

Nestor Primecare Services Limited

Allied Healthcare London East

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?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

The inspection took place on 23, 24, 25, and 27 May 2016 and was unannounced. The last inspection took place in September 2015 when the service was rated inadequate and placed in special measures. Following our last inspection the service had been issued with three warning notices regarding person centred care, safe care and treatment and good governance.

The service is a large domiciliary care service providing personal care to people in their own homes. At the time of our inspection they were working with 178 people.

The service had a registered manager in post. A registered manager is a person who had 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.

Care plans and risk assessments lacked details and did not contain the information required to provide safe care that met people's needs. Medicines were not managed in a safe way and staff did not have the information they needed to support people with their medicines. Assessments of people's needs and associated care plans had been poorly completed. People and staff told us care plans were out of date and did not contain the information needed to provide good care. The provider's policy was for care files to be updated annually, but files had not been amended when people's needs changed before a year had passed.

Records did not clearly record people's involvement in decisions relating to their care. Consent was not always clearly recorded in line with legislation and guidance. Care plans contained limited details about people's preferences. People were not asked about their sexuality and so were not given the opportunity to discuss if this affected their care preferences. We have made a recommendation about supporting people who identify as lesbian, gay, bisexual or transgender.

Where the service supported people to have their nutrition and hydration needs met, this was not clearly recorded and staff did not have the information they required to meet people's needs. When people required access to healthcare professionals, the service provided this. However, when staff were required to monitor people's health conditions they did not have the information they required to do this effectively.

People and their relatives provided mixed feedback about the attitude of staff. People said they felt safe and cared for by their regular carers. However, they did not feel that all staff had a positive attitude and did not think all staff knew how to perform their roles.

Staff completed a comprehensive induction before they started working in the service. However, on going training and support was insufficient to ensure they had the knowledge and skills required to perform their roles.

The service had a robust complaints policy and records showed that individual complaints and concerns were responded to appropriately. However, there was no analysis of complaints and no record that lessons were learnt in response to feedback.

The quality assurance and audit systems in place were ineffective. They did not address issues identified with the quality of work completed by the service.

We found five breaches of the regulations. We have taken enforcement action against the provider and will publish an updated version of this report when all legal appeals processes have been exhausted.

This provider is in special measures. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

People's medicines were not managed in a way that ensured they received them safely.

Risk assessments were not robust and lacked details on the measures in place to mitigate risks.

People told us there were not enough staff to provide good quality cover when regular staff were unavailable.

Staff had received training in safeguarding adults and were knowledgeable about different types of abuse people might be vulnerable to.

Is the service effective?

Inadequate ●

The service was not effective.

Staff did not receive sufficient support and training to ensure they had the knowledge and skills required to perform their roles.

Records regarding consent did not consistently demonstrate the service was seeking consent in line with legislation and guidance.

Where the service was responsible for supporting people with their nutrition and hydration needs this was not clearly recorded and people's dietary preferences were not included in their care plans.

People were supported to access health care professionals where required. However, when the service was responsible for monitoring people's health there was insufficient information to ensure this was done appropriately.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

People told us some staff did not show a caring attitude and they could not build up good relationships with them.

Records did not show that people were involved about making decisions about their care. People told us their preferences were not always respected.

People told us they were treated with dignity and respect.

The service did not ask people about their sexuality and so was not able to show they had considered if this had an effect on people's preferences for care.

Is the service responsive?

Inadequate ●

The service was not responsive.

Care plans were not personalised and did not contain the information required to provide good care.

Care plans were not updated when people's needs changed.

Complaints were responded to in line with the provider's policy. However, there was no analysis of complaints to ensure lessons were learnt.

Is the service well-led?

Inadequate ●

The service was not well led.

Quality assurance and audit systems had not addressed issues identified.

Management reviews did not improve the quality of the service.

The management did not consistently provide the support required by staff working in people's homes.

Allied Healthcare London East

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 took place on 23, 24, 25 and 27 May 2016 and was unannounced.

The inspection team consisted of one inspector, a specialist advisor with knowledge of this type of service, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we already held about the service. We reviewed notifications and safeguarding alerts. We reviewed the weekly action plan that the provider had been submitting to us regarding their progress since our last inspection which took place in October 2015. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with the local authority commissioning and adult safeguarding teams and sought feedback from the local Healthwatch.

During the inspection we viewed the care files of 17 people who used service. We reviewed 12 staff files including records of recruitment, training, supervision and appraisal. We spoke with 11 people who used the service and four relatives. We spoke with 15 members of staff including the nominated individual, the registered manager, the senior coordinator, an administrator, a typist, two care coordinators, two field care supervisors, a trainer and five care workers. We reviewed incident reports, complaints and safeguarding records from the last six months. We reviewed various policies and documents including feedback from staff and people who used the service and other records relevant to the running of the service.

Is the service safe?

Our findings

At our last inspection, in September 2015 the service was not safe. This was because risk assessments were not robust, medicines were not recorded or monitored safely, and recruitment processes were not robust. At this inspection we found the service remained unsafe.

Since our last inspection the provider had implemented new assessment and care plan documentation. The forms contained a series of mandatory assessments to be completed for all people which instructed the staff member completing the assessments to complete further plans of care and risk assessments if required. The assessments were poorly completed, lacked details and frequently contained inconsistent information regarding the level of support people required. For example, records of care delivered showed that one person was receiving support from carers to dress a significant pressure wound but there were no details regarding this wound, or how to manage the risks associated with it contained within the plan. An updated plan was requested from the provider however, this still did not contain sufficient information to mitigate the risks associated with this wound. The updated plan instructed carers that they were not to dress the wound and were to report on any concerns, it did not contain any details of what would constitute a concern. In addition, the updated plan advised carers that, "[Person] should not be in their wheelchair for long periods of time." However, there was no information about what would constitute a long period of time within the document. Likewise, carers were instructed that they should ensure "Pressure cushion is place correctly at all times." However, there were no descriptions to tell carers what the correct position was. Other people had been identified as being at risk of pressure wounds through the assessment process but their care plans contained only generic pressure wound prevention measures such as monitoring of the skin and reporting of concerns. One person's care plan stated "No problems with skin at the moment." Yet when we spoke with them they advised they were receiving treatment from district nurses and care staff to treat pressure damage.

Moving and handling risk assessments were poorly completed and contained information that was unclear. The template provided space for a description of each type of movement a person might require support with, such as getting out of an armchair, getting into and out of bed, transferring from one chair to another. The instructions for carers to follow lacked detail. Following feedback to the provider they submitted updated and amended plans, but these remained of a poor standard. For example, one person required carers to support them transferring from their armchair to a wheelchair, from their wheelchair to the toilet and into and out of bed. The instructions for each transfer were identical and were unclear stating, "Carer to stand in front of [person] with the rollator frame as [person] can use their armchair to help them stand up with the controls, and [person] then turns themselves onto the rollator frame and that can be wheeled to the bathroom and bedroom." Another person's care file, updated following our feedback, stated they did not need support getting on or off the toilet or commode. This conflicted with the information provided to us by this person and their regular carer who both stated that the person waits for the carer to complete this manoeuvre as they require supervision. This meant that risk assessments did not contain accurate or detailed information about how risks were mitigated.

The management of medicines remained unsafe as information contained within care plans regarding the

level and nature of support was inconsistent and lacked details. The provider was asked to update medicines plans for some people following our inspection, but these remained inadequate to ensure that people were receiving their medicines safely. For example, three of the seven updated plans contained incorrect instructions on their medicine administration record (MAR) including two where the instructions constituted an overdose. The care plans stated that people could receive a 1000mg dose of paracetamol every four hours up to six times in 24 hours, when the maximum dose is four times in 24 hours. In four of the seven updated plans there was inconsistent information about the level of support with medicines to be provided. It was not clear if staff were providing verbal reminders, physical assistance with containers, providing support to take the medicines or following instructions of the person who took the medicines. There was also conflicting information about whether or not people's medicines had to be administered at specific times. In two of the updated files a full list of which medicines the person had been prescribed was not available. There was no information in any of the files as to why medicines had been prescribed and if there were any side effects that the care staff should be monitoring. This meant that care staff did not have the information they needed to make sure people were taking their medicines in a safe way as prescribed.

For one person, the updated instructions for their medicines put them at risk of dehydration as it instructed carers, "Do not take more than one or two glasses of water grapefruit juice per day with this medicine." This could have been taken to mean that water intake should be restricted rather than just grapefruit juice. This person was also prescribed medicine administered through a transdermal patch. This meant the medicine was applied to their skin and it is absorbed over time. The instructions for carers were not clear regarding the positioning of the patch or removal of previous patches. The instructions for this medicine clearly state that the location should be varied and patches should not be applied to the same area within 14 days but the instruction for carers stated, "Carers to put it on the opposite sides of the upper arms every morning." This meant there was a risk this person received their medicines incorrectly.

Carers we spoke with were not confident in the actions they would take on discovering a medicines error. For example, when asked how they would respond to discovering that someone had missed a dose of their medicines, one carer said, "I would continue with the next dose and report to the office." They continued, "When someone has extra medicines I write it down and put a note on it so I remember." They did not consider that the MAR chart should be updated to reflect the additional medicines or that medical advice should be sought in the event of a medicines error. When asked what they would do if they made a medicines error themselves, another carer said, "I would panic."

The above issues are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff files showed that some improvements had been made in the recruitment practices, but these were not sufficient to ensure the branch was recruiting suitable people to work in care. Files showed the recording and analysis of interviews remained inconsistent, some answers were not scored and in others it was not clear how the answer recorded received the score it did. For example, one person had received a score of 4, which meant their "answer demonstrates a positive approach and enthusiasm towards the topic strength." Such answers included, "When I see an old person that may have difficulties I always ask them if they need help," "When you go to people who have challenging behaviour you have to be patient with them," and "I never had unexpected situations." Where the service was unable to obtain two suitable references, files contained a letter from the provider stating they would proceed to employ them on the strength of the single reference received. In the files viewed these references were personal references not professional ones and did not provide information about their work performance.

The above is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities)

Since our last inspection, aspects of the recruitment were now managed centrally by the provider's head office. This included reference collection and processing of criminal records checks to ensure people did not have convictions that made them unsuitable to work in care. Three of the seven staff who had been recruited since our last inspection had been employed on the strength of one personal reference and their files contained a letter from the provider stating that although this was contrary to their policy they would continue to employ this person based on their interview and training feedback. The staff in the branch carried out checks on people's identity to ensure they were eligible to work in the UK. The staff completing these checks told us they had received training from head office in how to do this and were confident in raising any issues with identity documents that they encountered.

Staffing levels were set by the local authority needs assessment which stated whether people required one or two carers and the length of the visit. The provider used a computerised system to book staff which ensured the correct number of staff were booked for each call. The issue where the systems had not been updated to reflect changes in people's needs had been addressed since our last inspection. Staff responsible for coordinating carers and compiling rotas told us they were able to find carers to cover unexpected absences. The registered manager told us they usually tried to have two or three carers per person so that there would be someone who knew the person who could provide cover.

However, people and their relatives told us that cover arrangements were not effective and frequently resulted in late visits that were of a poor quality. One person said, "Sometimes I have as many as three different people [carers] in one week and I have to tell them what to do. The office doesn't tell me when they will come and they come at different times. They are supposed to come at 9 and sometimes they turn up at 10 with excuses like they got stuck in traffic or they're covering." Four of the people we spoke with told us they did not think the service had enough staff and this had an impact on the quality of the care they received. One person said, "Sometimes I feel they are a bit rushed. I have to explain to them if they haven't been before." Another person said, "They're not given enough time to do things properly, it's a rush for them. Sometimes they have to say, 'got to go now' and leave. They've got so many people to see to." A third person said, "If they're too late my daughter has to help me."

People gave us mixed feedback about feeling safe with the carers. People told us they felt safe with their regular carers who were familiar with them and knew their support needs. One person said they only felt safe with "The ones that know what they're doing." Another person said they felt safe because, "[Carer's] not too bad. Not as bad as the ones I had before." This person went on to describe a number of interactions with their carer, including changing of call times, missed calls and verbal aggression which the inspector raised as a safeguarding alert.

Records showed that staff had received training in safeguarding adults from harm. Staff we spoke with demonstrated they understood different types of abuse people might be vulnerable to and told us they would report any concerns to the office. Office based staff were knowledgeable about safeguarding adults processes and records showed they escalated concerns to the local authority appropriately. The records of actions taken in response to incidents and concerns had improved since our last inspection and now included follow up actions. However, care plans and risk assessments had not been updated to reflect the outcome of these processes. This meant that people were not always protected from avoidable harm as measures to do so had not been recorded and shared with carers.

Is the service effective?

Our findings

At our inspection in September 2015 we found the service required improvement for effective as staff did not receive the training and support they needed to perform their roles, records relating to people's capacity and consent were not always clear, and the service was not always ensuring that people were supported to eat and drink enough to maintain a balanced diet. At this inspection we found the service had not improved in these areas.

The provider required new staff to attend a four day classroom based induction training programme before starting work with the service. The induction training included safeguarding adults, medicines, moving and handling and infection control. It corresponded with the criteria of the Care Certificate. The Care Certificate is a nationally recognised qualification designed to ensure that staff have the fundamental knowledge they require to work in a care setting. The induction training was assessed and the trainer would record comments and any additional training requirements before recommending staff to start work. The provider had a system in place to ensure that staff remained up to date with identified core trainings, staff were unable to work if their training had lapsed.

After staff had completed their induction training they completed 12 hours of shadowing. New staff were paired with a more experienced carer, their designated care coach, who recorded the tasks they had observed the new staff member completing and provided feedback. Records of these care coaching passports recorded that new staff had completed each task once. One file also contained records of conversations following their early shifts. In these the carer had stated that they had found travel a challenge but there were no recorded conversations about how to manage this challenge. The registered manager informed us that the service was facing significant challenges with the retention of newly recruited staff, telling us, "We have a high churn in our staff. They are not lasting past shadowing." None of the coaching records viewed had been signed off by a manager which means there was no oversight of the effectiveness of the induction support period.

The provider's policy stated that staff should receive support or supervision every three months. This could take the form of spot checks, field care supervisions or appraisals. Records showed that staff were not receiving support in line with the policy. In the five files of staff who had been in post for more than three months, none contained records of spot checks or supervisions that met the provider's policy. Field care supervision and appraisal records that were available were poorly completed and did not support the development of staff skills for their role. The form required care workers and their line manager to complete comments on their performance in specific areas of their role. One staff member had fully completed their part, but their manager had not completed their feedback they had simply signed the form. None of the supervisions viewed identified training needs or areas where care staff might wish to develop their work. One care worker had completed both their three and six month reviews with their line manager, the feedback remained positive in both reviews but their overall rating score had been downgraded from B ratings for all areas to C ratings for all areas with no explanation and no plan in place to support the carer to improve their performance. This meant staff were not being supported to develop the skills and knowledge they required to perform their roles.

At our last inspection we identified that the office based staff had not had the training they needed in order to perform their roles as they did not know how to operate the systems required to coordinate care. This had improved on this inspection as staff told us they were now confident using the systems. Our observations during the inspection supported this as staff were easily able to operate the systems to find information requested. However, records showed that staff who were completing assessments of people and writing care plans had received one training session about how to do this. The quality of the documentation produced demonstrated that this training had not been effective as the assessments and plans were of a poor quality. This meant that overall the service had not followed our recommendation to provide role specific training to support staff in their development and consider best practice for supervising staff.

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

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

People and their relatives told us that carers asked for their consent before performing care tasks. Care staff described how they offered people choices about their care, for example whether they wanted a wash or a shower, or what they wanted for breakfast. One carer said, "I work with one person who doesn't speak English but I still ask her. She will indicate, you show her some options [for example meal packets] and let her choose."

Care files contained a consent form which people had signed to indicate their consent to their care. In two cases this had been signed by a relative and it was not clearly indicated why the person using the service had not given consent. Care files contained conflicting information regarding people's capacity. For example, one person's local authority referral information recorded concerns about their capacity and stated, "Day to day best interests' decisions must be recorded." The provider's memory needs assessment described the person as, "Occasionally forgetful." Another person had had measures put in place to manage risks associated with their memory loss but their care file contained no information regarding their capacity to make decisions. Another person's medical history stated they had "short term memory loss" and a lot of the support described constituted checking that they had completed tasks and encouraging them to do so when they had forgotten. However, the section regarding capacity stated there were no issues. A further person's care plan stated they were living with dementia and, "Cannot do anything for themselves." However, the question regarding capacity concerns was marked no and there was no capacity assessment in the file. Although the principles of the MCA state that there is a presumption of capacity it was not clear that appropriate assessments of people's capacity to make decisions and consent to their care had been undertaken. This meant it was not clearly recorded that the provider was seeking consent in line with legislation and guidance.

Where the service supported people with their eating and drinking needs this was identified in their assessments and care plans. In most of the files reviewed family members ensured that food was available and carers were instructed to heat and serve food that was available. However, there were inconsistencies in the information, particularly when people had been identified by health professionals as at risk of malnutrition. For example, one person had been prescribed nutritional supplements. These are prescribed to people who have experienced weight loss and are at risk of malnutrition. This person's care plan

identified they were at high risk of malnutrition, however, the only instructions for care staff in relation to this was "My carers assist me with feeding me." Where the service supported people with meal preparation there was no information regarding people's dietary preferences in the care plans, instructions were generic and included "Assist me with a meal of my choice." And, "Ensure a drink is within reach." Records of care delivered varied in the standard of recording, while some recorded what people had eaten others did not. For example, one person's daily notes recorded "[Person] had their bath and breakfast and medication. [Person] had lunch and medication. [Person] had dinner and medication." This record was repeated every day for two weeks. This meant the service was not always ensuring that people were supported to eat and drink enough and maintain a balanced diet.

Most people were supported by relatives to access health services. However, where the provider was responsible staff described how they supported people to access health services, for example, by contacting the GP or district nurses via the office. Care staff we spoke with were able to describe the health conditions of the people they supported and how they supported them to manage them. However, where people had health conditions which required monitoring it was not clearly recorded in people's care plans what care staff needed to monitor. Instructions for staff repeatedly told them "Report any concerns to office and log in log book." However, there were no details on what a concern might be. This meant there was a risk that care staff might not recognise a change as a concern and people's health deteriorated.

Is the service caring?

Our findings

People and their relatives spoke positively about their regular carers. One relative said, "They [carers] are kind and chat to her and make her laugh." Another relative said, "They talk to her politely, they're kind and respectful." One person said, "I like the way she [carer] does things. She gives me my confidence and helps me to do things for myself. She just does it right. I can rely on her." Another person said, "She [carer] is nice and lovely." However, other people and relatives were less positive about carers' attitudes. One person said, "Some have a different way of going about things. They don't have the same experience." Another person said, "Most are very good but not all. I feel uncomfortable with some, it's always non-verbal. I comment on everything and sometimes I have to say things three or four times before they reply." Further comments included, "I know they both have kids, so they must care I suppose," and, "They are polite but it doesn't mean you get what you need from them."

The care staff we talked to spoke about the people they supported with kindness and affection, they were able to describe how they knew people's moods and how they attempted to improve people's moods when they were distressed. One carer said, "It's in your heart, it's my responsibility to do it well." Another carer became visibly upset when talking about a period when someone they worked with had become unwell and how they had supported them through their recovery. The carer said, "It's like going to my mum. I care a lot about her."

People gave us mixed feedback about whether or not they were informed of changes to their care. One person told us their carer had changed the time of their calls and had said, "He said I have to take it or leave it. I'd have to find a new carer." Another person told us they had requested an assigned carer but this had not happened and said "The office doesn't tell me when they [carers] will come, they come at different times and they don't bother letting me know." Two other people said their preferences regarding the timing of their evening calls had not been met. This meant that the service had not followed our recommendation that they seek advice and guidance about involving people in decisions about their care, treatment and support.

People told us they felt staff respected their dignity. One person said, "[Carer] always shows respect and takes his time. He undresses me at the top first and helps to put on the clothes first, I do it myself." The carers we spoke with explained how they support people to maintain their dignity during care tasks. They explained that they keep doors and curtains closed and keep people covered during personal care.

Care staff described how they supported people with their cultural needs. The service supported a large number of people from culturally specific backgrounds and care staff demonstrated an understanding of how to support people in a way that was consistent with their cultural values. For example, a care coordinator described how one person had one visit a week dedicated to washing their hair. Care workers described how they removed their shoes if this was appropriate to respect people's culture.

Both care staff and office staff were asked if they supported anyone who identifies as lesbian, gay, bisexual or transgender (LGBT). All the staff we spoke with said that they did not, though one care worker said they

had in the past. One care worker told us they thought the care plan would state if someone identified as LGBT, however, none of the 17 care files viewed contained information about people's sexuality. This meant that people had not been asked for this information and had not been given the opportunity to express if this had an influence on how they would like to receive care.

We recommend the service seeks and follows best practice guidance on supporting people who identify as lesbian, gay, bisexual or transgender.

Is the service responsive?

Our findings

At our last inspection, in September 2015 the service was not responsive. This was because care plans were not up to date and did not reflect people's needs. The service was not investigating or responding to complaints and concerns appropriately. At this inspection we found the service was still not responsive.

Since our last inspection the service had implemented an action plan which involved re-assessing people's needs and re-writing their care plans. However, care plans were of a poor quality and lacked the details required to provide care that appropriately met people's needs. For example, care plans contained a section called 'About me,' For one person this contained identical information to the section called 'summary of risk assessment' and this contained a list of their diagnoses from when they were first referred to the service three years ago.

The level of detail about people's preferences within care plans varied. Some care plans contained good detail about how people liked to be supported, however others were task focussed and only contained the information that had been received from the local authority when they had requested the care package. Some people told us they remembered having a meeting about their care. However, three people said they had not read their care plan and did not know its contents.

Records of care delivered did not correspond with people's care plans. For example, one person's care plan stated they were meant to receive four hours per week to access the community. This visit was not recorded in the person's log book and when asked about it the person said that they were not receiving this support. Other records lacked detail or contained support that was not detailed in the care plan. For example, one person's care plan described support as "Call 9 to 9:45 x 7 days a week (two carers) washing / dressing in bed, preparing breakfast and physical support with medication." The plan contained no information on their preferences for how they liked to receive their personal care, or any dietary preferences. The records of care completed showed this person was supported to have a shower which was not mentioned in the plan. Likewise, records of their meals stated "had lunch" and contained no detail on what they ate. This meant care plans did not include the information required to meet people's needs and records did not capture whether people's needs were being met.

Care staff told us they did not find that care plans contained the information they needed to deliver good care that met people's needs. One care worker told us, "Not all the information is in the care plans." Another care worker said, "The information [in the care plans] indicates what care they need, but you need to speak to people to get more." Care staff told us this had an impact on the care delivered, particularly when they were working with people who were unfamiliar to them. One care worker said, "I don't do cover shifts because you won't get to know the people. I won't do the job properly because I don't know what I'm doing because the care plan doesn't tell me." Another care worker said, "I do cover, but I prefer someone who I've worked with before because I know what to do with them. I'll know what they want and how to do it. The care plan does tell you, but sometimes you need more, like what they actually want to have for breakfast." Care staff told us the people they worked with regularly didn't like it when they had new carers, one care worker said, "[Person] tells me she doesn't like it when it's cover."

The provider's policy stated that care plans should be reviewed annually. As part of their action plan, the service had re-assessed everyone who received a service and written a new care plan. This work had started in January 2016 and therefore, according to the provider's policy no care plans had required a review. However, plans were not updated when people's needs changed. For example, one person said, "I have [a care plan] but it's out of date. It still reads 'shower' but it doesn't work so it's with a bowl." Care staff also told us that care plans were not always up to date. One care worker said, "[The care plan] might say they can feed themselves but maybe now they can't." This meant that care staff did not have the information they needed to provide support that met people's needs.

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

The provider had a complaints policy which provided details of the complaints process and escalation routes if people were not satisfied with the response. The provider used a computerised system to capture feedback and the response provided to this. The last six months of complaints, incidents and feedback were reviewed. Records showed that individual concerns and complaints were investigated and responded to in line with the provider's policy. However, there was no analysis of complaints or record of lessons learnt in order to prevent recurrence. This meant the service had not followed our recommendation to seek advice and guidance from a reputable source about learning from complaints, as they were still not learning from them.

Is the service well-led?

Our findings

At our last inspection in September 2015 we found the service was not well led as they had not been submitting notifications as required to CQC, the management and leadership of the service was not visible or supportive and the service was not monitoring the quality of care delivered in an effective way. At this inspection we found the service was still not well led.

As part of the action plan following our last inspection, updated care plans were signed off by the registered manager. This was in order to ensure that they were of a suitable standard. In the action plans submitted to CQC, it was stated that the registered manager had set aside one day a week to check and audit files. 17 care files were reviewed on the inspection and none of them were consistently of the standard required. This meant the audit was ineffective.

The provider's policy was that medicines records should be audited every six months. The audits were completed by field care supervisors. Records showed that these audits had identified gaps in record keeping for the administration of medicines. The actions taken in response to these errors related solely to advising and training care workers on record keeping. One recent chart was reviewed and showed gaps in administration and during conversation staff responsible for audits did not consider that gaps in recording might mean that people had not received their medicines. It was not until our intervention that the service contacted this person's relative who informed the service they would contact the office if they noticed medicines had not been administered. The provider told us they relied on care workers to report medicines errors and gaps in records in between formal audits. This was not an effective mechanism as the audits continued to identify errors.

The service used an electronic call monitoring system to record when care was delivered to people. Records showed that times that care was received did not match the times that care was planned. For example, one person regularly received support two hours after the system said they should, and another person did not receive care at the same time during the entire two week period reviewed. Other records showed that staff were not consistently using the electronic call monitoring system. Records showed that staff had not logged in or out, or had not used the system at all but had submitted a timesheet instead. The registered manager told us there was no routine monitoring of this information to check if people were receiving care as directed in their care plans. The registered manager told us the information was only reviewed in response to complaints or missed calls. This meant the service was not checking that care was delivered effectively.

The action plans submitted to CQC recorded that the registered manager was auditing recruitment files on a monthly basis and was discussing their findings with relevant staff. This had not been effective as records showed that recruitment practices were not ensuring that the staff recruited by the service were suitable to work in care.

The provider had recently implemented a new quality assurance and audit tool for managers to complete. The registered manager supplied a copy of this, recognising that they had not yet completed it. The registered manager had reviewed two care files and one employee file for this audit. The audit identified

that the care files did not contain all the relevant assessments and plans required to meet the person's needs and reviews had not been completed in line with the policy. The staff file reviewed identified that recruitment and induction processes had not been followed. This was despite the fact that all care files in use had been signed off by the registered manager and the staff file was identified as being a new member of staff, so had been recruited following the registered manager already having audited recruitment files. This meant the service was not able to demonstrate they were providing high quality care.

Nine of the people we spoke with did not know who the registered manager was. One of the care workers replied, "Who is [registered manager]?" when asked what they thought of their management of the service. Care staff told us they received the support they needed from the branch. One member of staff said, "I wouldn't complain about it, I've got nothing bad to say." However, another care worker told us the support they received depended on who answered their call. They said, "The branch is good 80% of the time. Sometimes you're in a client's house and you can't get a response, you want a call back. They don't call us back. If you're in someone's house you need the coordinator to call you back, you need to know what they are doing and what you are supposed to do. If it's not my usual coordinator I have to chase it up." This meant the service was not providing the management and leadership that staff required.

The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Following our last inspection, the person who had been the registered manager left the service. The acting branch manager successfully applied to be registered manager. The registered manager was now permanently based in the branch which addressed our previous concerns regarding on site management and leadership. The registered manager had been submitting notifications of incidents, safeguarding issues and deaths of people receiving a service as required.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed (1)(2)Recruitment practices did not ensure staff were suitable to work in a care environment.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1)(a)Staff did not receive the training and support they required to perform their roles.

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 Care was not person centred as assessments and care plans did not reflect people's needs and did not contain their preferences.

The enforcement action we took:

We have imposed urgent conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not safe as risk assessments were not robust and did not contain measures to mitigate risk. Medicines were not managed in a safe way.

The enforcement action we took:

We have imposed urgent conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place did not ensure the effective management of the service and did not assess, monitor or improve the quality of the service.

The enforcement action we took:

We have imposed urgent conditions on the provider's registration.