Nestor Primecare Services Limited

Allied Healthcare Maidstone

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place between the 01 and 19 October 2018, the first two days of the inspection were unannounced.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to people living with dementia, older people, people with learning disabilities and autistic spectrum disorder, people with a mental illness, people who have a physical disability and younger adults.

Not everyone using Allied Healthcare Maidstone receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. There were 141 people receiving support with their personal care when we inspected.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left on the 27 July 2018. The provider had employed a new manager, who was planning to apply to CQC to become the registered manager.

People were not always protected from abuse and harm. We found evidence that safeguarding concerns raised by staff had not always been dealt with following the provider's and the local authority's policies and procedures. Whilst the provider had taken some action to internally investigate the allegations, they had not contacted the local authority or the police.

The provider had not deployed enough staff to meet people's needs. This has impacted on people who have had missed and late visits. A person who had experienced a missed call explained they were found in bed by the lunchtime care staff that came. They were not able to mobilise on their own. They said, "I had to lie in bed, I could not do anything." They went on to explain that the experience was not pleasant, they could not go to the toilet and they were hungry. People did not always get their care at a time that met their needs and preferences. Care staff were not always allocated adequate travel time between care visits. People received shortened or clipped care visits.

The provider did not follow safe recruitment practices. Essential documentation was not available for all staff employed. Gaps in employment histories had not been explored to check staff suitability for their role.

Risks to people and staff had not been well managed. When people's health and mobility had drastically changed, risk assessments had not been reviewed and updated in a timely manner. People and staff were at risk because staff had been providing care to people alone when the person had been assessed as requiring

two staff. Accident and incident data on showed that a staff member was injured whilst carrying out a care visit to a person on their own instead of with another staff member. The provider had failed to take adequate action when accidents and incidents had occurred. Lessons had not been learnt from accidents and incidents to prevent further concerns and to strive for improvement.

Medicines had not been well managed. People receiving administration help and support did not always have medicines administration records (MAR) in place to detail what the person was prescribed, what time staff should administer the medicines, what route the medicine should be given and other essential information. We identified practice of leaving medicines out for a person putting the person at risk of harm from overdose.

Measures were in place to minimise the spread of any infection. Staff were provided with appropriate equipment to carry out their roles safely.

The provider had not provided staff with the resources to apply their training to ensure people received effective care and support. Staff had received training on how to move people safely but regularly carried out care visits which had been identified as needing two members of staff to safely support people by themselves. Although the systems were in place to support and develop staff, these were not being applied effectively. There was a programme of supervision in place which included 'spot checks'. However, this had not identified that staff were not applying their training effectively.

People's care and support needs had been assessed prior to them receiving a service which included recording their preferred name, religion, ethnicity and background. The assessment did not capture all of the protected characteristics under The Equality Act 2010. When people's needs changed they had not been reassessed in a timely manner.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service did not always support this practice. Staff knew and understood how to support people with decision making, such as offering people different options verbally or by showing them the choices to help them make an informed choice. People's capacity to make decisions had not always assessed or recorded.

The service had failed to provide care and support to meet people's nutritional needs. Essential information about one person's nutritional intake had not been effectively monitored. This meant that action had not been taken to address concerns about suitability of food to sustain the person's life and good health.

Most people received medical assistance from healthcare professionals when they needed it.
Care records showed where staff had taken action when people were unwell. However, the care records did not always record an outcome or whether there had been medicines changes. This is an area for improvement.

People told us staff that provided them care and support in their homes were kind and caring.
Despite the mainly positive feedback from people and their relatives about the care received. Allied Healthcare Maidstone had not treated people with dignity and respect by providing rushed and clipped care visits, cancelling care visits and not providing enough staff to meet people's needs. People and their relatives had not always felt listened to and in control of their own lives. The service has not always given staff the time, training and support they need to provide care and support in a compassionate and personal way. One person had complained of being left by the staff in soiled sheets for some considerable time. Staff recorded that they supported this person with their personal care but left them in a wet sheet as there was

only one member of staff at the call and the person needed two members of staff to support them to move. No telephone call was made to the office to ask for an additional member of staff to attend and support the person with their mobility so they could change the bed linen.

We observed staff supporting people in their own homes. Staff were friendly and discreet and clearly knew people well. Staff had a good rapport with people and knew people well. Staff were able to describe people's care routines, likes and dislikes. We observed staff chatting with people about their day and showing a genuine interest in people and their lives.

People and their relatives knew how to complain. At the time of the inspection records of individual complaints were not available. We were unable to asses if the complaints had been responded to effectively and within timescales. People did not feel that Allied Healthcare Maidstone listened to them. People and their relatives did not have all the information they needed to escalate their complaints. Each person received a pack of information about the service which included essential information and contact telephone numbers. The complaints information did not include information about how to contact the local government ombudsman.

Some people and their relatives told us they received a personalised service. They said they had been involved in planning their care so the support provided could meet their needs.

Care plans were personalised and had been developed from initial assessments of people's needs. However, care plans were not updated promptly when people's needs and wishes changed. We found care plans in place which did not represent people's current care and support needs both in the office and when visiting people with staff in their own homes. One person was described by staff as at the end of their life, their care plan had not been updated to detail their wishes and choices about how they wanted to be cared for when they deteriorated further.

There were multiple and serious shortfalls in key systems and processes used to assess, monitor and evaluate the service. Which meant the provider did not have adequate oversight of the service. Although there were systems and processes in place to monitor the service. The systems were not robust enough to capture the breaches of regulations found during this inspection. There has been a lack of management oversight at Allied Healthcare Maidstone with regional management and senior managers concentrating on other services in the south of the country. The providers intelligence systems had not been used by the management team to effectively monitor the service. It is very clear from the data from these systems that there were concerns in relation to staffing levels, clipped calls, complaints, medicines errors and missed care visits that have been apparent for some time. The provider failed to notify the commission of serious incidents such as safeguarding concerns.

Records were not complete or accurate. Care plans and risk assessments were not updated when incidents occurred.

People were sent quality surveys annually to gather their views about the service they received.
There was no record that people had been told the results of the survey and what action was being taken to address their concerns.

The provider had not worked in partnership with key organisations, including the local authority, safeguarding teams and clinical commissioning groups and multidisciplinary teams, to support care provision, service development and joined-up care in an open, honest and transparent way.

On occasions the service had received 'thank you' letters. Two people we spoke with told us they thought the service was well managed.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. We found the provider had displayed a copy of their rating in the office and on their website.

We found 10 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of section 33 of the Health and Social Care Act 2008 and a breach of The Care Quality Commission (Registration) Regulations 2009.You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and therefore the service is in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs. The provider had not always followed safe recruitment practices. Staff did not always have enough time allocated to them to travel to their next care visit.

There were shortfalls in the arrangements used to manage risks and provide safe care and treatment.

The provider had not always taken action in relation to accidents and incidents and as a result had not learned lessons from accidents and incidents to prevent them from happening again.

Medicines practice had declined since we last inspected the service. Medicines were not always managed safely.

Care staff understood the various types of abuse to look out for to ensure people were protected. The provider had not reported safeguarding concerns to the local authority or CQC.

Measures were in place to minimise the spread of any infection. Staff used personal protective equipment to safeguard themselves and people.

Is the service effective?

Inadequate

The service was not effective.

Although there was a training programme in place, staff were not always applying their training to ensure people received effective care and support.

Although people's care and support needs had been assessed prior to them receiving a service. The assessment did not capture all the protected characteristics under The Equality Act 2010. When people's needs changed they had not been reassessed in a timely manner.

People's capacity to make decisions had not always assessed or recorded. Staff knew and understood how to support people

with decision making, such as offering people different options verbally or by showing them the choices to help them make an informed choice.

People had not always been supported in the right way to eat and drink enough.

Most people received medical assistance from healthcare professionals when they needed it. It was not always clear what action had been taken.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect by Allied Healthcare Maidstone because they were not listened to and were not always provided with the care they had been assessed as needing. However, people told us staff providing their care respected their dignity, and privacy and staff were kind and caring.

People were supported to be as independent as possible.

People were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives knew how to complain. People did not feel that Allied Healthcare Maidstone listened to them. People and their relatives did not have all the information they needed to escalate their complaints.

Care plans were personalised and had been developed from initial assessments of people's needs. However, care plans were not updated promptly when people's needs and wishes changed.

Is the service well-led?

Inadequate

The service was not well led.

There were multiple and serious shortfalls in the systems and processes used to oversee the running of the service.

Improvements to the service had not been made in a timely manner to learn lessons from incidents, accidents, comments

and concerns.

Records relating to people's care and the management of the service were not well organised or complete.

The provider had not reported incidents to CQC. There was no registered manager in place.

The provider had displayed their rating on their website and in the office.

Allied Healthcare Maidstone

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.

The inspection site visit activity started on 01 October 2018. The first day of our inspection was unannounced. The inspection was carried out by three inspectors. The inspection included two inspectors visiting people in their homes, shadowing staff providing care and talking with relatives. Assistant inspectors supported the inspection by making telephone calls to people and their relatives to gain their feedback about the service received. These telephone calls took place over several weeks as we had trouble getting hold of people and staff. The last telephone calls were held on 19 October 2018. We visited the office location on 01 and 02 October 2018 to see the management team and to review care records and policies and procedures. We also visited the office on 24 October 2018 to provide feedback to the management team.

Before the inspection, we reviewed the information we held about the service including previous inspection reports. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information of concern that we had received from the local authority and from people and staff sharing their experience of poor care through our website. The information of concern received from the local authority included information about Allied Healthcare Maidstone not being able to provide care and support to some people because of a lack of staff. Some people had gone without care visits.

We spoke with 28 people who received a service from Allied Healthcare Maidstone as well as nine relatives. We observed care and support with permission of people in their homes.

We contacted health and social care professionals including the local authority commissioners and Healthwatch to obtain feedback about their experience of the service. There is a local Healthwatch in every area of England. They are independent organisations who listen to people's views and share them with those with the power to make local services better.

We spoke with 15 staff; including care staff, field care supervisors, care coordinators, the branch administrator and the branch manager. We also spoke with the care delivery manager, the care delivery director, the area support manager, the regional director, the quality manager and the nominated individual for the provider.

We looked at eight people's personal records, care plans, medicines records, risk assessments, staff rotas, staff schedules, five staff recruitment records, audits and action plans as well as policies and procedures.

We asked the management team to send additional information after the inspection visit, including action plans, business continuity plans, audits, meeting records, copies of daily records, medicines administration records and policies. The information we requested was sent to us in a timely manner.

The service was last inspected on 25 October 2016, the service was rated 'Good'.

Inadequate

Is the service safe?

Our findings

People were not always protected from abuse and harm. Staff confirmed they had received safeguarding training. The copy of the local authority safeguarding policy, protocols and procedures in the staff office was dated 2011. This contained telephone numbers that were no longer in use and out of date information. The local authority rewrote their policy in April 2015 and amended it further in September 2017. Staff we spoke with had a good understanding of abuse and how to report safeguarding concerns. Staff told us they would report safeguarding issues to the office. One member of staff said, "I would hope to think they would deal with it." Another staff member said, "I would like to hope that staff in the office would take the right action." We found evidence that safeguarding concerns raised by staff had not always been dealt with following the provider's and the local authority's policies and procedures. Allegations of abuse, ranging from theft to physical abuse had been made and in some cases, these had been investigated by the previous manager. Records showed that these incidents had been recorded but the local authority safeguarding team has not been advised and no alerts had been raised. The information was not consistent or clear to show what outcome or actions were taken to protect people from the risk of harm. One person's care records evidenced that they had reported that a member of staff had tried to strangle them. Whilst the provider had taken some action to internally investigate the allegation, they had not contacted the local authority or the police. The provider had failed to notify CQC that safeguarding allegations had been made. We spoke with the management team about this and asked them to notify the local authority so that the allegation could be fully investigated.

The provider had failed to ensure that people were fully protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The provider had not carried out sufficient checks on all staff to ensure they were suitable to work around people who needed safeguarding from harm. We checked the files of five employees, one of whom had been employed since the last inspection. A member of the management team told us that each member of staff was required to complete an annual declaration to confirm the details of the police check had not changed however this declaration had not been completed. Another staff member's file did not contain references from the staff member's previous employment to confirm their conduct was satisfactory to perform their role. Records showed that four out of five staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks in staff files. The management team could not find a DBS check on file for one staff member. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Photographs were in place for most of the staff members.

Systems were in place to confirm that staff had the required current driving documents, such as insurance and MOT's. These had been checked previously and each member of staff was required to complete an annual declaration that they remained up to date. These records were not consistent as this document was not always completed.

The provider had failed to operate effective recruitment procedures. This was a breach of Regulation 19 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not deployed enough staff to meet people's needs. This has impacted on people who have had missed and late visits. People gave us examples of the impact this has on them, particularly during the weekends. One person said, "At weekends I don't know who is coming and when. I have complained before to head office a number of times, it never improves". A person who had experienced a missed call explained they had used their emergency button to gain help as no staff had arrived. They were told that there was no staff available to provide their care. They said they were found still in bed by the lunchtime care staff that came. They were not able to mobilise on their own. They said, "I had to lie in bed, I could not do anything." They went on to explain that the experience was not pleasant, they could not go to the toilet and they were hungry. They were in pain and were due to have pain relieving medicine in the morning. They could not take a painkiller because they were stuck in bed as the staff member had failed to arrive. A relative told us that perhaps once a month there were not enough staff to provide their loved one with a care visit. They said, "Sundays are the day, they can't get people for Sunday mornings and when they do come on a Sunday, they come about nine thirty in the morning, so we have to get ourselves up." A staff member gave us an example of when they had been sent to a person's care visit on their own when the person had been assessed as requiring two staff to safely provide their care. The person had rung a relative and asked them to visit them to assist the staff member in providing care. The provider's records for August and September 2018 showed that there had been 130 care visits to 32 people that had been delivered by one staff member instead of two. We spoke with the nominated individual for the provider about the missed care visits. They told us, "It's unsafe and a safeguarding issue."

People did not always get their care at a time that met their needs and preferences. One person told us they had important events that wanted to attend twice a week so they needed an early care visit. The person told us, "My carers know about this and they come at 07:00 on those days but the office still has me down for 10:00. I have spoken to several people at the office but it is still down as 10:00. It's not an issue at the moment but my regular carer is going on holiday soon so I am going to have to start making calls again soon." Another person told us they had asked Allied Healthcare Maidstone for their morning care visit to be at 07:00 but the care staff still visit at 08:00. They told us that they had repeatedly requested the change but it still had not been done.

Care staff were not always allocated adequate travel time between care visits. Inspectors experienced this during the inspection process when shadowing care staff. Staff also reported that this was the case particularly during in rush hour. One person told us, "They don't seem to allow carers long enough to get from one call to the next call."

People received shortened or clipped care visits. The provider's live care call monitoring system had flagged up that this was a regular and reoccurring issue, however the data was not being monitored so was undetected. For example, in a two-week period one person should have received 21 hours of care and support, but only received 15 hours and 56 minutes. On only nine of the 21 visits was the person given their full care time or over. Another person's care records evidenced they should receive three and a half hours a day of care delivered to them over three visits a day. Their records evidenced that between 01 September 2018 to 01 October 2018 (31 days) they received 52.69 hours of the 108.5 hours of care they should have received. Another person should have received 126 hours of care in a 28-day period. The provider's records showed that they had received 95.33 hours. This was 30.67 hours short of the care that had been commissioned by the local authority. The provider had invoiced the local authority for the commissioned hours and not the actual hours provided. We reported this to a local authority commissioner during our inspection.

The provider failed to deploy sufficient staff to meet people's needs. This was a breach of Regulation 18 of The Health and Social Care Act (Regulated Activities) Regulations 2014.

Although risk assessments had been carried out, risks to people and staff had not been well managed. When people's health and mobility had drastically changed, risk assessments had not been reviewed and updated in a timely manner. One person's care file evidenced that staff should use a hoist to help them move between their bed to a chair and a standing aid to transfer from the chair to the commode. However, we met this person and found that they were cared for in bed. Staff told us that the person's needs had changed and the standing aid was no longer in use. Staff also informed us that the mobile hoist in the person's home was not used as it was not safe. This had been reported to the office, however the hoist had not been repaired. Staff told us that this hoist had been out of action for months. Another person's care plan detailed that they required the use of a hoist and two staff to support them to transfer from their bed to their chair. Their care plan listed that the staff should hoist the person using a dark blue sling, using the yellow straps. However, the person's risk assessment contained conflicting information. This meant staff had conflicting and inaccurate information which could put the person at risk of falling from a sling.

People and staff were at risk because staff had been providing care to people alone when the person had been assessed as requiring two staff. The provider's records evidenced this and the management team confirmed that the records were correct. The provider's tracking system named 'Ciams' that we were given a copy of showed that there were 16 care visits logged in 12 months, which should have been completed by two staff but were only completed by one staff member. This information was incorrect as the provider had shared information with a local authority commissioner which had been passed on to us which evidenced that this had happened in 130 care visits over a two-month period. This put people and staff at risk of harm as staff were using equipment and carrying out tasks alone that had been assessed as requiring two staff. One person told us, "Sometimes they are good and sometimes they are not. I might only get one carer when I am meant to get two. Nearly every week there are one or two days where there is only one carer turning up. I only have use of one hand and one arm so I try and help but it is difficult."

Each person's care records contained Health and Safety Executive (HSE) guidance regarding hot water. This showed that people should not be showering in water hotter than 44 degrees Celsius. Staff were unable to check the temperature of the water when supporting people to have baths or showers effectively as they had not been given thermometers. This meant they were unable to check that the water was at a safe temperature.

The management team told us during the inspection that no injuries had been sustained by staff from carrying out care alone instead of with another staff member. Accident and incident data on Ciams shows that a staff member was injured on 26 December 2017 whilst carrying out a care visit to a person on their own instead of with another staff member. The provider had not learnt lessons from this and had continued to put staff and people receiving care at risk of injury. Accident and incident data also showed that it was not always evident that appropriate action had been taken to address accident and incidents including medicines incidents.

Medicines had not been well managed. People receiving administration help and support did not always have medicines administration records (MAR) in place to detail what the person was prescribed, what time staff should administer the medicines, what route the medicine should be given and other essential information. People's daily records showed that staff were administering medicines which included; tablets, liquid medicines and prescribed creams. Two people's care plans stated they only required verbal prompts and assisting with opening medicines boxes and bottles. However, their medicines were contained within a monitored dosage system (MDS) not within boxes and bottles. The MDS was managed by staff. Several

people's daily records showed that staff were administering prescribed creams. These prescribed creams were not listed on MAR charts or within people's care plans. When we shadowed experienced staff during their care calls in the community we found that MAR charts were not in place and observed that staff were frequently administering prescribed creams. Medicines care plans and risk assessments had not always been completed to evidence that assistance was required. One person had been discharged from hospital with new or different medicines, however no one had reviewed and amended the MAR and care plan.

Two people's MAR charts (weekly and four weekly) had missing signatures when medicines should have been administered so we were unable to ascertain whether people had received these medicines. Handwritten changes on the MAR charts were not signed and most not dated. One person was prescribed teatime and bedtime medicines and staff had signed that these had been administered, but when we checked with staff they told us the teatime medicines had been administered, however the bedtime had been left in a pot for the person to take later. Although this was raised during the inspection on 02 October 2018, records obtained following the inspection showed this continued after it was raised (02 October 2018 to 04 October 2018 when the MAR chart was removed to send to CQC). Another person's bedtime visit had been moved forward to teatime, which meant tablets in the MDS bedtime compartment were administered at teatime; however, there had been no communication with the prescriber that this was safe practice.

One person's records evidenced they were in constant pain and required 'as and when' pain relief. Their care plan stated that staff could leave out two pain relief tablets when the person wanted to take them later in the day and they should not have more than eight tablets in one day. This person had four care calls a day. On 05 September 2018 daily records evidenced that the person may have had eight Paracetamol in a seven-hour period. The usual dose is two 500mg tablets and the maximum Paracetamol dose an adult should take is eight in a 24-hour period, with a gap of at least four hours in between doses. The care staff who provided the person their last care visit of the day wrote in the daily records, 'Looks like [the person] has taken 8 pain relief tablets today including 2 left by the morning staff so didn't leave any'. The practice of leaving medicines out for the person and administering medicines at care visit times meant that the person was at risk of harm from overdose.

Another person's daily records evidenced that they had received an overdose of liquid Paracetamol on 05 September 2018. Their records showed that 15ml of Paracetamol liquid had been administered by staff. This was 10 ml more than the person had been prescribed. The staff at the next care visit reported the concern and sought medical advice. A field care supervisor told us that they were unaware that the person was prescribed medicines until this incident was reported. They told us they put in place a MAR as soon as it came to light. The MAR showed that the person was prescribed Paracetamol oral solution and Promethazine oral solution. We checked through the person's daily records and found that staff were also administering antibiotics, an inhaler and the person had been prescribed drinks which were fortified with vitamins, protein and minerals. None of these prescribed medicines and items had been added to the person's MAR which meant that staff did not have clear guidance and information on when to safely administer.

The failure to manage risks to people's safety and failure to manage medicines safely was a breach of Regulation 12 of The Health and Social Care Act (Regulated Activities) Regulations 2014.

Measures were in place to minimise the spread of any infection. Staff were provided with appropriate equipment to carry out their roles safely. Staff confirmed that they could access more equipment when required. There was a stock of personal protective equipment (PPE) kept in the office. We observed staff consistently using PPE whilst providing care and support in the community.

Despite the areas of concern found. People told us they felt safe. Comments included, "They're very caring people and they make you feel safe"; "I get on well with the carers, they make sure I'm safe and wearing my button. They help with medication" and "Yes, very safe." A relative told us (when we asked whether they and their loved one felt safe with the care and support they received), "Oh yes, definitely, no question." People and their relatives praised the hard work of the care staff who visited them to provide care and support.

Inadequate

Is the service effective?

Our findings

Although there was a training programme in place, the provider had not provided staff with the resources to apply their training to ensure people received effective care and support. Staff had received training on how to move people safely but regularly carried out care visits which had been identified as needing two members of staff to safely support people by themselves. Even though people's care plans identified that these calls needed two people, and all staff were aware of this, records clearly showed that this practice occurred. This put people and staff at risk of injury. On one occasion on the morning care visit, it was written in the daily notes that the staff member asked the community nurse to move the person as there was only one staff member from Allied Care instead of two. The care delivery director told us that this was not acceptable as company policy was that two trained Allied Care staff should be available. All staff had received moving and handling training and were aware of the risks of moving people with one member of staff instead of two. Staff were therefore not applying their training or following current moving and handling regulations. The provider and managers were aware of this practice as calls had been recorded on the system as one member of staff attending.

Although all staff had received safeguarding training, the provider had failed to update the safeguarding training in line with the changes to legislation including the introduction of The Care Act 2014 which came into force in 2015. Some senior management staff had received this update; however, it had not been identified that all staff needed this updated training. Failure to provide this training to staff meant that safeguarding concerns had not been passed on to relevant parties when required.

Although the systems were in place to support and develop staff, these were not being applied effectively. Staff training and development had not been discussed to further enhance staff member's skills to perform their role. The company policy in staff handbook stated, 'The annual appraisal will discuss staff's long-term career aspirations and any appropriate development and support'. However, records showed that these had not been completed by the manager appropriately. On one staff members' file, in the development section the manager had written 'Happy as she is' and the section commitment to improve stated 'continue as I am'. In some cases, the objectives for the future and to identify any goals or aspirations had not been completed. Some records of staff development were not dated or signed by the supervisor or member of staff, to confirm the content and agree the outcomes.

Although there was a programme of supervision in place which included 'spot checks' this had not been sufficiently robust to identify the problems that we found with medicines and moving and handling practice. Staff were observed giving people their medicines and deemed to be competent but the shortfalls in medicine administration and recording had not been identified.

The provider had failed to provide staff with effective training, support, supervision and appraisal to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People's care and support needs had been assessed prior to them receiving a service which included

recording their preferred name, religion, ethnicity and background. However, the assessment did not capture all of the protected characteristics under The Equality Act 2010. When people's needs changed they had not been reassessed in a timely manner to ensure that Allied Healthcare Maidstone understood their current needs. One person had been discharged from hospital on 17 August 2018. Staff told us at the point of discharge the person had no mobility, was bed bound and had reached the end of their life. Their care plan and assessments had not been reviewed and amended. Their mobility care plan stated, 'I do not require support with my mobility.' The health and safety risk assessment had not been updated since 20 June 2017, this showed that moving and handling could be avoided with equipment however no equipment was listed as being is use. A staff member told us that this person's needs were completely different to the information on the person's file and had been for some time. Another person who we visited with staff was cared for in bed. Their care plan and assessment showed that 'I will require my carers to feed me my meals but I am able to manage sandwiches independently'. We checked with staff, they told us that the person's needs had changed and they were no longer able to eat independently. This meant that staff providing care to people did not have up to date and relevant information about people's care and support needs and this increased the risk that people would not consistently received the right care.

The failure to carry out an assessment in order to meet people's needs was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs had been assessed. Some people only required help with meal preparation, cooking and ensuring food remained in date. Some people had support to do these tasks from relatives or were able to do these tasks for themselves. Some people were living with diabetes and the care plan recorded they were to have a diabetic diet. Guidance on recognising the signs and symptoms of a hypoglycaemia (hypo) and hyperglycaemia (hyper) were detailed in people's care files. This included what action staff should take. One person's care plan stated for their lunch time call that it was important to monitor their eating and drinking habits and to limit the amount of sugar they were having. The staff needed to check the meals and cook them at lunch time. Staff recorded in the daily records what the person had to eat each day, such as; 'Two buttered tea cakes a chocolate bar', or 'Refused to eat but did have a chocolate bar'. There was no indication how this information was being monitored and what if any action needed be taken to support this person with their dietary needs, such as contacting the diabetic nurse or dietician for support.
The failure to provide care and support to meet people's nutritional needs was a breach of Regulation 14 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

We observed staff offering people choices of food and drinks at breakfast and lunch. One person needed a lot of encouragement to eat enough food to keep them healthy. Staff explained how they prompted and encouraged the person to eat, when the person refused all foods offered, the staff member made sure they had a milky coffee. The person told us, "They all try to make me eat, but I've never eaten much even as a child. I only eat salad". At another care visit, staff showed the person two ready meals and explained to the person what they were. They asked the person which one they preferred. Staff supported the person to eat their meal and gave them sufficient time in between each mouthful. Staff offered the person sips of their drink and gave assistance to hold the cup. Staff encouraged the person to eat a bit more and gave them a lot of encouragement. Staff engaged the person in conversation after their meal; they talked about the royal wedding which was on that day. Other people and their relatives told us, "My nephew does my shopping. I choose what I am having to eat. Today I had cottage pie and vegetables"; "They do her meal for her on Thursday lunchtime and mum buys what she wants and [name] the carer will cook it" and "They help me with my evening meal and I choose the food I would like to eat".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. People's capacity to make decisions had not always assessed or recorded. People's care records contained consent forms. Some of the consent forms had not been completed fully to detail what people had or had not consented to. For example, some did not evidence that people had consented to Allied Healthcare Maidstone sharing information with other professionals, confirmation that the complaints procedure had been explained and they had received a copy and consent for Allied Healthcare Maidstone to handle their medicines. One consent form had been signed by a relative, but there was no evidence to show whether the relative was lawfully able to sign on their behalf. The provider had not checked whether the relative was the person's Lasting Power of Attorney (LPA) for health and welfare. The person's care plan contained conflicting information. The care plan stated that they did not require others to make best interest decisions on their behalf. This person had their medicines locked in a box within their home. They could not access the key. There was a risk assessment in place but no evidence of a best interest meeting or the person's agreement. One consent form had been signed by a person with very limited eyesight. There was no record to evidence that the form or care plan had been read and explained to the person. Another person could sometimes present behaviours that other people found challenging. Care records did not show that this had been taken into consideration or discussed with the person or health care professionals to establish that they had capacity to safely self-administer their pain relief medicines. Care plans did state whether people had long or short-term memory problems and whether they could make decisions.

The failure to provide care without the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Staff knew and understood how to support people with decision making, such as offering people different options verbally or by showing them the choices to help them make an informed choice. We observed staff actively encouraging people to make decisions about their day to day care needs. For example, staff gave choices of clothing, food, drink, toiletries and other items they may need, such as access to items to keep them occupied such as knitting, television remote control, newspapers and their telephone. One person told us, "They are very good. They wash me, I don't like a bath and they give choices."

Most people received medical assistance from healthcare professionals when they needed it. Staff we spoke with understood the signs and symptoms of a stroke and urinary tract infection (UTI). They gave good examples of the action they would take to get medical help to people if they presented with any of these signs and symptoms. Care records showed where staff had taken action when people were unwell. A staff member called a person's GP because they had a swollen leg. However, the care records did not always record an outcome or whether there had been medicines changes. One person's care records stated '(medicine) stopped', but no explanation of why or by whom. During inspection one person became stuck on their toilet, the staff member called the emergency services for help and stayed with the person until their relative arrived, who took over waiting for the paramedics. One person had been overdosed on 05 September 2018 by being given 15ml of Paracetamol instead of 5ml. When the error was identified, staff contacted healthcare professionals to gain advice. The advice given was recorded in the person's daily records. The advice was not followed. At the person's next care visit staff reported that the person was feeling very sick, there was no record that further medical advice had been sought. This is an area for improvement.

People had been supported to make arrangements to maintain and adapt their accommodation when required. One person told us how a staff member had helped them contact the occupational therapist to gain hand rails to enable them to mobilise in their home.

Requires Improvement

Is the service caring?

Our findings

People told us staff that provided them care and support in their homes were kind and caring. Comments included, "Staff are very kind and caring and they help me to not be lonely. I get an opportunity four times a day to converse with people"; "Staff are kind and caring and friendly, we have banter, we joke it's important otherwise I would feel like a piece of meat"; "I am satisfied with the care. My regular carers are pretty good and kind"; "I am happy with the care I receive from the carers and they always stay the full length of time. I have regular carers; they come twice a day"; "The carers are pleasant"; "She [staff attending care visit] is one of the best carers I have. I have known her for many years" and "The carers are very friendly and caring, you get a feeling of being safe." Two people told us, "Carers are very good, excellent, it's the office that's useless" and "The care staff are lovely the office staff are not."

Relatives told us, "The carers she does have she loves; she is really happy with them"; "Staff are brilliant. They are doing a great job"; "The girls are very good. I don't know what we would do without them"; The Carers are very affable people"; "They're really excellent, I can't say anything else" and "Carers are definitely kind, they really are very nice people."

Despite the mainly positive feedback from people and their relatives about the care received. Allied Healthcare Maidstone had not treated people with dignity and respect by providing rushed and clipped care visits, cancelling care visits and not providing enough staff to meet people's needs. People and their relatives had not always felt listened to and in control of their own lives. The service has not always given staff the time, training and support they need to provide care and support in a compassionate and personal way. People who had been treated in this way said, "I am really angry as I have not had weekly sheet so I don't know who is coming and when. On Sunday night they had not told the carer that came what she had to do to get in the house and I was shouting from the bedroom window and a passer-by had to tell the carer what to do. This week I have a sheet and it is says four reliefs [staff] will be coming. I know who is coming tonight but not tomorrow or Thursday. We used to get our weekly sheets regularly but since they moved to Maidstone about a year ago, we sometimes get them and have a good run of a few weeks getting them but then a few weeks without them. They have lost some lovely carers as well because of the way they treat their staff"; "They are meant to come in the evening after 20:30 but some of the carers don't turn up until 22:00 because they are doubling up and I am tagged on to the end. They also do this in the mornings as well. A couple of times people have not arrived by 11:00 so I have rung the office and told them not to bother"; "They did miss a visit about four weeks ago on a Sunday. They called me at 08:00 and said they were finding it difficult to find anyone and then rang back at 10:00 to say they would not be able to send anyone. I was ok as I rang my daughter and she was able to come" and "I would be worried if we had meal time calls that they wouldn't turn up (because of their experience with missed care visits)."

One relative explained the impact of missed care visits on them and their loved one. They detailed that they could sometimes use other family members to help them but that sometimes they had to it themselves. They explained that they could hardly see now and therefore cannot empty her loved one's commode. They said they were able to help their loved one undress but struggled to help them get dressed. They were unable to shower their loved one so if there is no care visit, their loved one cannot have a shower. A person

explained that care staff take the medicines out of the monitored dosage system so they can then take the medicines. The person explained that they had been requesting an earlier morning care visit because the painkiller that they take before going to bed has worn off by 08:00 in the morning when the care staff visit. The requests have not been listened to. This means the person had been lying in bed in pain waiting for care staff.

There was a statement on file which described how one person had complained of being left by the staff in soiled sheets for some considerable time. Staff recorded that they supported this person with their personal care but left them in a wet sheet as there was only one member of staff at the call and the person needed two members of staff to support them to move. No telephone call was made to the office to ask for an additional member of staff to attend and support the person with their mobility so they could change the bed linen. Apart from the statement by a member of staff, there was no evidence that this information had been recorded on the system or the provider had carried out an investigation. There was no formal complaint or safeguarding raised and no evidence that any further action was taken. We asked the staff if they could tell us any further information about this incident but no one was able to do this. We showed the statement to the care delivery director who said this was unacceptable.

The failure to treat people with dignity and respect was a breach of Regulation 10 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

A number of people had key safes outside their homes to enable staff to let themselves in. We observed that staff used these and on entering people's homes they called out to say who it was. After the care visit staff ensured people's homes were secured and the key was placed back in the key safe.

We observed staff supporting a person to mobilise from their bed to their chair and another person from their bedroom to their bathroom. When people had been supported to wash or shower they were covered with towels to protect their dignity. Staff were friendly and discreet and clearly knew people well. Staff supported people in a gentle manner and we heard them talking with people throughout the care provided, with the door closed to maintain privacy. When people were transferred into chairs staff ensured that their clothing was straight and they were suitably covered. Relatives said, "They always cover her with a towel and ensure her dignity is respected" and "She [loved one] definitely feels like her privacy and dignity is respected."

People were supported to live independently as possible in their own homes. People told us that they only had care and support in certain areas. Some people were able to manage their own medicines and prepare food and drink for themselves and others could not. People were given flannels to wash their face and hands when they were able to do this themselves and staff encouraged people to this. We observed one person administering their own medicine from their monitored dosage system.

People's confidential records relating to their care were kept by the provider on computer which was accessed using passwords to protected people's data and to maintain people's privacy. Paper records were kept in locked filing cabinets in the office.

Staff we shadowed had a good rapport with people and knew people well. Staff were able to describe people's care routines, likes and dislikes. We observed staff chatting with people about their day and showing a genuine interest in people and their lives. One member of staff supported a person at lunchtime to leave their flat and join their friends and neighbours in a communal dining room on site. The staff member knew who the person liked to sit with and gave them time to have their meal and interact with their friends, when the meal had finished the staff member gave the person time to say goodbye to their friends

and neighbours.

Staff had built positive relationships with people and their relatives. One person told us, "I've got no complaints, [name] is a marvellous carer". Another person said, "Staff are always very helpful." A relative said, "The carers are very good, everything they do is good. They always go the extra mile. They will close windows and do things that [person] asks that are not in her care plan."

The management team told us that people were not accessing advocacy services currently as people self-advocated or relatives spoke on their behalf, where needed. However, they would refer them to the relevant service if required. Advocacy services offer trained professionals who support, enable and empower people to speak up.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives knew how to complain. People and their relatives told us, "My wife has no problem with the girls that come but last month they sent a man. We told Allied that were not happy with this and it has not happened since"; "I can ring the office if I have any issues"; "I am not one to complain but would call the office"; "I have not had to make a complaint"; "I did raise an issue with the office, they listened and didn't send some of the carers again" and "I don't need to make a complaint. I just phone the office, that's all I know." At the time of the inspection records of individual complaints were not available. Therefore, we were unable to asses if the complaints had been responded to effectively and within timescales. Complaints were recorded on the computer system and monitored by head office but these records did not show the full detail of the complaint to confirm what action had been taken.

We reviewed the provider's quality survey results from August 2018. There were mixed comments about complaints. People said, "The only thing I complain about half the time is that I do not know who is coming in the evenings and weekends"; "I have no complaints and am satisfied with my carers but I feel new people to the job need to be better instructed". These comments were made in August but there was no further evidence of how these had been actioned to ensure people were satisfied that action had been taken when they raised these concerns. People and their relatives provided feedback during the inspection to evidence that this had not changed. People told us during the inspection, "Carers do exactly what they are supposed to do. My gripe is with the office, they are supposed to send a weekly schedule so I know who is coming. The times of my visits are normally ok except at weekends. At weekends I don't know who is coming and when. I have complained before to head office a number of times, it never improves. I would like to have my schedule by email, how difficult can this be to send it" and "I raised this with the office about the sheets [weekly schedule] a few months ago and I spoke to a lady who put the phone down one me. I spoke to my carer about it and she said I was not the only one this had happened to". People did not feel that Allied Healthcare Maidstone listened to them.

People and their relatives did not have all the information they needed to escalate their complaints. Each person received a pack of information about the service which included essential information and contact telephone numbers. The complaints information did not include information about how to contact the local government ombudsman. The local government ombudsman investigates complaints about care services when the complainant is not satisfied with the response from the provider.

The provider had failed to establish and operate an effective system for identifying, receiving, recording, handling and responding to complaints received. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service followed the guidance in the Accessible Information Standard when assessing people's needs. The management team told us relevant information would be made available in large print, braille or other formats for people with visual impairments or sensory loss, where required. The Accessible Information Standard makes sure that people with a disability or sensory loss are given information in a way they could understand.

Some people and their relatives told us they received a personalised service. They said they had been involved in planning their care so the support provided could meet their needs. People gave examples of when the service had been responsive to their needs. One person who lived alone and was unable to mobilise independently detailed that they had called the office and asked for an urgent care visit or to bring forward their next visit as they needed to use the toilet. They explained that the office staff rang round to find care staff in the area to see if they could assist. Another person told us, "The carers are really helpful. They do everything for me. They wash and shave me and give me breakfast."

Care plans were personalised and had been developed from initial assessments of people's needs. These covered a range of areas including personal care and daily routine, medicines, nutrition and hydration, communication and mobility. They included information regarding people's likes, dislikes, their views and preferences in the way in which they received support, as well as descriptions of their preferred routines when attended by staff. However, care plans were not updated promptly when people's needs and wishes changed. We found care plans in place which did not represent people's current care and support needs both in the office and when visiting people with staff in their own homes. Staff providing care and support were delivering care to people which met their needs. However, if a person's regular staff member was off work this meant replacement staff who did not know the person as well as others would not have all the information they needed to provide care. One relative told us that their loved one had an initial review and both them and their loved one were included in building a care plan. However, since then they have only had one review and no changes were ever made to the care plan although there had been changes to their loved one's needs. They confirmed the care plan in their home was currently out of date. One person told us there was a care plan in their file but the care staff never read it because they do not have time to read it.

Care plans did not reflect people's current needs. Staff told us one person was being encouraged to have a bath. They told us this was a recent change and therefore the care plan had not yet been updated. However, daily reports made by staff mentioned the person having support to bath as far back as the 18 May 2018. The daily notes also reflected that staff were applying a cream to the person's legs, but this was not mentioned in the care plan. One person's morning care visits had been changed to seven days a week and the teatime care visits cancelled, but the care plan had not been updated to reflect this. This change had happened in June 2018. In one care plan there was good detail about the person having a 'strip wash', but no wishes and preferences about their shower. The daily reports made by staff mention there was a commode in place, which staff emptied and they also left drinks of water by the bed for night time, but none of this was mentioned in the care plan.

Reviews of people's care packages had not always been identified as being required through the providers computer system. One person's care plan had not been reviewed since 20 June 2017. The person's needs had changed completely since that time. The computer system did not flag up that the review was due. We spoke with the management team about this and they told us it was because the person had spent a period of time in hospital so the care package had been suspended until they returned. However, when they did return from hospital, they had not been reassessed and reviewed to capture their current care and support needs.

Where care plans detailed that people required full support with personal care tasks this did not specify whether people needed support to manage their oral hygiene, such as brushing teeth or removing dentures. We checked through two months of two people's daily records and found there were no entries or records that staff had supported people to brush their teeth. During four shadow care visits that we attended where staff supported people with getting up, washed, showered and dressed we observed that three out of four people did not have any oral hygiene care and this was not offered.

One person was described by staff as at the end of their life, their care plan had not been updated to detail their wishes and choices about how they wanted to be cared for when they deteriorated further. This meant that staff would not have information about how they could provide care and support to the person so the person could receive a pain free and dignified death in their last weeks and days.

The failure to regularly review, reassess and develop care packages to meet people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The provider did not have adequate oversight of the service. Although there were systems and processes in place to monitor the service such as the self-audit tool (which was completed by the manager), the 'sense' check (which was completed by a senior manager every three months), monthly reporting to the senior management team and a branch warning system in place. These were not sufficient to get an oversight of what is happening in the service and whilst they had highlighted some areas of concern and action plans put in place, the systems were not robust enough to capture the breaches of regulations found during this inspection. We spoke with the nominated individual for the provider about this. They advised "We had an issue with audits being completed, we are now getting a clear view." Action plans created by the management team following self audits and sense checks appear to focus on paperwork and documentation rather than improving people's customer experience and staffing practice. There has been a lack of management oversight at Allied Healthcare Maidstone with regional management and senior managers concentrating on other services in the south of the country. At the same time the registered manager had left, a new manager was brought into post, there were staffing issues because a number of staff left at the same time which was also the outcome of the Kent branches merging.

The provider's intelligence systems had not been used by the management team to effectively monitor the service. It was clear from the data there were multiple and serious shortfalls in the systems and processes that there were concerns in relation to staffing levels, clipped calls, complaints, medicines errors and missed care visits that had been apparent for some time. The provider had not monitored this data which led to delays in effective communication with CQC and the local authority commissioners until the service had reached the point of crisis.

We spoke with the management team to ascertain whether the service had followed duty of candour processes and to check that formal apologies or meetings had taken place with people affected by missed visits and other concerns. The care delivery director told us that these had not happened.

Records were not complete or accurate. Care plans and risk assessments were not updated when incidents of behaviour or changes in moving and handling occurred. One person's medicine record showed that they had been given pain relief tables over the recommended safe amount and this had not been identified. Audits of daily records were not robust. The audit checklist only detailed that five pages of the daily records needed to be checked. Therefore, staff carrying out the audits were missing essential information. For example, one person's daily records were audited on 01 October 2018. The daily records were for the period 16 May 2018 to 01 September 2018. The staff member looked at pages three, six, nine, 12 and 16 only, they had written 'All calls visited at correct times'. We checked these pages and found that some staff had not recorded the start and/or finish times of the care visit. We also found that the auditor had not picked up that prescribed items such as nutritional drinks were being given by staff without a medicines administration record in place or that some of the care visits were considerably shorter than scheduled. The auditor had recorded 'Care plan requirements are not being met as the care plan is currently out of date.' We spoke with the staff member who audited the daily records and they told us they had written that as we had identified during the inspection that the care plan was out of date. This evidenced that the audit systems in place in

the branch were not effective or robust.

People were sent quality surveys annually to gather their views about the service they received. This year's survey was sent out in August 2018. There were mixed comments from the people about the quality of care being provided, for example, people said that staff did not stay the correct amount of time, and there was a lack of staff rotas to know who is coming. The survey also indicated that people felt communication with the office could be improved. They said, "Get the office to return my calls", "Get the office staff to support carers and don't treat people as a hinderance" and "Better communication with clients regarding time of carers arrivals particularly on the weekends and more notification of any changes". One person told us during the inspection, "They send surveys and ask yes or no questions, they should have a sometimes box on the form to tick which would be more helpful. There is space to write comments, I sent a very long letter in with the last one." There was no record that people had been told the results of the survey and what action was being taken to address their concerns.

It was evident that action had not been taken as people and their relatives told us during the inspection that communication was poor. Comments included, "Not well led at all, no communication and disorganised"; "The care staff do what they can but the leadership is terrible"; "It's the blind leading the blind"; "Staff are leaving and you have to ask yourself why are they leaving"; "Too many chiefs and not enough Indians"; "The office staff could help more"; "I have to phone up the office if I don't see them by 11:00. Weekends are worst, you can't get hold of them"; "I don't see anyone from the office; social services come once a year"; "I don't receive any calls from the office; they used to do so before" and "Sometimes the left hand doesn't know what the right hand is doing. When we used to ring to give them the timings, we'd say we don't need anybody at a certain time and the person would say that is ok but then a carer would turn up."

People told us they had repeatedly asked for copies of the rota so they knew which care staff were coming and when. One person explained that during week beginning 08 October 2018, they had received two rotas and both were out of date. They had asked for the rotas to be emailed. Sometimes this had been done but usually they were sent by post. They explained the rotas usually arrived after the week has already started. They said they had complained about this and the response they received to his complaint was that the rotas are sometimes not sent on time because they have not yet filled all the slots. We observed that the coordination staff were still actively covering care visits for the week commencing 01 October 2018 when we inspected. Another person told us that Allied Healthcare Maidstone had contacted them to arrange a visit to them to carry out an annual care plan review. However, no one visited and they hadn't heard anything more from them.

The regional manager told us that the rotas had been reviewed and they were being remotely monitored by the business team. However, invoices had been sent to the local authorities for payment for care calls that had been contracted and not for the actual amount of care delivered. We discussed this with the management team, they told us that the rota information and supporting documentation to evidence that care calls were being shortened had not been used to adjust the invoices.

Three staff reported communication was not always that good. One staff member told us they had sometimes found additional care visits on their rota they had not been contacted about. Another staff member said, "I feel no one has my back. We are always getting calls and [they are] harassing me to work Sundays." Another staff member said, "We are not always kept in the loop of what is going on. Communication could be better."

The provider had not effectively used information from incidents, investigations and feedback about the service to learn and improve and drive forward quality. The regional director sent an email to Allied

Healthcare Maidstone and other services within the region on 28 September 2018 identifying that a local authority request for information indicated that over 100 care visits were delivered with one staff member instead of two in an eight-week period up to 23 September 2018. The regional director stated, 'This does raise some very serious questions over our service delivery, As I am sure you will all agree. Therefore, due to the very serious risk factors involved in such local decisions the policy going forward will be as follows: All double handed calls will be delivered as double handed calls. Any branch staff that are found to be scheduling double calls as singles will be subject to the companies Disciplinary Procedures along with the relevant Branch Manager. This is effective from today 28th September 2018.' The improvements to the service should have taken place at a much earlier stage, the information about missed care calls, shortened care calls and staff providing care to people on their own when the person had been assessed as needing two staff was all available to the provider through their computer system as far back as 2017.

The provider had not worked in partnership with key organisations, including the local authority, safeguarding teams and clinical commissioning groups and multidisciplinary teams, to support care provision, service development and joined-up care in an open, honest and transparent way. The local authority had not been informed by the service that they were unable to meet people's needs in one area of Kent; the service had contacted other care providers to ask them to meet people's needs because a large number of staff had left the service. This was then alerted and flagged up to the local authority by another care provider.

The failure to establish and operated effective systems and processes to assess, monitor and improve the quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings had not taken place frequently. Three staff meetings had been scheduled in August 2018 however no one attended any of them. The manager told us they had planned further meetings in October 2018, staff confirmed they had been invited to attend these.

The service did not have a registered manager. The current manager had started to work with the service in June 2018 and at the time of our inspection, they had not yet applied to register with CQC. The provider had failed to apply to register the manager with CQC.

This was a breach of section 33 of the Health and Social Care Act 2008.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries and deaths. When we spoke with the management team they demonstrated a clear understanding of their role and responsibilities in relation to notifying CQC about important events such as deaths, serious injuries and abuse, however, they had failed to notify CQC of safeguarding concerns which occurred in the service, such as allegations of a person being strangled by a staff member.

Failure to notify CQC of these events is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Some people and their relatives had not had negative experiences of the service. One person told us, "I have been with agency for a few years and they regularly send someone from the office to check if I am happy with everything. The last lady came in the summer." Another person said, "I am happy with the care." A relative said, "We are pleased with everything. Mum is happy and that is what counts."

On occasions the service had received 'thank you' letters, recently a relative had commented, 'Just wanted

to say a big thank you to you all for the care and compassion you have shown towards my relative over the last few years. Without your help we would not have managed to keep them at home.' Two people we spoke with told us they thought the service was well managed.

Staff told us the new manager was supportive. Comments included, "The manager seems really lovely, she listened and is very understanding and will help and support"; "We do get support from the office and kept informed on changes" and "We have meetings and we do get calls if there are urgent things we need to know."

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. We found the provider had displayed a copy of their rating in the office and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of safeguarding concerns which occurred in the service. Regulation 18

Regulated activity	Regulation
Personal care	Section 33 HSCA Failure to comply with a condition The provider had failed to apply to register the manager they had employed with CQC.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to treat people with dignity and respect. Regulation 10 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to provide care without the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014

	Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people were fully protected from abuse and improper treatment. Regulation 13 (1)(2)(3)(4)

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to provide care and support to meet people's nutritional needs. Regulation 14 (1)(2)(3)(4)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate an effective system for identifying, receiving, recording, handling and responding to complaints received. Regulation 16 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operated effective systems and processes to assess, monitor and improve the quality of the service. Regulation 17 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effective recruitment procedures. Regulation 19 (1)(2)(3)

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out an assessment in order to meet people's needs and failed to regularly review, reassess and develop care packages to meet people's needs. Regulation 9 (1)(3)

The enforcement action we took:

We served the provider a warning notice and asked them to fully comply with the regulation by 11 January 2019

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to manage risks to people's safety and failed to manage medicines safely. Regulation 12 (1)(2)

The enforcement action we took:

We served the provider a warning notice and asked them to comply with the regulation by 30 November 2018

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient staff to meet people's needs. The provider had failed to provide staff with effective training, support, supervision and appraisal to enable them to carry out the duties they were employed to perform. Regulation 18 (1)(2)

The enforcement action we took:

We served the provider a warning notice and asked them to comply with the regulation by 30 November 2018