a number of changes so far. They told me that I would get profiles in the post of each staff member – but I have never had one for any of them. It would be nice to have a little bit of information." Another person said: "We have just clicked (they) are the best so far." The importance of matching care staff with people was identified by senior staff within the service. They explained that they were extending the advance time that they planned ahead for. During our inspection plans were being made to ensure that people had the best match of care staff for the winter holiday period.

Regular care staff knew people well and were able to describe their support needs and preferences with confidence. One member of staff described the way a person liked to be spoken with, another described how they supported them to go out. A person described how their regular care staff knew them well enough to understand the nuances of their mental health and how this affected their abilities. Where people had a

regional care manger in their area they told us that they were responsive to them, one person told us "I have established a relationship with (name) I can call and they know what I need."

Care plans included detailed personalised information. This included information about people's physical and emotional health, people, places and activities that were of importance to them and information about how they communicated. These care plans were reviewed annually or more regularly if appropriate. Where changes were made a note was made of which part of the care plan had altered. One person told us: "The area manager (regional care manager) came after about two weeks to see how things were going…" We saw examples of changes to how people were supported at night and with their mobility and medicines. However, care plans we looked at had not always been appropriately reviewed. There were examples of important reviews and changes not being reflected in care plans. For example one person had experienced bereavement and their care plan had not been updated to reflect this. This could have put the person at risk of distressing experiences with care staff who did not know them well. Another person's care plan had not been updated to reflect changes in their support needs when their health deteriorated. Another person's care plan had been reviewed in May 2017 but had not been updated to reflect changes in July 2017. Another person's care plan dated February 2017 detailed that a movement sensor was needed and that this was being sorted. It also required the care worker to 'communicate any changes in mobility'. A reference in the person's care records in March 2017 indicated that the sensor mat was not in place. There was no reference to mobility concerns or the sensor mat in the records of communication between the care staff and the office. Discussion with a regional care manager referenced the care staff's concerns regarding mobility and there was no follow up to ensure action was taken to reduce the person's risk of falling. People and care staff supporting them were put at risk because the information available in people's homes did not reflect the care and support needed.

People and relatives told us they felt listened to and were able to speak with staff although we saw examples of people waiting until care staff they were unhappy with had left, or regional care managers visited, before they spoke with anyone in the service about their concerns. We spoke with senior staff about this and they told us they were aware that some people found it difficult to raise concerns. One person explained: "I would not call if I was just exasperated." Another person told us it was hard to complain when the care staff were with you. Regional care managers told us they encouraged people to make contact with them and they acknowledged that this remained a challenge due to the nature of the service. They identified visits and weekly calls as part of how they addressed this issue. People commented that their regional care manager was accessible and they felt confident in them as their point of contact with the service. One person said: "I am very happy with (name) –they do what they say they will do." Another person gave examples of concerns they had highlighted that had been addressed quickly. The complaints procedure was available to people in their homes and we saw that where complaints had been made these had been addressed in line with the policy and people had been informed of outcomes. It was possible to identify the actions taken following complaints although we also found opportunities to improve practice had been missed. For example information that was secondary to a complaint such as staff understanding of manual handling was not identified as a learning need as it was not the primary issue of the complaint or concern.

Requires Improvement

Our findings

Since our last inspection Agincare Live In Care Service had grown and the staffing and operational systems had been changed. The registered manager described the ways that they maintained oversight of the service through regular contact with operational managers and regular reports related to identified quality measures. We found that whilst structural changes had been beneficial the oversight and systems in place were not always sufficient to ensure the quality and safety of the service.

The oversight of organisational growth did not adequately reflect the capacity of the service to deliver on the measures it had decided to be appropriate to ensure quality. This had resulted in the service continuing to take on new packages of care in areas where oversight of quality and safety was not being achieved. We spoke with staff responsible for setting up new packages of support and they told us that availability of oversight and support for staff was not considered as part of the decision to take on a new person's care.

The registered manager told us that oversight had improved and that regional care managers visited people at least every eight weeks and made calls weekly. In addition they told us that these calls and visits formed part of "a wider network of contact and monitoring" through care assessment visits at the start of care, care coordination calls, welfare calls, telephone surveys and through quality assurance visits. The registered manager described how some of these changes had been implemented following a safeguarding where changes in need were not responded to appropriately. The registered manager shared reports with us that showed achievement against this target to be high. During our inspection, however, we found that this audit process was flawed leading to inaccurate information. This meant senior staff and the registered manager believed checks were being made on quality and safety that were not happening. For example we discussed the oversight of a region that did not have a regional care manager in place and the registered manager told us that these people were receiving weekly calls. We reviewed the calls made to four people living in this area and found they had been spoken with once during a four week period. One person had not been seen or spoken with by regional or office staff since February 2017. Calls had also not been made weekly whilst another member of the regional care manager team had been off work for a sustained period of time.

Structural changes reflected the service needs and people and staff all commented on the benefit of the creation of the regional care manager role as being of benefit to them. We identified examples of this role improving the care people got due to relationships and knowledge being established. For example people told us that they trusted their regional care managers and were able to share information with them. Two people identified times when they had shared information with the regional care manger that resulted in a change of care staff working with them. There was not, however, enough capacity amongst the regional care

managers to ensure that agreed levels of monitoring and support were maintained. Following our inspection the registered manager told us that new staff had been recruited to fill vacant regional care manager posts.

Regional care managers did not get the information they needed to monitor the service effectively. We spoke with regional care managers who told us they did not receive information about the skill level of new staff who began working in their area. This meant that they were not aware if a member of staff had been identified as requiring early checks on their competency with medicines or helping people to move. If the member of staff had gone to work in one of the provider's associated homes they did not receive information about the training and checks they had undergone during this time. This meant the regional care managers were not able to use professional judgement to determine when they should schedule to check the member of staff's competency.

We spoke to the director of the team of assessors about competency checks on assessors. At the time of our inspection they were under the impression that these staff had been assessed as competent in supporting people to move safely. This was not the case and whilst they and the operational director of the service were responsive to this omission being identified this had reduced the safety of the service and put people at risk of harm. We were told that they would seek to provide all these staff with an appropriate training and competency checks during September 2017.

Oversight of complaints and safeguarding was not sufficient. There was a weekly management meeting in place to monitor safeguarding concerns. The member of staff responsible for this work was not available during the main part of our inspection and their line manager and the registered manager were not able to answer all our questions about harm that had been experienced by people and decisions regarding investigations that had been made. It was not clear what the systems were for overseeing these complaints and safeguarding in this person's absence. It was important that the registered manager understood where the service was not meeting its obligations as they had a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations.

Care staff kept records which included: the care people had received; what they had eaten and drunk if this was appropriate; physical health indicators and how content they appeared. The records were sent by unsecured mail to the office on a monthly basis. When looking at the care and support received by two people we found that records were not available and could not be located. This had not been picked up by the service. People were put at risk because the system in place did not protect their confidential information

The system of monitoring incidents and accidents was not effective for monitoring and improving the safety of the care people received. Information associated with falls was not utilised effectively to reduce the risks people faced. 11 of15 accident forms regarding falls and slips in March 2017 had not been reviewed to determine if any further action or review of risk management processes was needed. Of the four that included action we checked if this action had been taken and in two cases it had not. One of the actions had been to check if a person's GP had been informed of a fall in order that their health and medicines could be reviewed. This check had not taken place. The other action related to ensuring staff understood their reporting responsibilities. This had not been followed up which meant further information about the person's mobility may not have been reported. This meant that actions were not being identified or to do everything practicable to reduce the risks to people associated with falling. We spoke with the registered manager who told us which staff had taken on the work of reviewing accident and incident forms. They were not aware that actions were not being identified or completed.

We reviewed the falls recorded in a person's care delivery notes in March 2017. During this time they were recorded as having fallen ten times. The regional care manager visited half way through the month and reviewed the paperwork. They did not pick up that accident forms had not been completed and submitted. There was only one accident form submitted relating to the person falling in this time. The failure to notice the omission when reviewing the paperwork completed by the staff meant that monitoring of their falls remained insufficient to enable appropriate review or mitigation. We came across two further examples of incidents reported by phone to the office that were not reflected in incident forms. This meant this information was not available to senior staff undertaking audits of incidents and accidents. This information is necessary to assist planning for example by identifying trends and training needs.

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

Statutory notifications had not always been appropriately submitted to the CQC. We found four examples of allegations of abuse that had not been notified to the Commission. These notifications are necessary to ensure regulatory oversight and enable the Commission to monitor the risks people face and how a provider is reducing these risks.

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

The registered manager and senior staff were actively working to develop innovative working models and were working in conjunction with statutory agencies and academic establishments to achieve this. A discharge from hospital project had been successful in one area and an enhanced dementia service was being established. This culture of development encouraged learning and had the potential to result in positive outcomes to the service. For example all care staff will receive specialist training as a result of the work developing the dementia service.

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (1) (2) (b) (c) of the Health and Social Care Act 2008 (Registration) Regulations 2009 Statutory notifications had not been submitted.

The enforcement action we took:

We followed our step by step guidance in response to a breach of this regulation. We served a notice of decision to vary the provider's conditions of registration. We added conditions requiring the provider to report to the CQC on a monthly basis.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) of the Health and social care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not administered safely.

The enforcement action we took:

We served a notice of decision to vary the provider's conditions of registration.We added conditions requiring the provider to submit a report to CQC on a monthly basis setting out how they will meet this regulation.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Systems were not operated effectively to prevent

abuse or respond to allegations of abuse.

The enforcement action we took:

We served a notice of decision to vary the provider's conditions of registration. We added conditions requiring the provider to submit a report to CQC on a monthly basis setting out how they will meet this regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Systems and processes were not operated effectively to mitigate the risks to the health and safety of people using the service. Records were not kept securely

The enforcement action we took:

We served a notice of decision to vary the provider's conditions of registration. We added conditions requiring the provider to submit a report to CQC on a monthly basis setting out how they will meet this regulation.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staff were not assessed as being competent to carry out their roles and were not deployed with regard to their assessed skills and abilities.

The enforcement action we took:

We served a notice of decision to vary the provider's conditions of registration. We added conditions requiring the provider to submit a report to CQC on a monthly basis setting out how they will meet this regulation.