Unicare (London) Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We undertook this comprehensive inspection, on 21 September and 1 October 2015, to check on the progress the provider had made to address our concerns from the previous inspection of 22 July 2014, and to check on the standard of care people using the service were receiving.

At the time of this inspection the agency was providing a care service to just under 30 people in their own homes. This included providing a continuous care worker at a supported living scheme for nine people.

Whilst we found evidence to demonstrate that some of our concerns had been addressed, we found a number of breaches of legal requirements. This continued to put people using the service at unnecessary risk of receiving inappropriate or unsafe care.

We found instances where people's scheduled visits did not occur as planned, because staff did not attend. This compromised people's safety and wellbeing, for example, one person did not receive support to take their prescribed medicine as a result of no staff attendance. Processes for supporting people with medicines were not being managed safely. Records about care delivery in people's homes were not made at each visit, and insufficient action was taken to rectify this once the provider identified this risk.

Some new staff provided lone care in people's homes without criminal record checks being in place. This put people at risk of being supplied with a care worker who

Summary of findings

was not of good character. We also found that new staff did not receive the necessary induction training and support before carrying out care to people in their own homes.

The service had not completed relevant risk assessments in some people's homes, for example, on the environment, pressure care, and medicines. Foreseeable fire safety risks had not been identified in one person's home where a fire safety incident occurred.

There remained shortfalls in the effectiveness of the provider's governance of the service. There was limited use of audit tools to identify and address potential service risks. Whilst direct complaints were responded to, the service did not consistently listen to and learn from people's experiences and comments so as to improve the quality and safety of services provided.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager had been appointed shortly after our last inspection, whom we met during this inspection. They had started the process of applying to be the registered manager.

The management of the service was not well-organised. For example, the provider's website was not displaying the rating from the previous inspection.

Whilst training courses were provided to staff on a regular basis, staff were infrequently supervised, and annual appraisal systems were not established. This did not support staff with carrying out their roles and responsibilities.

The service was caring and people were treated respectfully. Most people received the same staff to attend to their care needs, which helped to build trusting relationships.

People or their representatives were involved in making decisions about care packages. There were individualised plans for each person's care delivery that staff followed. The service supported people to maintain good health and a balanced diet.

We found overall that people using the service continued to be at some risk of receiving inappropriate or unsafe care. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the registered provider and will report further on this when it is completed.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. 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.

Summary of findings

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 occasionally did not receive planned care visits. Some new staff provided lone care in people's homes without criminal record checks being in place. Processes for supporting people with medicines were not being managed safely.

The service had not completed environmental risk assessments in some people's homes. Where people had medicines or pressure care support, risk assessments on these matters were not completed. Foreseeable fire safety risks had not been identified in one person's home where a fire safety incident occurred.

Is the service effective?

Requires improvement

The service was not consistently effective. Whilst training courses were provided to staff on a regular basis, new staff did not receive appropriate induction training and support as was necessary before carrying out care to people in their own homes. Staff were infrequently supervised, and annual appraisal systems were not established.

The service supported people to maintain good health and a balanced diet. Principles of the Mental Capacity Act 2005 were followed.

Is the service caring?

Good

The service was caring. People were treated respectfully. Most people received the same staff to attend to their care needs. This helped to build trusting relationships.

People or their representatives were involved in making decisions about care packages.

Is the service responsive?

Requires improvement

The service was not consistently responsive. Whilst direct complaints were responded to, the service did not consistently listen to and learn from people's experiences and comments so as to improve the quality and safety of services provided.

The service assessed people's care needs and set up individualised plans for care delivery that staff followed.

Is the service well-led?

Inadequate

The service was not well-led. There were some systems of assessing and addressing quality and risk. However, these were not consistently and effectively used for oversight of the service and to address identified risks.

Summary of findings

Records about care delivery in people's homes were not made at each visit, and insufficient action was taken to rectify this once the provider identified this risk.

The management of the service was not well-organised. For example, the provider's website was not displaying the rating from the previous inspection.

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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 21 September and 1 October 2015. The provider was given two working days' notice so as to ensure key members of the management team were present. The inspection team consisted of three inspectors and an expert-by-experience (someone who has personal experience of using or caring for someone who uses this type of care service). Their involvement was limited to phoning people, to ask about their experience of the care services provided.

Before the inspection visit we reviewed the information we held about the service including notifications, information from the local authority, and information the provider had sent us.

During this inspection we spoke with seven people who use the service and eight other people's representatives to obtain their views on the service provision. This included visiting four people at a supported living scheme where the service provided personal care to people. We also spoke with nine care workers and had feedback from three community professionals.

During the inspection visits we spoke with the manager and the office co-ordinator. On the second day of our visits, we also spoke with the provider's nominated individual. We looked at the care records of 14 people using the service and five care workers. We also looked at electronic care planning and delivery records, and various other records used for the purpose of managing the service. The manager provided us with further documents at our request after the inspection visits

Inadequate

Is the service safe?

Our findings

Most people using the service and their representatives told us they felt safe using the service. At the supported living scheme, people had no concerns about staff availability, for example, "I know staff will come to help me straight away if I needed them to." However, there were mixed views amongst other people and their representatives on whether there were enough staff to provide planned care visits at all times. Representatives' comments included, "They seem to be having problems getting new carers and they are not getting rotas up to scratch" and "The agency won't answer my questions on the number of carers they have." We were told of occasional visits that were missed. One person said missed visits occurred "quite often. I ring and ask but they don't have anyone to send instead."

One person said, "They missed my Sunday calls. My family were at home and did the care but as I pointed out to the office if I was on my own this would not be satisfactory." When we checked this person's care delivery records, we found no care entries for the first three Sunday evenings of August 2015. In response, the manager told us that the usual care worker had told the person she was not able to attend those visits, that the person had agreed to cancel the visits, but the care worker had not informed the management team of this arrangement. However, the person's care delivery schedule for those visits identified different care workers to attend. As the person told us these were missed visits, and the unattended visits took place across three consecutive Sundays, safe care was not provided to this person on these occasions.

Two people's recent care delivery records included no care delivery entry for either person at a planned morning visit. The evening visit entry for one of them stated that the person had not had their morning tablets. At our first visit, the manager told us this would have reflected a visit cancelled by the person's representative, and that she was not aware of any missed visits. However, the booking schedule for one of the people showed that a care worker was assigned to visit. We asked the manager to look into this. She confirmed at our second visit that these were missed visits, with further checks being made to establish how that occurred and an action plan set up to prevent reoccurrence. We also noted that minutes of the July 2015 staff meeting included discussion about a missed visit, despite the manager telling us none had occurred. Safe care was not provided to these people on these occasions.

People's representatives provided mixed feedback about medicines support. Comments included, "They give mum her medication and make sure she takes it" and "This is an area they could do with better training. One particular medication is complicated and they find it so." Three out of four representatives could not confirm that specific records of providing medicines support were made, for example, "They don't fill in anything to record what medicines they have given and when."

At the supported living scheme, people told us they always got their medication on time. One person said, "Staff know me and respect my decision, there are times when I am just not ready to take it, but they always come back with it." Medicine administration records (MAR) were completed correctly, these included records of refusal or when a person was absent.

For people outside of the scheme, there were two recent MAR available in the office, covering the last three months. There were occasional administration gaps in the MAR despite care delivery records confirming staff attendance. The MAR did not clarify what medicines staff provided support with, as the prompts on the MAR for this were left blank. The management team told us that there was a separate list of what medicines people were being supported with, however, we found this was not kept up-to-date. The process did not enable staff to sign for each specific medicine they were providing support with.

One person's MAR from June to August 2015 included staff signatures three times a day. However, lunchtime signatures stopped on 6 August 2015. Their care plan stated that staff only provided medicines support on Sunday mornings, which contradicted the medicines support that staff were signing for on the MAR. The MAR for July 2015 has staff signing for support at lunch until the 23rd, then signing at tea from 24th onwards. The person's recent care delivery records referenced supporting the person with two different inhalers, however, inhalers were not part of the service's current list of medicines for the person. This was not proper and safe management of the person's medicines within the care being provided.

Inadequate

Is the service safe?

The manager confirmed that there were no individual risk assessments in place for any support that was being provided to anyone with their medicines. The provider's medicines policy included for recorded competency assessments of new staff supporting people with medicines for the first time, with documented monitoring of the support after three months and then annually. However, we saw no record of any such assessments in the files of the three current care workers we looked at. These omissions put people at further risk of unsafe management of medicines.

Staff gave us examples of how they encouraged safety within people's homes. Their comments included, "I check to make sure the cooker is off and that windows are locked" and "One of my clients smokes. I always check his ashtray and make sure that he has one near him. If I'm worried I call the office for help." All staff knew to phone the office if there was no answer when they attended someone's home.

Of the 11 care files we checked at the office, seven had environmental risk assessments in place. There were none for two out of five people at our first visit, which the manager confirmed as accurate despite identified risks around medicines safety recently referred to her. Environmental risk assessments were in place for those two people by the time of our second visit, however, the medicines issue was not mentioned. We also found at that visit that there were no environmental risk assessments for two out of six other people. The failure to assess risks to people's health and safety when receiving care did not ensure that safe care was provided to people.

One person's file included a specific pressure care risk assessment that was only half completed. There was no entry, for example, against the person's skin type, medicines and continence, despite other records showing they received medicines support. No overall risk for developing pressure ulcers had been established. We saw reference to staff applying cream to one person so as to minimise the risk of ulcers developing, however, their pressure care risk assessment was blank, over a year after starting to use the service. Another person's needs assessment stated that they began the service with a pressure ulcer. Their care plan provided staff with guidance on support needs in respect of the ulcer, and referenced district nurse involvement. However, there was no risk assessment relating to their pressure care needs, over three months after starting to use the service. This failure to assess risks to these people's skin integrity when receiving care did not ensure that safe care was provided to people.

One person told us they felt safe at the supported living scheme but expressed concern about how they would exit the front door in the event of a fire "as it is dependent upon staff deactivating the lock." The manager told us there was ongoing work to ensure that individual fire evacuations plans were in place for some people at the supported living scheme. We saw that this was recorded as needed on two people's files, which did not assure us that all reasonable actions had been taken to minimise risks to these people.

One person using the service experienced a fire safety incident following a care delivery visit to their home a few months before our visits. They came to no harm, but they were put at avoidable risk to their health and safety. We noted that the care worker at that visit had not worked alone for the provider before. The management team informed us the care worker had worked a shadowing visit at that person's home beforehand, however, records of this were not available on request. Following the incident, the person's care plan had been updated to include guidance on fire safety matters; however, the environmental risk assessment had not been reviewed and updated, including for key safe use despite clarifying action on that point being set in the action plan arising from the incident. This did not demonstrate a comprehensive assessment of health and safety risks for care delivery to this person, which compromised the safe care of this person.

The last spot-check we found of staff at this person's home was dated 12 April 2015. The management team stated that a further spot check had been planned following the incident, however, it had not occurred at the time of our first visit. This did not demonstrate a prompt action to help ensure the action plan arising from the incident was ensuring that safe care was being provided to the person.

The above evidence demonstrates a breach of Regulation 12(1)(2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records of five new care workers who had provided care to people in their own

Is the service safe?

homes. The files included paperwork showing that application forms were filled out, identity checks were made, written references were acquired, and right to work in the UK was established where needed.

The management team told us that they made sure they had a cleared criminal record check before allowing new staff to shadow experienced staff in advance of working alone. The provider's recruitment policy and induction policy stated that new staff would not work alone until the criminal record check was in place.

There were cleared criminal record checks in place for each care worker. However, there was no date on the copy made of the criminal record check of one care worker, so we could not confirm that it was in place before the care worker started work. We found that two of the five care workers had been providing care alone in people's homes before the date of the criminal record check held by the provider. The criminal record date for one care worker was 8 May 2015, however, we found they had made regular care delivery records in one person's home from 10 April 2015.

The other care worker worked alone at the same person's home three days before the date of a criminal record check. The provider did have a copy of another criminal record check on file for that care worker, however, it again lacked a date. The provider had not taken all reasonable steps to ensure the good character of these care workers before supplying them to provide care to people alone in their homes.

The above evidence demonstrates a breach of Regulation 19(1)(a)(3)(a) Schedule 3 part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with about safeguarding people from abuse told us they had done relevant training. They demonstrated a clear understanding of the types of abuse that could occur, the signs they would look for, and what they would do if they thought someone was at risk of abuse including who they would report any safeguarding concerns to. One member of staff said, "people can face different sorts of abuse and we have to be very alert to this."

Requires improvement

Is the service effective?

Our findings

Most people and their representatives told us that staff received training, for example, "They seem to have been trained quite well" and "Everyone could do with more training but they have a lot of common sense. One carer is going through a training programme at the moment." However, feedback included that new care workers did not shadow experienced care workers. One person said, "New carers don't shadow regular carers; I tell them what they need to do." A representative told us, "Whilst new carers are introduced to us they seem to learn on the job; no shadowing."

We checked the induction process for four care workers who started working for the service in the last year. There was evidence of them signing receipt of staff handbooks, company contracts and specific policies such as non-acceptance of gifts. The management team told us new starters spent a few hours in the office, before typically working five days with an experienced care worker. There were forms for this shadowing process that identified 15 specific tasks including personal care, medicines, meal preparation and records. However, this whole process omitted various important topics required for the new care worker to carry out their duties. For example, it did not consider abuse awareness and prevention, or least restrictive practices. The process did not follow the provider's staff induction policy, which stated, for example, "Before the new employee begins work, the manager, or their delegate, will ensure that a full induction programme is specified." The policy guided managers towards using induction packs that would be signed off as completed, however, none of these were evident on the files of new care workers. This did not ensure that new staff received appropriate training as was necessary to carry out care to people in their own homes.

Care delivery records showed that one care worker was providing care alone at someone's home on a number of occasions during April 2015 despite their shadowing process not being recorded as starting until 10 May 2015, two days after the date of a cleared criminal record check. When we checked the five days of work of the experienced care worker during the shadowing period, we found it amounted to six care visits to the same person, which did not belatedly give the new care worker a broad experience of care delivery. The provider did not ensure that this care worker was provided with the comprehensive training needed to ensure that could carry out their employment duties, both when the care worker started providing care to people alone, and beyond their formal induction process.

The manager told us that there was improved training for staff. Staff commented positively on the training provided, for example, "Training is very good, we learn from it. We are continuously refreshing our knowledge." At our first visit, we saw evidence of broad training sessions having been run on three occasions this year, for which the manager said staff were encouraged to attend all so as to be refreshed, and that the training covered all identified needs. However, whilst the training included appropriate topics such as nutrition, dementia and diversity, it did not include training on pressure ulcer awareness and mental health needs. As we found the service to be providing care to one person who had a pressure ulcer throughout their time with the service, and support to a number of people with mental health needs, the training provision was not sufficiently broad. By the time of our second visit, we were shown that the mental health training had been provided to staff and that pressure care training was planned for.

The management team told us that the expected frequency of staff supervision was at least three-monthly, with additional spot-checks in people's homes of the standard of care provided. The supervision file had 27 supervision records of individual care workers across the previous ten months, giving an approximate supervision frequency of the 16 staff at once every five months. In particular, there were only six supervision records across the last four months. This fell short of the manager's stated supervision frequency, and did not demonstrate appropriate support of staff for their roles and responsibilities.

When we checked supervisory support for individual care workers, we found that one new care worker, working regularly for six months, had no record of supervision. The manager told us they supervised this person at the time of a visit to a person's home, however, there was no record of this and it contradicted the supervision arrangements we were told of at the start of the inspection visits, that supervisions took place at the agency's office. This did not demonstrate appropriate support of the care worker for their roles and responsibilities.

The manager told us there had been only one staff appraisal in the previous ten months, as only one care

Is the service effective?

worker had brought back a completed appraisal form. However, whilst the last two staff meetings reminded staff of the value of supervision meetings, for example, for development opportunities, staff were not reminded to attend appraisal meetings. This did not demonstrate appropriate appraisal of staff for their roles and responsibilities.

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

One person told us of good support with hydration, saying, "They made me a cup of tea at night before bed and in the morning before I got up." People at the supported living scheme told us staff supported them to prepare meals. One person said, "They are always advising me on what is good for me and what is not." Another said, "Staff encourage me to eat at least one substantial meal a day." We were also shown a range of food in a fridge in the office and were told this was "for people to use when they run out of things; they will never go hungry here." A community professional told us the service encouraged people to eat healthily and kept them informed if significant concerns were arising.

However, some representatives were concerned about the ability of care workers to provide good nutritional support. One representative told us, "They seem to lack basic cooking skills and only seem to want to do ready meals." Another said, "I don't think they understand enough about her diet and needs or about cooking. Neither carer is cooking as even trying to do an omelette they find difficult."

People's care plans provided individualised guidance on nutritional support. One person needed staff to encourage them to eat breakfast, and recognised that they preferred to eat dessert at lunch first. Staff were reminded to leave people with drinks, and to provide people with choices for meals. Another person had specific guidance on how to enable them to access drinks easily. We saw care delivery records for one person that reported on the home-cooked food provided to them. The manager told us that another person was assigned specific staff wherever possible who could cook according to their cultural preferences. We saw that the specific staff member was often assigned to visit this person.

We saw advice from a speech and language therapist in relation to one person's dietary needs. A care worker demonstrated an awareness of the specific needs of this person according to the recent guidelines and told us, "We make sure they eat what is safe for them."

Most staff told us of having had training on nutrition and food hygiene, which records confirmed. They spoke of ways in which they encouraged people to eat and drink enough, for example, "I make sure my client is sitting upright when she's eating, then she'll eat. I have to keep encouraging her to eat. If I'm concerned I'll call the office." We were assured that people were supported to eat and drink enough and maintain a balanced diet.

Some people made positive comments about the service supporting them to maintain good health. One person said, "When I had a diabetic 'hypo' the carer waited with me until the ambulance came." A representative told us, "If ever they were worried about her they would talk to us, for example, once they found a red spot on her leg and told us that she should see the doctor about it." Another representative said, "They will change times to fit in with hospital appointments and if we need them to stay longer they will try their best to accommodate us. They will bend over backwards to try and support her needs."

Records and feedback from the management team demonstrated occasions when they had responded to concerns about people's welfare. For example, ensuring people attended hospital where staff identified the need. The manager wrote to one person's GP in response to wound care concerns, and told us that reassessment of someone's needs was to take place after a period in hospital. Care delivery records included when staff accompanied people to healthcare appointments, and when people were visited by community professionals. We were assured that the service supported people to maintain good health.

Feedback indicated that people were asked for their consent to care. For example, one person's representative told us that "they ask her consent" before personal care support. Staff demonstrated a sufficient understanding of the Mental Capacity Act 2005 (MCA) and told us how they sought consent from people "for everything." Records and feedback showed recent training on MCA principles, and we saw that the provider had a current policy in place on the MCA.

Requires improvement

Is the service effective?

We saw occasional reference to people consenting to their care within care delivery records. The manager told us that people's views were listened to, and consent to care acquired, for example, with sending self-assessment forms to people and their representatives before agreeing to provide a service. Where any restrictions on care practices were in place, this was with the agreement of the involved person. We were assured that the service was provided in line with MCA principles.

Good

Is the service caring?

Our findings

People and their representatives fedback positively about getting on well with staff. People's comments included, "The carers were delightful" and "The staff are so caring, so respectful of your dignity. They speak to you, rather than over you." Representatives told us, "Mum got on really well with the carers, had a good rapport and a good relationship with them" and "They have a great rapport with mum and they have a laugh and a joke."

We saw evidence of positive, caring relationships between staff and people using the service. At the supported living scheme, we observed good interactions, and noted that people were confident when speaking with staff. We saw a care delivery record about a care worker calling a person's representative because the person was not well. Staff spoke positively about their relationships with people, for example, "I take my time to feed my clients. I use a small spoon as my client prefers this." The manager told us that at one visit, a relative of the person using the service was found injured, so staff waited extra time until an ambulance arrived. For another person, the manager wrote to the social worker on the family's behalf to explain the person's increasing needs.

Most people and their representatives told us of receiving the same care workers for most visits. One person said, "I have the same three." Another person told us, "I get same lady during the week." Representatives' comments included, "When we set up the care for mum we were reassured that we would have regular carers and there about three of them" and "Yes she gets two regulars. I asked for that as she gets confused." Most people's care delivery records indicated that the same staff usually attended to people. This helped to better meet people's needs and build trusting relationships.

People and their representatives fedback positively about being treated with respect. One person told us, "They help me with toileting and personal care but encourage me to do the areas I can reach myself." Another person said, "She covers my private parts when necessary but encourages me to do my hair and the places I can reach." Representatives' comments included, "They are nice to her and close the door when dealing with her personal care so no one can walk in on her."

Staff gave us examples of how they treated people respectfully. Their comments included, "I make sure that no one else is in the room when doing personal care. I close the door as well. I ask them if it's alright for me to do the care" and "I close the curtains and the doors and try not to fully undress the clients."

At the supported living scheme we observed staff speaking to and treating people in a respectful and dignified manner. Care plans and records were respectful to people and there was some emphasis on enabling choice and independence, for example, explicitly stating to give one person time to complete tasks themselves.

People and their representatives had mixed views on being kept informed of late or altered visits. Representatives' comments included, "If carers are going to be late they might tell us but not always" and "They don't ring and let you know so when I get anxious I ring the office and they then look into it."

However, people and their representatives all told us they were involved in making decisions about care packages. One person said, "Yes I was involved in my plan. I decided what times I wanted as I am a late riser." Another person told us, "They are always checking with me if things are as I want them to be." Representatives' comments included, "Yes we were all involved. They understood what was required" and "We were involved and our views were taken on board and the plan implemented after I had been sent a draft which didn't require amending."

Staff gave us examples of how they involved people in the care delivery, for example, "I'll ask the client what they'd like. I'll give them choices so they can choose for themselves" and "I try and encourage them to do as much for themselves as they can."

The management team told us of plans to provide a service to someone imminently. They had met family members, but were aiming to meet the person themselves in advance of providing care, to ensure the person was involved in the planning process.

Requires improvement

Is the service responsive?

Our findings

People's care files showed that before they started receiving a service, their needs were assessed. We saw copies of these assessments in all of the care files we looked at. They were comprehensive and had a good account of the person's support needs and any challenges presented. They also listed the other professionals involved and family contacts where available.

A person using the service told us, "The staff speak with me about my care plan and we discuss the support I need." We saw that there were individualised care plans in place for each person. For example, following a safety incident in one person's home, their care plan had been revised to clearly guide staff on keeping the person safe. However, we noticed that where there had been updated guidelines issued by a Speech and Language therapist for one person, this was not reflected in the person's care plan. The manager told us the care plan was in the process of being updated, but staff had been made aware of the amendments. We subsequently spoke with a member of staff who was able to tell us how this person should be supported, in accordance with the new guidelines.

The manager told us that they ordinarily reviewed people's care packages six monthly, although more frequently in response to changed needs. We found instances where the care plans did not completely match people's current needs. For example, the management team told us of one person having five visits daily which their visit schedule confirmed, however, the care plan stipulated four visits and so had not been updated. Another person's care plan indicated their last visit of the day was at 14:30; however, care delivery records for the last couple of months showed that the visit was now taking place at about 18:00. There was a risk that out-of-date care plans could result in people receiving care that did not match their needs and preferences.

Most people and their representatives told us of the service being responsive to their particular requests. However, there were feedback trends about visits being late and even missed, not being kept informed, care workers sometimes failing to record their visits, and invoices not reflecting actual visit times. The manager told us she was not aware of this feedback apart from late visits. On that point, we saw staff meeting minutes and a care worker's supervision record addressing punctuality concerns, indicating that action was being taken.

Some people and their representatives did not think the service had recently asked them their views on service quality. One person said, "Never been asked for feedback." Representatives' comments included, "We have never been asked for any feedback on the service and no spot checks have taken place over the six months of care" and "Managers do tend to check up now on carers in one way or another."

The manager showed us a file containing a number of surveys that people and their representatives had returned within the last few weeks, along with a number from earlier in the year and records of some phone calls to people about service quality. The manager said she was aiming at quarterly checks of people's views on the service. However, when asked for evidence of analysis of the surveys and actions taken to address concerns, the manager said there was none. We saw two responses to people thanking them for sending surveys in, with a five month gap in-between. The same letter was used, including a brief statement of the same service-wide shortfalls to improve on. This confirmed that detailed analysis of the surveys had not taken place, and so people's experiences were not always learnt from.

Some people and their representatives told us of directly raising concerns and complaints. Most added that they felt the management team had resolved matters promptly. One person said, "I did complain over the phone; should have put it in writing though. They did sort it out fairly easily." Representatives' comments included, "As a family we do ensure the office is aware of things that happen and need improvement. I feel the manager does take our complaints seriously."

A complaints system was in place, and we saw that people at the supported living scheme had a copy of it in their Service User Guide. The manager showed us a complaint file there. It had four complaints raised since the beginning of the year. We saw these complaints were resolved, with the written resolution logged in the file.

The service's complaints policy welcomed complaints, aimed to resolve matters to people's satisfaction, and hence make improvements to the service. Most feedback

Requires improvement

Is the service responsive?

confirmed this approach to complaints. The policy added that complaints were to be recorded in the service's complaints book, including verbal complaints. The manager said there had not been any complaints from people using the service or their representatives in the last ten months, outside of the supported living scheme. This was in contrast to a number of people and their representatives telling us they had complained. In conjunction with the feedback about some service shortfalls that the manager said she was not aware of, and the lack of analysis and action arising from survey results, we concluded that the service did not consistently listen to and learn from people's experiences, comments and complaints so as to improve the quality and safety of services provided.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was evident that the manager and co-ordinator knew the individual needs and preferences of people using the service well. This also came across in people's care plans and reviews, where people's particular needs and preferences were established, for example, not visiting one person before a certain time each day.

All staff we spoke with told us that there were care plans available in people's homes to guide them. Most spoke of guidance from the management team before visiting people, for example, "Before seeing a new client we are given information about them and their family, everything."

The manager told us how the service's role at the supported living scheme included "getting people back into the community, so we support and encourage them as much as possible to learn new skills such as cooking and budgeting." One person told us, "Staff support me to regain my independence, I am sure I will get back to fully independent living." A community professional praised the service's work with people. This indicated care that responded to the needs of people at the scheme.

Inadequate

Is the service well-led?

Our findings

People and their representatives had varied views on the management of the service. One person said, "Office needs better organisation" and cited missed visits they had experienced. One representative described the manager as "conscientious" and "compassionate." Another told us, "They need training on efficiency and handling resources" but "when I am not happy and have phoned they have responded appropriately."

Most people and their representatives told us that care workers did not always make a record of their visit. One person said, "Only one of the carers writes in the book; the others say they don't have the time as they are in a rush." Representatives' comments included, "Not all the carers write up what they have done. They have time to fill it in but some are rushing so claim they can't fill in the forms" and "They only fill in the plan once a day not on each of the visits per day."

Our checks of people's care delivery records confirmed the above feedback. For example, one person's records for an eight day period in April 2015 had staff booked to visit on 19 occasions, however there were only 11 care delivery records. A similar 14 day period in July 2015 for the same person had staff booked to visit on 30 occasions, however, there were only 19 care delivery records. This did not demonstrate accurate, complete and contemporaneous records of care delivery at this person's home.

Following a fire safety incident in the above person's home in mid-July 2015, the provider set an action plan that included ensuring care workers recorded the care delivered at every visit. The manager said staff had been verbally informed of gaps in people's care delivery records occurring, and that evidence of recording their visits was needed. However, at a staff meeting eight days after the incident, this concern was not documented as being brought to the attention of staff. The incident itself was not discussed according to minutes of the provider's management meeting the subsequent day. This did not demonstrate effective systems to monitor and address risks arising from staff failing to record the care delivered at each visit.

The management team told us, for the purposes of checking people's care delivery records, they relied on staff bringing these into the office on a monthly basis. However, some people's care files did not have recent care delivery records. For example, the most recent for one person was from May 2015. There were no records being made to document the detail of any checks of care delivery records, despite the shortfalls previously identified. The management team told us that the overall plan to address the identified recording shortfall was to provide staff with training in September 2015. However, as the issue was identified in mid-July 2015, the actions taken to address the issue did not demonstrate effective operation of systems to monitor and address risks arising from staff failing to record the care delivered at each visit.

We noted that other records relating to people using the service were not always accurate and complete. For example, at our first visit, one person using the service for over three months was found not to have an entry on the provider's computer system that was used, for example, to plan care visits. Another person's visit records on the same system had no care worker assigned for five out of 40 visits in September. We checked the care delivery records and found that care had been recorded as delivered at those visits. The manager told us that risk assessments relating to one person's care package were with the person's representative for signing. There was no copy of the assessments available in the office, despite the office having a photocopier.

The manager told us she aimed for quarterly spot-checks of staff delivering care in people's homes. The spot-check file demonstrated that this was not occurring as planned, as there were approximately 20 spot-checks in place for the last nine months, indicating an average of a spot-check of each care worker once during this period. The file included an oversight document on who had been spot-checked, however, this had not been updated for five months. This was not effective operation of a system to assess, monitor and mitigate risks to people's health, safety and welfare.

Records showed that one care worker had been working in people's homes since April 2015. A spot-check of their performance took place shortly after starting work, which identified that they did not have an identification badge on them. No actions were listed in response to this. We established that the care worker did not have a cleared criminal record check at this time, and so had no contract in place or initial induction records at that time. The

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spot-check system was not operated effectively in this instance, to mitigate the risks to people's health, safety and welfare arising from the care worker recruitment and induction processes not being complete.

When we asked if there had been any suspensions or staff disciplinary processes this year, the manager told us of an incident involving this care worker in early September 2015 that may have compromised the safety of a person using the service. This resulted in an action plan being set up including for additional training for the care worker on safeguarding, and a spot-check of their work taking place within a week. However, there were no recorded spot-checks of this new care worker since they began working over five months beforehand, and the incident was not recorded in the service's incident file. This was not effective operation of systems to assess, monitor and mitigate risks relating to people's health, safety and welfare.

The provider's quality assurance policy stated that monthly audits would take place across the service, using standard audit tools, for discussion at management meetings. When we asked to view current management audit and oversight tools, they could not be provided. We were told that, for example, an administrator was updating the training matrix at a separate location. The audit tools were not provided for viewing during or following our visits despite our requests. We also saw no reference to their use in the provider's last two management meeting minutes. This did not demonstrate effective systems to assess, monitor and mitigate risks to people's health, safety and welfare arising from the care delivery.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our first visit, the current rating of the service's performance was displayed in the office. However, it was in black and white, which did not make the rating conspicuous. This was rectified at the second visit. At the time of drafting this report, the provider's website did not display the rating. The manager told us the website was due to be renewed. However, since April 2015, it has been a legal requirement to display our rating on each website maintained by the provider in relation to the service.

The above evidence demonstrates a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with reported a positive and inclusive culture at the service. They told us, for example, that they could phone the management team for support at all times. One care worker said, "They take needs of clients and staff to heart" which we saw examples of. There were seven staff surveys that were five months old, all providing positive feedback about support for their role.

Records and staff feedback demonstrated that staff meetings took place at least every quarter. A further meeting was planned following our visits, to remind staff of performance standards relating to concerns we identified at this inspection. Following our visits, the manager sent us a template for the oversight of staff matters such as training and supervision, and a template for visit-monitoring where identified as needed for five people using the service. We were also sent a copy of a letter to all staff reminding them about ensuring all visits took place punctually and that records of the care delivered at each visit were promptly made.

The service did not have a registered manager in place at the time of the inspection visits or drafting the report, a period of just over a year. The manager told us she had been in post since October 2014. She had applied for registration in that role just before our first visit. The application was being considered at the time of drafting this report. The manager told us she was currently taking a national qualification in management that included fortnightly assessments.

We asked about the lack of spot-checks of one care worker since they had an employment contract in place over six months ago. The management team and told us they had not worked since 1 May 2015, which the computer booking system confirmed. However, we found a record of the manager supervising the care worker on 20 August 2015. The manager told us that the care worker was attending training and so the opportunity was taken to supervise them. However, the recent training sessions given to all staff did not include training during that month, and the care worker's training certificates were most recently dated as May 2015. The supervision record referenced the care worker providing care to people. For example, the record stated the care worker "feels more relaxed at her permanent service user" and "to speak with some of the

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carers to swap their shifts." The manager explained that this referred to work the care worker undertook for another care provider. However, the supervision record was within the provider's office supervision file, and the care worker was declared on the list of current care workers supplied by the manager a few weeks in advance of the inspection visits. This did not demonstrate an organised, well-led service.

The police were called to one person's home as a result of a fire safety incident involving a care worker. The manager notified us of the incident 15 days after it occurred. This delay in notifying us did not indicate an organised, well-led service, although we noted that a further incident was notified to us promptly.

During the inspection visits, we were told of the provider's computer system malfunctioning. We were told it also occurred the week before our first visit. We noted that our request for people's contact details, in advance of the inspection visits, was delayed as the password used to protect people's data was not supplied for five additional days. During our first visit, we were told that the email address for the provider's nominated individual had changed and so the email address we had been using was not reaching that person. At our first visit, we asked the manager to arrange for the correct email address to be sent to us. We reminded the manager and the nominated individual of this at our second visit. We emailed the manager a further reminder eight days later, which resulted in the new email address being supplied after considerable delay. We also saw documents that referred to legislation that had been superseded over five years ago. For example, the provider's Statement of Purpose referred to 2002 regulations, and staff application forms referred to the Care Standards Act 2000. All of these matters did not demonstrate an organised, well-led service.