Genesis Recruitment Agency Limited

Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London

Inspection report

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Date of inspection visit:
14 June 2018
21 June 2018

Date of publication:
14 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Is the service well-led?

Inadequate

Summary of findings

Overall summary

We undertook an announced inspection of Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London on 14 and 21 June 2018. We told the provider three 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.

Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London is a domiciliary care agency that provides personal care to around 89 people in their own homes in the London Borough of Ealing and 18 people living in the London Borough of Brent.

We previously inspected Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London on 4 and 5 October 2017 and we identified issues in relation to safe care and treatment (Regulation 12), need for consent (Regulation 11), good governance (Regulation 17) and staffing (Regulation 18). The provider was rated inadequate in the key questions of Safe and Well-led and overall. As a result, the service remained in Special Measures.

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

The provider had a medicines policy and procedures but medicines for some people were still not managed or administered appropriately as information was not provided for care workers as to how the prescribed medicines should be administered.

Improvements had been made in relation to risk management plans but there was no process for assessing the levels of risk to people's safety and wellbeing and recorded assessments indicated that all risks were 'low' regardless of the seriousness and impact of the particular risk. As a result, the provider did not ensure that appropriate action were in place to mitigate risks according to the severity.

The visit times identified in the agreed care plans did not always reflect those shown on the care worker rota. Therefore, people did not receive care at the times which had been planned meaning that there was a risk that their needs were not being met according to their preferences and wishes.

The provider's mental capacity assessment process was not sufficient because it did not relate to the ability of the person to make decisions in relation to a specific aspect of the care they received and their daily life. Where a relative or representative consented to care being provided it was not clear if the person receiving support did not have the mental capacity to consent to their own care and if the relative had the legal right to make these decisions in the person's best interests.

The provider's assessments of staff competency in relation to moving and handling and medicines management did not provide appropriate information to demonstrate that care workers were competent in these areas or had sufficient knowledge.

The provider did not always learn lessons, identify themes and act to improve safety for people using the service as their quality monitoring system did not always identify areas for improvement. The information recorded when a visit occurred either earlier or later than planned but the care provision was not reviewed to identify if any changes were required to the visit time agreed with the person or if the care worker had been given enough time to complete their rota.

Records relating to people using the service did not always provide accurate information relating to the care and support they needed.

Improvements had been made to the recording and review of incidents and accidents. Care workers were allocated visits on their rotas with travel time and the visits did not overlap.

The provider had a clear recruitment process in place.

The provider completed assessments of people's support needs before care was provided in their home.

Care workers had completed the Care Certificate and training identified as mandatory by the provider.

We received mixed feedback from people with the care they received with some people telling they were happy whilst other people identifying times when they were not happy.

People told us the care workers were kind and caring and treated them with dignity and respect when providing care. The care plans identified each person's cultural background, personal history and any religious beliefs.

Care plans identified how the person wanted their care provided including their likes and dislikes. People knew how to make a complaint and provider had followed their complaints procedure.

People told us that in general they felt the service was well-led but they did provide some examples when it was not.

We found four breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to safe care and treatment of people using the service (Regulation 12), the need for consent (Regulation 11), good governance of the service (Regulation 17), staffing (Regulation 18).

We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The service has been in special measures and has been inspected within six months as we state in our guidance. As insufficient improvements have been made and there remains a rating of inadequate for the key question of well-led the service therefore remains in special measures.

Services in special measures are 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.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

The provider did not ensure medicines were managed safely.

Risk management plans had been developed but there was no process in place to assess the level risk for the person to make sure the control measures were adequate to manage the risks.

Visit times recorded in the care plans did not reflect the times shown the care worker's rotas. Travel time had been added to the rotas and no visits overlapped with the next planned visit.

Improvements had been made in the recording of incidents and accidents to identify the actions taken.

The provider had systems in place to protect people using the service. All care workers had completed safeguarding adults training.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had a policy in relation to the Mental Capacity Act 2005. However, they could not demonstrate that they were always working within the principles of the Act to ensure people's rights were upheld and that where people did not have the mental capacity to give consent care was provided in their best interests.

The provider could not ensure that the assessments of staff competency reflected their understanding in relation to the administration of medicines and moving and handling.

Care workers had completed the Care Certificate and the training identified as mandatory by the provider.

People's nutritional needs, if they required support from care workers and any food preferences were identified in the care plan.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Some people confirmed they had regular care workers while other people told us they had different care workers visit them.

People told us the care workers were kind and caring and treated them with dignity and respect when providing care.

The care plans identified each person's cultural background, personal history and any religious beliefs.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The provider had not ensured appropriate actions had been taken in response to a possible change in a person's support needs.

Care plans identified how the person wanted their care provided including their likes and dislikes.

People knew how to make a complaint and provider had followed their complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not implemented systems for monitoring and improving quality as the breaches of Regulation identified during previous inspection had not been resolved.

Records relating to the care of people using the service did not provide an accurate and complete picture of their support needs as information was not consistently recorded.

The provider had introduced a range of audits but some of these did not provide appropriate information to identify areas of the service requiring improvement so these could be addressed.

A process was not in place to monitor the reasons for visits not occurring when planned to identify if any actions were required.

People and care workers felt the service was well-led.

Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London

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 14 and 21 June 2018 and was announced. The provider was given three days' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

Two inspectors 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.

Prior to the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports. Registered providers need to send notifications to the CQC about certain changes, events and incidents that affect the service or the people who use it.

The provider completed a Provider Information Return (PIR) in September 2017. This is a form that asks the

provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager who was also the provider's director, an improvement consultant, deputy manager and the care coordinators. We reviewed the care records for 12 people using the service, the visit summary records for five people, the employment folders for three care workers, training records for all staff, visit rotas for four days and records relating to the management of the service. The expert by experience contacted 10 people who used the service and one relative by telephone. We sent emails for feedback to 54 care workers and received comments from seven.

Requires Improvement

Is the service safe?

Our findings

During the previous inspection we found the provider had a procedure in place for the administration of medicines but some people's medicines were not being recorded appropriately and information was not provided for care workers about how to support people with their medicines. At the June 2018 inspection, we found that this was still the case.

During the previous inspection we also found that the information about the administration of prescribed creams was insufficient. At the inspection in June 2018 we found this information for care workers was still not provided. It was not identified on the person's medicines administration record (MAR) chart or care plan if a cream being applied as part of personal care had been prescribed and there were no instructions to state how the cream should be applied.

Medicines were not always being administered to people as prescribed. For example, the MAR chart for one person included a topical medicine that was prescribed as 'PRN' (as required). The MAR chart showed that care workers had administered the medicine twice a day every day for the month. There was no record to show the provider had followed this up with the person, their relatives or GP to establish the maximum frequency the medicines should be applied every day.

The provider had not ensured that people were given the support they needed with their medicines. For example, one person's care plan stated that the staff should administer their medicines. However, we saw that the MAR for this person and their daily care notes for April 2018 stated that the staff had prepared the medicines and left them with the person to take by themselves later.

Also, the daily records of care for this person indicated the care worker administered paracetamol for pain. The daily records indicated this had been prescribed by the person's GP. There was no record of paracetamol on the MAR chart or in the care records if this was prescribed and no information relating to dosage or frequency of administration. We asked the registered manager and deputy manager why the MAR chart had not been updated to include this medicine and they explained the MAR charts were produced during the previous month and they were not aware the pain relief had been prescribed.

Where a person had been prescribed a medicine, which had a variable dosage, for example one or two tablets to be taken at night, the MAR chart did not indicate the exact quantity which had been administered when recorded.

This meant medicines were still not being recorded appropriately and information provided for care workers as to how the prescribed medicines should be administered.

At the last inspection we saw risk assessments for specific risks were in place for some people but the information was not always available for care workers as to how to reduce possible risks. During this inspection we saw a range of risk assessments and guidance for care workers as to how to manage those risks had been developed for example plans relating to hypertension, arthritis, Alzheimer's, continence and

skin integrity. However, the level of risk had not been assessed for each person based upon their care and individual needs. The principles for risk assessments were not followed because there was no information about the impact and likelihood of the harm happening to determine the seriousness of the risk.

All of the risk assessments and management plans we saw had been assessed as being a low risk and there was no clear system in place to access the risk level based upon the individual it related to. For example, the risk management plan for a person who received their care in bed, was unable to reposition themselves in bed and was incontinent stated their risk of developing problems with their skin including pressure ulcers was low, which is inconsistent with the level of risk expected for someone with these needs

The risk assessment and management document for another person identified they lived with high blood pressure and document explained for care workers the symptoms the person may experience if their blood pressure was higher than usual. As the care workers were not responsible for administering any medicines for the person they were directed to check with the person's relative if the relevant medicine had been taken as prescribed. The level of risk identified was low but there was no information as to how that assessment level had been reached or if the person regularly experienced episodes of high blood pressure or what the risks to their wellbeing would be when this happened.

The frequency for review of the risk management plans was quarterly for those identified as high risk, every six months for medium risk and annually for low risk. Therefore, none of the risk assessments we viewed were due to receive a review for up to a year because they had all been classed as low. This meant that risks to people's health and wellbeing may not be appropriately managed or planned for.

The above was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider was still not deploying staff to ensure that visits by care workers always took place on time. Their comments included "[The agency] being on time is one of the problems. One of the carers was late today as I have a double up. One carer came at 8am and the other turned up at 9am. So, the first carer washed me before the other carer arrived", "If the buses are not on time, carers have difficulty getting here on time", "If carers are on holiday or sick they should let you know of the changes in carers" and "Yes, now and again when my regular carer is on holiday the other carers rush me and leave very early."

During the inspection we reviewed the electronic call monitoring system (ECMS) records for all the visits made on four days. These dates were 19, 23, 26 and 31 May 2018. The ECMS was used for many visits and required the care workers to log their arrival and end time for each visit. We reviewed the information relating to the planned time of each visit and the actual time they occurred and we saw a number of visits happened more than 45 minutes earlier or later than planned. For example, on 26 May 2018 we saw 213 visits occurred of which 41 happened more than 45 minutes earlier or later than planned on the rota. We also saw on the 31 May 2018 there were 222 visits recorded of which 34 occurred more than 45 minutes earlier or later than stated on the rota. The registered manager explained that if the visit did not start at the planned time an alert would show on the computer system in the office where a care coordinator would contact the care worker to find out why the visit was not on time. The reason would then be noted on the person's computer record.

We provided the registered manager a list of 19 visits over two of the days which showed some of the biggest differences between planned and actual visit time. We asked them to send us the reason for the visit not occurring at the planned time which was recorded on the computer system. The registered manager provided information relating to seven of the visits we identified but did not provide this information for the

further 12 visits. The information provided for the seven visits indicated the planned visit times for two of them had been altered following discussion with the person receiving support but this information had not been updated on the rota system and was not reflected on the ECMS at the time of the change. Two of the visits did not occur at the planned time as the care worker was running late with one further visit having to be covered by a different care worker due to sickness. The remaining of the visits times were altered at the request of the person or a relative for that particular day.

We could not therefore be assured that the provider was deploying staff according to people's agreed care plans to make sure they received care and support according to these plans and at the time agreed with them.

We saw in some of the care plans we looked at the visit times recorded on the summary page did not reflect the times shown on the rota and ECMS. We also saw that some visits regularly occurred at the time stated in the care plan but not the time shown on the rota. For example, the care plan for one person stated they should have a visit between 12.30 pm and 1pm but the rota on each for the four days we reviewed showed the visits were scheduled for 11.50am to 12.20pm. This meant the rotas to deploy staff did not provide accurate information to ensure the visits were carried out at the time indicated in the care plan which was agreed with the person receiving support. As a result, there was a risk that people might not be cared for as stated in their care records.

The above was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the inspection in October 2017 we saw care workers had not been allocated travel time between some visits and that the rotas for some care workers showed visits which overlapped which meant they would need to be supporting more than one person at the same time. During this inspection we saw that the care workers had been allocated travel time between visits. Although, some of the travel time allocated would still not provide adequate time to get between the visits and we raised this with the registered manager who confirmed the actual travel time required would be checked when visits were being added to the rota. We did not see any planned visits had times that overlapped with the next scheduled visit.

During our previous inspection we saw that the procedure for recording and responding to incidents was not always followed.

At the June 2018 inspection we saw some improvements had been made to the recording in incidents and accidents. The records included details of what had occurred, any immediate actions taken, the outcome of these as well any other action taken. It also recorded when the incident and accident had been reported to the manager and to social services.

People we spoke with told us they felt safe when they received care and support in their own home. Their comments included "I have faith in my care workers so yes", "Yes, I feel quite safe from any harm from my care workers" and "Yes and I have a key safe so I know who is coming into my home." One person told us "I do when I know who the care worker is – I trust this care worker" and they explained they had previously had a bad experience in their own home so "I am very cagey who comes to my home." Relatives also confirmed they felt their family member was safe when they received care in their home. The provider operated effective systems to safeguard people from abuse. They had reviewed their safeguarding policy and procedures in June 2017 and we saw they worked with other agencies to investigate any safeguarding concerns. Care workers told us they had completed safeguarding training and could explain what safeguarding people meant to demonstrate their understanding.

The number of care workers required to attend each visit was identified from the information provided by the local authority during their initial referral and from the needs assessment carried out once the care package had been accepted. This was reviewed annually or if a change in the person's support needs was identified.

We saw care workers completed infection control training as part of the induction training and the Care Certificate. Care workers were provided with personal protective equipment for example gloves and aprons to be used when providing care.

The provider operated safe recruitment practices to make sure the care workers they employed were suitable to work with people using the service. During the inspection we looked at the recruitment records for three care workers and saw that recruitment checks were carried out as required. These included an application form, full employment history, interview record, two references and proof of the applicant's identity, address and right to remain and work in the United Kingdom. The provider also obtained an enhanced check from the Disclosure and Barring Service.

Requires Improvement

Is the service effective?

Our findings

During the previous inspection we saw the provider had a Mental Capacity Act 2005 (MCA) policy but action had not been taken to ensure the requirements of the Act were met when providing care. We saw during this inspection the provider had made some improvements but was still not working within the principles of the Act.

The 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 provider had introduced a new mental capacity assessment form which was completed as part of the initial assessment of the person's support needs. The assessment was based upon the Act in relation to the person being able to understand, retain and weigh up information to enable them to make a decision and then be able to communicate their decision. The form which was used did not focus on the person's ability to consent in relation to a specific decision or area of the care provided but was a general assessment of the person's capacity to consent to any care. This meant the person's ability to consent to a specific aspect of their care was not assessed and a generic decision about their ability to consent to care had been made which was not in line with the principles of the Act. We also asked the London Borough of Ealing DoLS team for a view on the form and they agreed with us that the document was not adequate to use as a tool to assess people's mental capacity to make decisions.

The records for one person showed their relative had consented to care by signing the informed consent form and the person's care plan. The informed consent form stated a best interest decision had been taken to proceed with the proposed care due to the person having a serious physical illness. The use of best interest decisions would usually be for a person with a cognitive impairment but this has not been specified in the assessment. The medical history assessment and the care plan did not indicate the person was living with a serious physical illness. The mental capacity section of the person's care plan stated they could not do anything for themselves and was unable to communicate but the physical health section of the care plan stated the person could still make choices related to their care via a family member. It was indicated in the care plan that no Lasting Power of Attorney (LPA) was in place. A Lasting Power of Attorney can be issued in relation to either finance or health and wellbeing and legally enables a relative or representative to make decisions in the person's best interest as well as sign documents such as the support plan on the person's behalf. This meant it was not clear if the person lacked the capacity to consent to their care and if the family member had the legal right to make decisions in the person's best interests.

We saw the records for another person indicated they had been assessed as not having capacity to consent to care and a family member had signed the informed consent form, care plan and mental capacity assessment. The LPA section of the care plan indicated an LPA was not in place which meant the family member who had signed the informed consent form did not have the legal authority to do so. A deputy is a person that has been appointed by the Court of Protection to make decisions on behalf of a person who could not make decisions for themselves at the time they needed to be made. The person may still be able to make decisions for themselves at other times and there are two types of deputy, one for property and financial affairs and the second for personal welfare. This meant the family member may not have had the legal right to make decisions in the best interests of the person including consenting to care being provided.

The informed consent form for a third person was signed by the person's relative to consent for care to be provided. The form stated a best interests decision had been taken as the person had a serious physical illness but there was no indication the person did not have capacity to consent to their care or that alternative ways for the person to give their consent had been identified. The care plan had been previously signed by the person seven months before the informed consent form was completed but there was no indication in the care plan as to why the person could no longer consent. There was no record that the person confirmed that they wished the named relative to consent to the care they received. This meant the person may have been able to consent to their care but this was not supported as part of the process to support people make decisions and consent to their care.

The above was a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessments of the competency of care workers in relation to the administration of medicines and moving and handling had been completed but these did not provide robust information to demonstrate the knowledge of the care worker. We asked the registered manager if these competency assessments were carried out in a classroom setting or in a person's home as this was not indicated on the forms and they stated they believed these had been carried out during care visits in people's homes. The forms we looked at indicated each care worker had been assessed as competent in all areas of the assessment but the range of areas identified would not usually be found in relation to one person. For example, for the moving and handling care workers were assessed in relation to use of slide sheets, lying to sitting in bed using aids, transfer boards, manual stand aids such as rotunda, hoists and wheelchairs. The assessment does not indicate if the care worker was observed undertaking the moving and handling tasks or verbally explained their understanding to the assessor.

In relation to the administration of medicines we also saw the activities assessed included what the care worker did if the MAR chart was not legible, if the directions were different on the MAR chart to that on the label and if the care worker had used the appropriate measure for liquid medicines. In relation to the MAR chart information there was an option of "none seen at this time" but all the assessments had been marked as "Yes" indicating the care worker was competent for that task.

The staff responsible for assessing other staff member's competencies were not always qualified to do so. We saw one field care supervisor had completed additional training in relation to moving and handling which enabled them to carry out competency assessments of care workers. A second field care supervisor had carried out competency assessments of care workers in relation to moving and handling but had not completed any additional training to support the completion of these assessments such as a train the trainer course. We saw this field care supervisor had carried out administration of medicines competency assessments. The registered manager provided a certificate indicating the field care supervisor had

completed a level 3 qualification "Championship in safe medicine administration at Level 3 in care environments" but the paperwork did not indicate what the Level 3 related to and if this was a recognised training course.

This meant the provider could not ensure that these assessments reflected the competency and understanding of the care workers in relation to the administration of medicines and moving and handling.

The above was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people using the service if they felt the care workers had received appropriate training to provide care in a safe way. We received a range of comments with most people providing positive feedback but some people felt care workers required additional training in some areas of the care provided. These comments included "I think sometimes some carers need more training in moving and handling. It puts me at risk as some of them do not have the skills or training, I often feel uncomfortable when some carers put me in the sling", "They seem to be ok as far as I know", "Yes, the carers have been caring for me for years", "Yes, they have the training and skills to look after me well", "I think what they need to do is learn to cook. The new carers can't even boil an egg" and "Not always the agency doesn't train the carers in domestic tasks." A relative also confirmed they felt the care workers had received appropriate training."

At the previous inspection we identified the care workers had completed the Care Certificate but competency assessments had not been completed. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. The training records showed all the care workers had completed the care certificate in 2017 which included the training identified as mandatory by the provider.

We also saw at the last inspection that regular supervision sessions and an annual appraisal had not taken place in line with the provider's policy. During this inspection we saw regular supervisions had been completed with a schedule for meetings for each care worker planned for the rest of the year. There were copies of supervision meeting notes and appraisals in the care worker records we looked at.

A detailed assessment of a person's care needs was completed before they started to receive care in their home. The registered manager explained when a referral was received from the local authority it was assessed to ensure the service could meet the persons' support needs. Once the care package had been accepted a field care supervisor would visit the person and complete the needs assessment. This information would be transferred in to the care plan format and the risk assessments would also be developed.

The care plans identified if, as part of each visit, the care worker was involved in preparing meals and/or supporting the person to eat. The section in the care plan related to nutrition identified if the person had any restrictions related to food as well as their preferences for food and drink. The training records indicated all the care workers had completed food hygiene training.

We saw the care plans included the contact details of the person's GP and other healthcare professionals who were involved in providing medical support. The care plans for each person included sections relating to their physical health and sensory issues such as visual impairment or loss of hearing. There was also a medical history assessment which identified any medical conditions the person was living with and any actions which were required in relation to the way care was provided.

Requires Improvement

Is the service caring?

Our findings

We asked people if they had visits from the same care workers or if they often changed so that they could develop good relationship with their care workers. We received feedback with some people confirming they had regular care workers while other people told us they had different care workers visit them. Their comments included "I am lucky now I have regular carers", "Yes I do, it only changes when she is on holiday" and "Yes I have had a regular carer for six to seven weeks now." Other comments included "It varies. I have one regular carer during the week but at the week end it chops and changes", "By and large it is regular carers, but there have been changes because it is a double up (two carers). If someone new turns up the regular carer has to train her up", "It's regular carers during the week but not at the week end. I never know who is coming then", "No I don't have regular carers, they are always changing the carer", "No its always different carers, never regular carers. I don't like it when they change so frequently" and "Always regular carers during the week and a different regular carer at the weekends."

The above shows that the provider had not always ensured consistency in the care workers to enable them to build trusting and caring relationships with people who use the service. In addition, because the provider had not always ensured people were attended punctually staff might not have spent all the time they needed to care for people in a compassionate and caring way.

When we asked about people's experiences of service one person commented "It's ok, new carers are not always very good. Once or twice there are hiccups with the service. Very often the carers beliefs get in the way with my needs. Such as, I like a glass of wine with my evening meal and some carers of a certain religion have refused to give it to me." We asked the registered manager about the person's comment and they told us that when this had occurred some time ago they allocated a new care worker to carry out the visits who was able to meet the needs of the person.

As staff did not fully understand the MCA principles this meant that the service could not always support people in an appropriate way to make decisions about their care and when to involve other people such as relatives to support them to make decisions. We saw an example of a person whose first language was not English and whose care plan did not address the fact that the person could understand information if this was presented in a format suitable for their needs or if the person's relatives were involved in communicating with the person. This meant arrangements were not always in place to help the provider to meet the accessible information standards.

Other people we spoke with told us they felt the care workers were kind and caring when they provided support. Their comments included "They do all the tasks that I want and especially a good chat", "The carers always make sure I am comfortable with the care tasks and we also have a chat", "There is a lot of care and social feeling when I am cared for. I am extremely grateful for them to administer my liquid medications as well", "Well the carers that come here are'' and "The carers are very kind and caring to me daily."

People told us they felt the care workers treated them with dignity and respect when providing care. They said, "Yes they treat me as a person, friend and take care that I am alright and read my needs on a daily

basis", "Yes, they cover me when I am having personal care tasks" and a relative told us "Yes, they respect my family member's dignity at all times."
We asked care workers how they helped people maintain their dignity and privacy when they received care and support. The care workers all confirmed they ensured people's bodies were covered when supporting with personal care, respecting people's preferences and beliefs and getting the person's consent before they started to provide care. For example, "To ensure people's dignity and privacy is maintained by firstly announce myself in upon entering the house. By respecting their choice in how they would want the care, allowing them to do what they can during personal care. Be respectful at all times" and "By respecting their choices and preference, addressing them in the manner of their choice; knocking on their doors and announcing myself before entering, covering their bodies with towel when giving personal care, using words which are respectful, being non-judgmental."

People confirmed they felt the care workers helped them maintain their independence whenever possible when they provided support. Their comments included "Yes the morning visit helps me with personal care, my problem is my backpain", "Yes very much so. The carer is allocated to do my shopping once a week and I accompany him", "Oh my goodness, Yes, I don't know what I would do without the carers help" and "Yes definitely, without this help I would be in a home." A relative told us "Yes the support and care helps my family member to be as independent as he possibly can."

Requires Improvement

Is the service responsive?

Our findings

During the inspection we saw that most care plans were detailed and identified how people wished their care to be provided. There were also a few instances when care plans were not detailed and did not address how people needs would be met. The care records for a person whose first language was not English, stated in the section on personality that if the care workers wanted to tell the person something interesting they should ask a family member to interpret as this would make the person happy. We saw other sections of the care plan, including that on communication, stated the person was unable to communicate their needs but no mention was made to indicate that they could not communicate in English as it was not the person's first language and their relatives would be available to translate when required. This meant the care plan was not clear about how the communication care needs of the person were going to be met and care workers were not provided with appropriate information to help them ensure the person received the care they wanted. We discussed this with the registered manager, deputy manager and care coordinators who explained the person communicated using hand gestures and a family member was usually present but this was not recorded in the care plan.

For another person the initial referral from the local authority stated the person could be moved with the support of two care workers using a turning stand. Since the initial referral the care plan for the person now stated that care should be provided in bed and the person was now bed bound. While the person needs seemed to have been addressed in the care records there was no information in the care folder to indicate that referrals had been made to relevant healthcare professionals such as occupational therapists for a review of the person's needs to ensure they were receiving the appropriate support to meet their needs. This meant the provider had not ensured appropriate actions had been taken in response to a possible change in a person's support needs.

We asked people if they were involved in decisions about their care and support needs. Most people we spoke with confirmed they had been involved with the development of their care plan and their comments included "I presume there is a care plan which is reviewed three or four times a year, which I am involved in", "There were several assessments conducted prior taking on the service, so yes I have been involved in the decisions" and "Yes once a year I have a review of my care plan." Two people could not remember being involved in developing their care plan and one person confirmed they had not been involved. One person told us "No I have never been involved in my care plan."

Care plan folders included a visit summary section with a detailed description of what activities the care worker needed to complete during each visit and identified the person's preferences as to how they wished their care to be provided. For example, the visit summary included if the person preferred to receive personal care in their bedroom or bathroom, when meal and snacks should be provided and if the person required support

We saw the care plans were signed by the person receiving care or their representative when the care plan was developed to show their involvements. The registered manager confirmed a review was completed annually or sooner if the persons care needs had changed.

The care plans identified each person's cultural background and if they had any religious beliefs. A section in the care plan focused on the person's spirituality, hobbies and entertainment. This included what activities people enjoyed doing and how the care worker could help the person to enjoy them. The name the person preferred to be called as also identified for care workers. Information about the personal history, who is important to them and what they were interested in was included in each person's care plan.

As people were not being supported to meet end of life care needs at the time of the inspection the care plans did not include information relating to their end of life care wishes.

We asked people if they knew how to make a complaint and if they had ever made a complaint. We received a range of comments with most people indicating they knew the process of how to raise concerns with some of them confirming they had made a complaint. Their comments included "I presume I ring the office and I have only complained about the carers time keeping", "Yes I do. I made one complaint when one of the carers left a bathroom tap running full on", "My son made a complaint two years ago because of the carers time keeping", "Yes, I phone the office. Yes I have complained when one carer who could not speak English left my kitchen in a dreadful mess', "My son usually does this if I have a complaint, but up to now I haven't had to" and "Yes I would phone the office and no I haven't made a complaint." A relative we spoke with told us "Yes I would phone the office if the office is at fault. But initially would speak to the carer if I am not happy with them. No, I haven't needed to complain."

Care workers demonstrated they knew how to respond to any concerns or complaints raised by people using the service. They told us they would support the person to either discuss the issues with them or contact the office. For example, one care worker told us "I will listen to the complaint and let the services user know that it is their right to complain and pass on information received from them to my supervisor. I will also tell them to put it in writing if they would prefer and show them the complaint from in the service user's folder."

The provider had reviewed their complaints policy and procedures in June 2017 and this referred to Care Quality Commission guidance on how to make a complaint about a care service.

We saw the provider recorded and investigated complaints they received, in line with their procedures and responded to complainants with the outcomes. Where required, the provider sent a letter of apology with details of actions they had taken in response to the complaint. Where the provider made changes to improve the service in response to a complaint we saw this included use of their disciplinary procedures, verbal warnings for care workers, additional training and increased supervision.

Inadequate

Is the service well-led?

Our findings

During the inspection in June 2018 we found four repeated breaches of Regulations that had previously been identified following the inspection in October 2017 with three of the breaches also identified in the February 2017 and May 2016 inspections. Following the June 2018 inspection, we found that whilst there had been a little improvement in some areas, the provider had not made significant improvements at the service to ensure people were not placed at risk of receiving unsafe care and support. We noted that the provider was again breaching a number of regulations and had not met the action plans they had sent us and in the timescale, they had said they would make improvements.

In addition, the provider has been in special measures following the February 2017. When a provider is placed in the special measures framework this sends a clear message to them that they need to make significant improvements at the service. We have further emphasised the need for the provider to make improvements at the service during our inspections in February 2017 and October 2017. However, the provider's management structure and governance arrangements had been ineffective in making the necessary improvement within the provider's own stated timeframe.

When monitoring and assessing the quality of their service, the provider did not always learn lessons, identify themes and act to improve safety for people using the service. Since our last inspection the provider had introduced new systems for auditing daily records care workers completed when they supported people, medication records and people's finances. They also told us they planned to extend the system to audit people's care plans and risk assessments.

However, while we saw the audits office staff had completed of people's daily care records, finances and medicines from December 2017 – April 2018, we did not see evidence that the provider had consistently followed up issues identified in the audits and acted to make sure there was no recurrence. For example, errors and omissions in people's medicines records were not always followed up to identify the cause and any remedial actions needed to improve safety.

Where concerns had been identified, and the provider had recorded that action was needed, this action did not always take place. For example, the audit of one person's daily care notes showed three consecutive days when care workers had not completed the daily care records and it was possible that no visits took place. There was no evidence that the registered manager had followed up this possibly serious omission, as required by the provider's policy and procedures. The audit of a second person's daily care records for March 2018 identified five issues, including missing entries, care not provided in line with the person's plan, legibility, the use of inappropriate language and lack of information in the daily notes. Again, we saw no evidence the registered manager had followed up the identified issues and acted to make sure care workers recorded the care and support they gave people accurately.

Similarly, the audits of medicine administration records (MAR) were not always effective and therefore the provider had not taken action to mitigate the risks associated with mismanagement of medicines. For example, in one case we found that the audits which identified errors in these records had resulted in

changes to the original MAR instead of action being taken to investigate what went wrong and offer support, retraining or supervision to the member of staff responsible for making the errors. The MAR chart audit for another person showed 14 of 22 doses of one medicine were not signed for. Recorded actions by the auditor included discussing with the team and the person's care workers but there was no explanation for the omissions or evidence that further action was taken. We discussed this with the registered manager during the inspection and they were unable to provide an explanation.

During the inspection, we identified a discrepancy between the planned and actual times of care visits. The provider's system for monitoring visits, an ECMS (electronic call monitoring system), allowed for the staff coordinating visits to record any changes to the original planned visits, or the reasons for discrepancies. However, they were not always recording this. The provider had not identified areas of concern, trends relating to visits not taking place as planned or taken action to update records to reflect changes in people's preferences.

The registered manager confirmed that the information recorded explaining the reason for the change in visit time was not monitored to identify any trends in relation to the reason for the delay for example if a person receiving care was regularly changing a visit time due to other commitments. As a result, they had not considered that the care plan may need to be reviewed or insufficient travel time was allocated between calls which caused a delay.

The provider did not always demonstrate they were operating the service in an efficient and effective way. At the start of the first day of the inspection we provided the registered manager with a list of documents including care plans which we wished to review. There was a delay in obtaining these documents with care plans being provided almost four hours later. At the end of the inspection we provided the registered manager with a list of information that we had not seen during the inspection and needed to see. The registered manager had been unable to locate these records when they were requested during the inspection. This information was still being received by us over a week after the end of the inspection and was related to the day to day provision of the service.

On the first day of the inspection we asked the registered manager for the up to date training records for all care workers he currently employed. We were given the information and it was confirmed it was the current record. On the end of the second day of the inspection we were discussing the information in the training records when the registered manager identified the information was not up to date. The current information on the training completed by all care workers was sent to us the following week.

During our previous inspections we had identified that records relating to people using the service did not always provide accurate information relating to the care and support required by an individual and sometimes provided conflicting information. During this inspection we found there were still some concerns about the accuracy of records.

For example, the description of the care to be provided during each visit indicated a person should be helped to move using a rota stand but their care plan in relation to physical health stated a hoist should be used. The moving and handling plan for the person did indicate the use of different equipment was dependant on the person's ability each day but this was not clear in the description of the care visits. This meant people could be at risk of poor care because of inconsistencies in the care records.

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

We saw some examples where audits had identified issues the provider needed to follow up and they had done this. For example, one person's audits of daily records for December 2017 included evidence that the auditor had discussed issues they identified with the person's care workers. A second person's audit for December 2017 identified the need for care workers to record in a person-centred way and again we saw evidence the auditor had followed this up with them. Audits for nine people living in the London Borough of Ealing for February 2018 identified missing dates and visit times, illegible entries, use of inappropriate language and missing care worker signatures. In each case there was evidence the auditor had discussed the issues with the care workers involved. There were no records it indicate that any further action had been taken following the discussion with the care workers.

The registered manager confirmed a questionnaire had been sent to people using the service to get their feedback in December 2017. The responses had been analysed which identified the three main areas that people suggested improvements could be made related to communication, time keeping and staying the expected duration and the standard of work. A list of action areas was recorded as part of the analysis but who was responsible for undertaking the action and when it should be completed by was not identified. There were also no records to demonstrate the progress on completing the actions identified in the analysis.

We asked people if they felt the service was well-led and we received a range of feedback with most people saying they thought in general it was well led but some people gave examples of their experiences. Their comments "Yes, it seems to be ok, it's fine", "I think it could be better, it has improved over the last two years" and "I have got no complaints, sometimes the carer goes out of his way for me." A relative commented "They are ok, but could be a bit more proactive."

Care workers told us they felt the service was well led and they were supported by their manager to carry out their job. Some of their comments included "Regular meetings and interactions with line managers. Training and refresher courses. Support regularly given when required", "Very well led. The concerns raised are respected and dealt with in appropriate manner", "Issues and concerns are dealt with efficiently", "I have always received rapid replies to my concerns, I have always been told on how to carry out my duties, the support plan is self-explanatory and explicit", "Whenever I raise my concerns and issues they are attended to straight away" and "There is appropriate management structure in place in managing the day to day challenge of the staff including complaints. The management is open, transparent and clear and support for development of staff."

We also asked care workers their views on the culture of the service and if it was open and fair and they told us they felt the culture was open and fair. For example, "I think the culture is fair and open", "They are good in guiding and supportive in any situation" and "Yes, I feel the culture of the organisation is fair and open as my input is valued."

People confirmed to us they knew who to contact if they had any questions related to their care. Their comments included "Yes I just ring the office", "Yes the manager or supervisor", "Yes all the information is in the folder" and "Yes I phone or the manager comes out to check all is ok."

We asked people if the information they received from the service was clear and easy to understand. The majority of people told us the information they received was clear with their comments including "The supervisor spent a lot of time two weeks ago discussing my care plan with me, so yes", "I haven't had any recent information, but usually it is" and "As far as I can see it is, yes." Two people told us they found it difficult to answer the question as they felt they had either not received any information or very little information.

The service had a registered manager in post and he was also the director of the company. At the time of this inspection the registered manager had arranged for support from an improvement consultant in relation to quality assurance and auditing. In addition, the registered manager had been meeting with the local authorities that commissioned care packages from the service to discuss the action plan which had been developed following the last inspection and improvements being made.

Meetings for care workers were held quarterly and we saw the minutes of the most recent meetings. The registered manager told us they sent regular emails to care workers with updates on good practice and procedures. We asked the registered manager to provide a list and examples of these emails following the inspection but it was not provided.