Care Outlook Ltd

Care Outlook (Hillingdon)

Inspection report

11-21 Clayton Road
Ground Floor
Hayes
Middlesex
UB3 1AX

Tel: 02085618295

Date of inspection visit:
23 November 2016
24 November 2016

Date of publication:
20 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an announced inspection of Care Outlook (Hillingdon) on 23 and 24 November 2016. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

Care Outlook (Hillingdon) is a domiciliary care agency that provides personal care to around 248 people in their own homes in the London Borough of Hillingdon.

We previously inspected Care Outlook Hillingdon on 3 May 2016 and we identified issues in relation to people not always receiving care that reflected their needs or met their individual preferences, because the care was not delivered at the same time each day and sometimes people had to wait for food or care without knowing when the care worker would arrive. During the inspection in November 2016 we found some improvements had been made but further action was required to resolve the issues fully.

The service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

There was a procedure in place for the management of medicines but care workers were not recording the administration of medicines accurately.

The provider had suitable recruitment practices but information was not always accurate in relation to the previous work experience of new care workers.

People did not always receive care that reflected their needs or met their individual preferences, because the care was not delivered at the same time each day and sometimes people had to wait for food or care without knowing when the care worker would arrive.

Daily records were focused on the tasks completed and not the person receiving the support.

The provider had a policy in place in relation to the Mental Capacity Act 2005 but they did not undertake assessments to identify if a person using the service was able to make decisions about their care and ensure the appropriate actions were taken to support them.

Some new care workers completed their induction training a number of months before they started to provide care. Care workers had received the training identified as mandatory by the provider, supervision and appraisals they required to deliver care safely and to an appropriate standard.

The provider had a range of audits in place but the audits in relation to the administration of medicines, recruitment and other records relating to care did not provide appropriate information to monitor quality.

People told us they felt safe when they received support and the provider had policies and procedures in place to deal with any concerns that were raised about the care provided.

People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care. Care plans identified the person's cultural and religious needs.

The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

People using the service told us they felt the service was well-led. We received both positive and negative comments from care workers when asked if they felt the service was well-led and if they received enough support.

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?

Requires Improvement

Some aspects of the service were not safe.

There were procedures in place for the safe management of medicines but staff did not always complete records relating to medicines use as required by the provider's own systems.

The provider had suitable recruitment practices but information was not always accurate in relation to the previous work experience of new care workers.

People using the service said they felt safe when they received support in their own home.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had a policy in place in relation to the Mental Capacity Act 2005 but they did not undertake assessments to identify if a person using the service was able to make decisions about their care and ensure the appropriate actions were taken to support them.

Some new care workers completed their induction training a number of months before they started to provide care. Care workers had received the necessary mandatory training, supervision and appraisals they required to deliver care safely and to an appropriate standard.

There was a good working relationship with health professionals who also provided support for the person using the service.

Care plans indicated if the person required support from the care worker to prepare and/or eat their food.

Is the service caring?

Good

The service was caring.

People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care.

People told us they were happy with the care they received in their home.

The care plans identified the cultural and religious needs of the person using the service.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Care plans did not provide accurate information in relation to the times of care visits and daily records were focused on the tasks completed and not the person receiving the support.

An initial assessment was carried out before the person started to receive care in their home to ensure the service could provide appropriate care.

The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had a range of audits in place but the audits in relation to medicines, recruitment records, daily records of care, care plans and other records of care provided did not provide appropriate information to monitor quality.

Records relating to the times of the care visits were not accurate on the computer system. Other records relating to the care provided for people using the service did not provide accurate information.

Care workers gave both positive and negative comments when asked if they felt the service was well-led and they received enough support.

People gave positive feedback when asked if they felt the service was well-led in relation to how the care was provided.

Care Outlook (Hillingdon)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 23 and 24 November 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

One inspector undertook the inspection and an expert-by-experience carried out telephone interviews of people who used the service and relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service. The expert-by-experience at this inspection had personal experience of caring for older people.

Before the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

During the inspection we spoke with the registered manager and director of operations. We reviewed the care records for nine people using the service, the care plans for the employment folders for seven care workers, a spread sheet containing the training and supervision records for 102 care workers and records relating to the management of the service. We also undertook phone calls with seven people who used the service and three relatives. We sent emails for feedback to 50 care workers and received comments from six care workers via email.

Requires Improvement

Is the service safe?

Our findings

The provider had an administration of medicines policy and procedure in place but care workers had not completed the Medicines Administration Record (MAR) charts accurately.

We looked at the MAR charts for one person which indicated the care workers should apply three prescribed creams three times a day. We saw care workers had not recorded the administration of one cream on 30 occasions, the second cream on 24 occasions and the third cream on 22 occasions.

The MAR chart for September 2016 for another person did not include information on which medicines were included in the blister pack provided by the pharmacy. The care workers had not recorded the administration of medicines on four occasions. The person had been prescribed a cream to be applied four times a day and we saw care workers had not recorded the administration of the cream on 47 occasions during the month. We also saw the MAR chart did not identify if the creams should be administered regularly throughout the day or only when required.

We saw care workers had been administering medicines since May 2016 but the registered manager was unable to locate the completed MAR charts for this period as they had not been returned to the office.

This meant that people were at risk because the provider could not ensure they were receiving their medicines as prescribed and the staff did not follow safe practices for administering medicines.

The above paragraphs demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service followed suitable recruitment practices but we saw some application forms and references did not provide appropriate (or enough) information regarding the suitability of the person for the care worker role. During the inspection we looked at the employment records for six care workers. The majority of these were applications from people who had no previous experience of providing care for people in their homes. The records for one care worker showed the description of the person's role on one reference did not match that on their application form and the dates they carried out that role also differed. Another application form we looked at indicated that the person had worked for an employer for over one year but the reference provided by that employer stated it had been less than six months. The person had also provided the contact details for a previous employer to provide a reference but the person could only supply a character reference as they no longer worked for the person's previous employer. We looked at the employments records for one new care worker and saw one reference had been received from a previous employer but their second reference was a list of qualifications they had achieved more than ten years ago. This did not give the provider any supporting information in relation to the applicant's suitability for the care worker role. A reference for another new care worker was received from an employer that did not provide any personal care services but they had commented on the applicant's ability at a range of personal care tasks. The applicant's second reference was from a different home care provider but they did not complete the sections asking about the person's competency in relation to personal care activities. These issues were

discussed with the manager during the inspection and they confirmed they would review the recent applications.

This meant that the provider could not ensure the care workers had the appropriate knowledge and skills to provide safe and suitable care as suitable references had not been obtained.

The above paragraphs demonstrate a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at how accidents and incidents were managed in the service. Care workers completed a form if an incident or accident occurred. If an incident or accident almost happened this was recorded as a 'near miss'. The form included details of the person involved, what happened, if the General Practitioner (GP) was called, who was informed and the actions taken. During the inspection we looked at five incident and accident forms completed during 2016. The forms included information about the event; a body map was completed if required and the actions taken at the time. We noted that the forms did not enable care workers to record the outcomes of the action taken and this was discussed with the registered manager.

We asked people if they felt safe when they received support in their own home. They told us "I feel safe", "Yes, I feel safe here. The staff make me feel safe", "The staff make me feel safe, they know what they are doing" and "My care worker ensures I am well." Relatives commented "I'm confident my family member is safe when the care workers are here" and "Absolutely feel my family member is looked after." We saw the service had policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. During the inspection we saw three records for safeguarding concerns received during 2016 which included records of the investigation, copies of correspondence and the outcome.

We saw that risk assessments were in place. We looked at the care folders for five people and saw a risk assessment was completed as part of the initial assessment process. A general risk assessment was completed which reviewed the home environment including access and safety as well as any issues specific for the person relating to their support needs, health or behaviour. A range of risk assessments were also carried out in relation to fire safety, administration of medicines and the control of substances hazardous to health (COSHH) and moving and handling.

The registered manager explained where a specific risk had been identified through these assessments care workers were provided with guidance. A range of information sheets were included with the care plan and provided detailed guidance on a range of issues. The registered manager explained information had been obtained from reliable websites including the Multiple Sclerosis Trust and Diabetes UK. The relevant information sheets were included in the care folder at the person's house as well as the folder kept in the office. This meant care workers could access detailed information relating to the specific support and health issues for the person they were providing care for. We saw guidance sheets in relation to diabetes and dementia in the care folder for one person but these information sheets were not in place in all folders. The registered manager confirmed that the relevant information sheets would be in place in the folders accessed by care workers in the person's home and they were unsure why the sheets were missing in the care folders kept in the office. The registered manager said they would ensure the correct information sheets were placed in all care folders.

The number of care workers required to attend each visit was identified from the information provided in the local authority referral document and during the assessment carried out before the care package started. The manager explained that they also allocated care workers based on their skills, experience and if they already had visits in the area to reduce travel time.

Requires Improvement

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.

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.

The registered manager explained if a concern was identified about a person's capacity to make decisions about their day to day care a mental capacity assessment form should be completed and the local authority would be contacted for further guidance and assessment. During the inspection we saw where people had been identified as not having capacity to make decisions the provider had not carried out assessments or identified if a Lasting Power of Attorney (LPOA) was in place. A LPOA in health and care matters legally enables a relative to make decisions in the person's best interest as well as sign documents such as the support plan on their family member's behalf.

During the inspection we looked at the records for two people and we saw one care plan had been signed by the person's relative but the initial assessment and care plan did not identify if the person had the capacity to make decisions about day to day care. The care plan for another person stated they were able to sign documents but their care plan was signed by a family member. There was no indication in the care plan that the person had agreed to this and a mental capacity assessment had not been completed. The care plan for another person stated they were unable to sign documents but no reason had been identified and a mental capacity assessment had not been completed. We saw the care plan had been signed by a relative. The care plans for these people did not identify if a LPOA was in place. This meant that people were not appropriately supported when decisions about their care were made to take into account their wishes whenever possible.

The above paragraphs demonstrate a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some new care workers had an extended amount of time between completing their induction training and starting to provide care for people in their homes. The registered manager explained new care workers completed a four day induction programme which included the training identified a mandatory by the provider and modules based upon the Care Certificate. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to care. During the inspection we looked at the recruitment records for five care workers. We saw one care worker completed their induction eight months before they started to provide care. Two other care workers completed their induction three months before starting to carry out visits to provide care.

The registered manager explained new care workers would complete a period of shadowing an experienced care worker during their visit. They confirmed new care workers should complete around six hours of shadowing if they had previous care experience and up to 14 hours if they were new to care. Feedback from the experienced care worker should be recorded relating to the person's competency to complete care activities. When we looked at the care worker employment records we saw the information relating to the amount of shadowing completed was either not completed or the records did not indicate how much time the new care worker had completed observing their colleague or actually providing care under supervision. This meant the provider could not ensure the new care worker understood how care should be provided and that it was carried out in a safe and appropriate manner.

We saw some care workers provided support for a person who used a Percutaneous Endoscopic Gastrostomy (PEG) tube for fluids and medication. We asked the registered manager what training these care workers had received and they explained a quality monitoring supervisor had completed training with an external provider and then trained the care workers. There was a record of the training completed by the senior member of staff but there were no records to indicate the care workers had completed the training and had been assessed as competent. This meant the provider could not ensure the care workers had completed the relevant training.

The above paragraphs demonstrate a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had identified specific mandatory training courses to meet the needs of each staff role. The training included first aid, safeguarding adults, moving and handling and medicines management. We looked at the spread sheet containing the training records for 102 care workers and saw they had completed the training identified as mandatory by the provider. Care workers commented, "I had my training including safeguarding, moving and handling, food hygiene, infection control, medication, confidentiality. Once a year we are sent for refresher information training. I have informed the office that I'm happy to attend any new training but no answer so far", "Only induction at Care Outlook" and "I had training on medication, health and safety and first aid."

The registered manager confirmed care workers completed four supervision sessions per year which included an office based meeting with their line manager, an observation of their work and a spot check during a visit to a person's home and an annual appraisal. We saw the records for 102 care workers and we saw regular supervisions had been undertaken and the majority of care workers who had been employed for more than a year had completed an annual appraisal.

We asked care workers if they had regular supervision sessions and care workers told us "I work with Care Outlook and until now I had only one supervision with my manager.", "Yes I have supervision sessions" and "If I'm concerned about any issues I will discuss with the manager who usually clarify any issues." We also asked how often supervisions occurred and they told us "Don't know never had one with Care Outlook", "Every two months", "When required" and "Once a year or more if there is something new that needs to be told to me."

There was a good working relationship between the service and health professionals who also supported the individual. The care plans we looked at provided the contact details for the person's General Practitioner (GP).

We saw care plans indicated if the person required support from the care worker to prepare and/or eat their food. Some of the care plans indicated the person's food preferences and if the person's family provided

pre-prepared meals for the care worker to prepare.

Good

Is the service caring?

Our findings

We asked people if they felt the care workers were treating them with dignity and respect and they told us "Care workers respect me and my home", "Very respectful care workers", "Care workers are lovely and respect all my needs" and "All care workers respect me and talk to me in a lovely friendly manner."

We asked care workers how they helped maintain a person's privacy and dignity when providing care. They said "I ensure that individuals privacy and dignity is maintained by, explain all actions to the individuals, respecting their decisions, ensure that doors are shut and curtains close when providing personal care and offering a choice", "Keep them informed of everything I am doing and always gaining consent" and "I ensure people's dignity and privacy by making sure I do not discuss information about the service user to people who are not involved in their care. Also I make sure individuals who receive care and support are able to make choices about the care they receive." Other comments included, "To safeguard the confidentiality of personal information. Ask for permission when entering their personal space or accessing their personal belongings" and "To be respectful and listen to clients requests and do what they want if they are able to speak for themselves. Not to embarrass them when carrying out personal care."

We asked people if they were happy with the care and support they received from the service. People told us they were happy with the care they received in their homes. People using the service were asked if they felt the care workers supported them in maintaining their independence. People said "Any issues I can just ask, they will always help", "Care workers encourage me to do as much as I can", "I like that the staff encourage me to keep independent", "My care worker encourages me to do what I can" and "The staff encourage me to make decisions."

People told us they felt care workers were kind and caring when they received support. People told us "My care workers are lovely", "Very caring staff, can't do enough for me", "Staff are lovely and meet all my needs" and "Kind, caring and lovely." Relatives of people using the service told us "Some care workers are kind and caring" and "lovely kind staff."

We asked people if they had the same care worker or if they regularly changed. People commented "Regular team of care staff", "I see the same group of care workers" and "I have the same care worker and the office will tell me of any changes." Relatives gave mixed comments which included "Big staff turnaround so see lots of different carers", "I am not told if the care worker is running late", "Continuity at the weekend is poor" and "We have the same care workers."

Care plans identified the person's cultural and religious needs as well as the name they preferred the care workers to call them by. We saw care workers were provided with some information about the personal history for people they were supporting where the information was available.

Requires Improvement

Is the service responsive?

Our findings

Following our comprehensive inspection of Care Outlook Hillingdon on 3 May 2016 we found people did not always receive care that reflected their needs and met their individual preferences, because the care was not delivered at the same time each day and sometimes people had to wait for food or care without knowing when the care worker would arrive.

During this inspection on the 23 and 24 November 2016 we received positive comments from people using the service regarding care visits but other information indicated visits were not occurring at the times recorded in care plans.

We asked people if the care workers arrived at the agreed time and if they were going to be late were they contacted. People told us "Care workers are more or less on time", "My care workers are on time", "Always accommodate any time changes for me so I get my call" and "No issues with carers or the times they come."

We looked at the care plans for 11 people using the service and reviewed the times recorded for each care visit during the day and their support needs. We saw the visit times recorded in the care plans which did not reflect the actual time the care workers visited. The care plans we looked at had all been reviewed since January 2016.

The care plan for one person showed the care visits should occur at 6 am, 1.15 pm and 4 pm. The records for the week of the 7 November two morning visits occurred more than one hour after the time shown in the care plan. The records indicated all the visits due at 1.15 pm during that week occurred between one hour and two hours 15 minutes before the time shown in the care plan. The person had limited mobility and required two care workers to help them access the bathroom and around their home.

We saw the care plan for another person showed there should be four visits per day at 8.30 am, 12 noon, 3.45 pm and 6.30 pm. The records showed on three days the visits were over one hour later than shown in the care plan. The person required assistance from a care worker to stand and received support in relation to personal care, medicines and providing meals.

The care plan for another person indicated they had a care visit at 10 am each morning and the records showed on two days during this week the visit was more than 45 minutes late and one hour early on another day. This person required support from care workers in relation to personal care and medicines.

The care plan for a person using service who received support with personal care showed they had two visits per day at 10 am and 7.30 pm. We saw one morning visit was two hours later and three evening calls were between one and two hours later than indicated in the care plan.

We looked at the care plan for a person who received support with their personal care and it showed they received four visits per day at 9 am, 1pm, 5 pm and 9 pm. The visit records for the week of the 7 November 2016 showed four morning calls were up to two hours later than shown in the care plan. Three lunchtime

calls were more than an hour later with four 9 pm calls of between one and a half and two hours later then indicated in the care plan.

The daily records completed by care workers, which described the care received by each person, were focused on the daily care tasks and not the experience of the person. This did not provide a complete picture of the person during each visit.

The above paragraphs demonstrate a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans were often written in a way that identified each person's wishes as to how they wanted their care and support to be provided. During the inspection we looked at the care plans for 11 people using the service which included information on the care activities during each visit. The care plans also included information relating to the person's preferences as to how their care should be provided, when care workers should encourage the person to make choices and any health issues the person lived with. The care plans we looked at in the office had been regularly reviewed.

We asked care workers how often they read the care plans for people they visited. We received mixed responses which included "Every visit if they are in the person's home", "Every time I go to the service user's home I read the support plan and risk assessment" and "I check regularly in case of any changes." One care worker told us "I always make sure that I read care plans each time I visit my clients to check if there are any changes. I have read risk assessments. Unfortunately for all of the clients I am visiting, care plans are not updated and not suitable for client any more. Many times we reported to the office but still no feedback."

We asked people if they had a care plan and did the care workers read it. They told us "The care plan is in the home and the staff do read it", "Care planning, they listening and took note of my likes and dislikes", "Care planning was very sympathetic to my needs" and "Care plan was very good, I was involved in all the planning."

People using the service were asked if they felt their care needs were being met. They told us "All my needs are met", "My care needs are listened to" and "Care workers and office staff listen to my needs." We asked relatives if they felt the care needs of their family member were being met. We received mixed comments which included, "I do not feel the care workers meet my family member's needs", "They always ask my relative if they need anything and leave drinks" and "All needs are met, I can ask them for any other little tasks, no trouble."

We asked people if they were involved in decisions regarding their care and support needs and they said "Care workers always give me choice", "Care workers always ask me if I need anything", "The staff encourage me to make choices", "Always involved in care decisions" and "The care workers involved me in and I can make decisions on my care." Relatives told us "They always involve my family member in decisions" and "I am involved in all decisions."

People's needs were assessed prior to them using the service. A referral was received from the local authority which included an assessment of the person's care needs. Once it had been identified if the service could meet the person's care needs appropriately the information was added to the computer system and care workers allocated to the visits. The registered manager explained they aimed for the person to be visited before the first day planned care visit to complete an assessment of their needs as well as checking to ensure the appropriate equipment was in place. This information, in addition to the local authority referral, was used to develop the initial care plan. The registered manager told us the person would be contacted

after three months by telephone to check the care they received was appropriate. When we looked at the care folders we saw the assessments and telephone checks had been completed.

The registered manager told us people using the service and relatives could provide feedback on the quality of the service during quality monitoring visits which happen every six months. We asked the registered manager what other ways people could provide feedback of the care they received and they confirmed a questionnaire had not been sent to people using the service during the last year and they would discuss this with head office to find out if this could be arranged.

The provider had a complaints policy and procedure in place. We asked people if they knew how to raise a complaint with the provider and if they had ever made a complaint. We received comments which included "Any complaints I call the office and they will listen and always try and help", "If I complain action will take place", "I've not had any complaints but if I did I am confident the office would help me" and "I complained about a care worker and they changed them". Other comments were "I asked for a different carer and they changed it, put my mind at rest", "Office staff listen to my concerns and take on board my feelings" and "If I don't like something they listen."

During the inspection we looked at the records for five complaints that had been received during 2016. The complaints had been recorded on a log sheet describing the date received and when completed with the outcome of the investigation. We saw these records were detailed and included information identified during any investigation, any correspondence and if the complaint was resolved. Information on how to make a complaint was included in the pack provided when people started using the service.

Requires Improvement

Is the service well-led?

Our findings

The provider had a range of audits in place but those in relation to the recording of medicines, recruitment records, daily records of care, care plans and other records of care provided were not effective in identifying issues.

During the inspection we identified a number of issues in relation to the recording of the daily records not reflecting people's care which had not been identified when audited. We also saw that the audit process did not identify when issues had been recorded and no action was noted. MAR charts had not been completed in full but the audits for some MAR charts completed earlier during 2016 had only been carried until October 2016. We saw other MAR charts had not been audited for up to four months after completion. We saw that where an audit had been carried out recently the care workers had been spoken with regarding appropriate recording but this meant that any action to reduce the risk of care workers continuing to complete MAR charts incorrectly was delayed and further recording issues occurred. Audits had been carried out in relation to care worker employment records but these only identified if the required paperwork was in place and not the accuracy of the information received. In addition when other records had not been completed in full this had not been identified through the audit processes in place.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we saw information was not accurately recorded between assessments, care plans and risk assessments. We saw the assessment, care plan and medicines risk assessment for one person indicated different information in relation to whether medicines were administered or care workers would prompt the person. This meant care workers were not provided with accurate information about the level of support that should be provided.

The records of daily care for one person indicated they had a specific medical issue but this was not mentioned in the care plan and risk assessments. Therefore the care plan did not include current information in relation to the care required.

We saw the care plan for the same person directed the care workers to read a report from the occupational therapist to identify what support the person required when being moved. This information was not provided in the care plan or as part of the moving and handling assessment. This resulted in care workers having to read a separate document to identify how they should provide appropriate support for the person when helping them move.

The care plan and moving and handling assessment did not indicate that the relative of this person would sometimes act as the second care worker to assist with moving the person. This meant care workers were not aware that the relative had agreed to provide the additional support when required.

We saw the referral information for one person stated they experienced behaviour which could be

challenging but the care plan and risk assessments did not mention this information.

The daily records of care for one person stated that care workers had applied a cream for the person during their visit but the care plan and medicines risk assessment did not refer to any creams to be applied.

During the inspection we asked the registered manager for details of planned arrival and departure times for visits compared to the times care workers actually carried out the visit. We reviewed the records showing the planned arrival and departure times and actual visit for two separate days during September and October 2016.

We saw a number of visits started more than 30 minutes before or after the agreed call time recorded on the electronic monitoring system (EMS) which was used to identify when care visits were due for each person, the length of time of each call and which care workers attended. We also noted that approximately a third of the people using the service experienced at least one visit on each of the selected days that were a minimum of an hour earlier or later than scheduled on the EMS.

We asked the registered manager this they could identify why this number of people had received visits at a different time recorded on the EMS. The registered manager explained a review of the times recorded on the EMS had been undertaken but the differences in the planned and actual visit times could be due to the information on the computer system still being incorrect. They told us that the person using the service would contact the office if a care worker had not arrived.

They confirmed that if a care worker was late arriving the person using the service would usually contact the office. The information recorded for planned visit times on the EMS may not represent the actual times agreed with people using the service for their visits. This meant that the provider could not ensure that care workers attended people's home at the agreed time.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed a monthly return for the local authority which included information on the number of complaints received, new staffing levels, supervisions and incidents and accidents. Quality monitoring visits to the homes of people using the service were carried every six months to obtain feedback on the quality of the service and ensure the correct paperwork was in place. Following each visit a form was completed and if any issues were identified and resolved. Telephone monitoring calls were also carried out if a specific issue was identified and the provider required feedback more quickly.

The service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

We asked the people using the service if they felt the service was well-led. People gave feedback including "The service seems to work well", "I have no reason to complain" and "Office staff are very helpful." We also asked people what they felt about the service in general and they said "Care Outlook is very open to listening to you", "My overall wellbeing is upheld", "I couldn't ask for better staff" and "Very happy with my carers."

We also asked care workers if they felt the service was well-led. The care workers gave us mixed feedback which included "Unfortunately not . Some of the clients are not happy with service. Times of the visits not

always suits clients. Clients can't decide about their carers. Three of my clients are not happy with their carers, office is aware but nobody is willing to change anything. Few of the carers I know not doing their job properly. I have been reporting this to the office from months unfortunately office took no action", "No!!" and "Yes, always someone available to speak to if any concerns."

We asked care workers if they thought the culture of the service was fair and open. We received mixed comments which included "Unfortunately not. I have feeling that every carer is treated different by company. Some of the carers struggling to have some work while others have full rotas", "Not at the Hayes branch" and "The organisation is always willing to help and support me at work. It is fair and open."

We also asked care workers if they felt that they understood what they were doing and that they had the proper support to do their job and meet people's needs. The comments we received were varied including "I feel very confident working as a carer. I think I have proper training. Unfortunately I have no support in my work. I work mostly on weekends, unfortunately it's very hard to get through to the on call service, usually nobody answer the phone. People working on call are not always competent and most of the time we need to deal with emergency alone", "Yes, completely up to date with training (just not provided by Care Outlook). I feel there is no support from branch or manager" and "Yes I'm well supported."

People using the service were given a booklet which included information on the philosophy, aims and objectives of the organisation, how care was provided and the contact details of the provider. Care workers also received a handbook and code of practice document which included a summary of the main policies and procedures, for example a code of conduct, policies, emergency procedures and how care should be provided. Therefore, both people using the service and care workers were given information in relation to how the service provided care.

Team meetings for care workers were held every three months and the registered manager explained they had the meetings at various times on the same day or on different days during the week to enable as many carer workers to attend. We saw minutes from the recent meetings and these were sent to all the care workers for their information.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs or reflect their preferences. Regulation 9

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure the proper and safe 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 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 (5)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that people employed for the purpose of carrying on

a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them.

Regulation 19 (1) (b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate induction and specific training as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed, monitored and improved the quality of the services provided. Regulation 17 (2) (a) The provider did not have a system in place to maintain an accurate, complete and contemporaneous record in respect of each service user including a record of care provided and any decisions taken. Regulation 17 (2) (c)

The enforcement action we took:

Warning notice