London Care Limited

London Care (South London)

Inspection report

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12 December 2018
13 December 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced inspection of London Care (South London) between 10 -13 December 2018. This was carried out as we had received information of concern about the service.

London Care (South London) is a domiciliary care agency which provides care and support to 430 people in the London Borough of Southwark. At our last inspection in October 2016 we rated this service 'Good'. At this inspection we rated the service 'Requires Improvement'.

People were put at unacceptable risk of neglect due to missed visits. There had been a failure to plan visits in advance which lead to office staff struggling to cover calls at the last minute. People frequently had one care worker attend when they needed two. Care workers were often unable to meet people's basic needs as a result. People and their families spoke of their extreme frustration at the situation and were unable to contact the office for help. Care workers also reported being unable to contact the office if they needed crucial information.

There were failures in the management of the service. This included key care co-ordinator roles falling vacant and being covered by supervisory staff. The service had taken on additional people's care packages that they were unable to manage. The service had a registered manager, but they had resigned. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had recruited a new branch manager and care co-ordinators, but these staff were yet to start work. There had been a breakdown in the regular functioning of the service which impacted on the supervision of care workers and audit processes. There were failures in the management of medicines and important records relating to medicines, care and handling people's money were not checked for mistakes. The provider was aware of the failings of the service and had an action plan in place to address these. This did not fully prioritise the highest risks to people using the service and at the time of our inspection this had not yet been fully implemented.

People told us their regular care workers were kind and caring, but the consistency of staff had deteriorated due to recent events. The provider had good processes to assess risks and plan people's care. There were sometimes missing and incomplete records of the support people received to manage risks and equipment was not checked to ensure it was safe to use.

People had good quality care plans which reflected their needs and preferences for care. Until recently care workers had been recording how they had provided support which met people's needs, but often staff had to record how they had been unable to care for people. The provider lacked systems to assess people's capacity to make decisions about their care.

We found breaches of regulations concerning consent to care, safe care and treatment, staffing and good governance. Following the inspection, we requested an urgent action plan from the provider on how they would address these breaches. This described in more detail what would be done to address the most serious failings we identified and safeguard people from missed visits.

We issued two warning notices regarding staffing and good governance. The provider is required to be compliant with these regulations by 31st January 2019. We will carry out a further inspection of this location within six months of the publication of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People suffered neglect as their basic needs were often not met.

There were processes in place to assess risks to people but mitigation plans were not always followed. Equipment such as hoists were not checked for safety.

Staff were recruited in line with safer recruitment processes but often insufficient staff were deployed to meet people's needs.

Medicines were not safely managed and there was insufficient auditing of medicines records.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

The provider did not assess people's capacity to make decision or follow best interest processes.

Care workers received appropriate training to carry out their roles. Office staff did not always receive training in operating systems. There were processes to supervise care workers but these had recently deteriorated.

Care workers supported people to maintain good health. People had support to eat and drink, but recent disruption had affected this.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

People felt their regular care workers were caring and treated them with respect. There were often poor consistency of care workers and people often did not know who would be supporting them.

People's communication needs were assessed and included in their plans. People felt care workers respected their dignity and

promoted their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's plans were designed to meet their needs and care workers followed these. However, recent disruption in the service had impacted on how people's basic care needs were met.

The provider did not follow accessible information standards.

There were processes followed to investigate and respond to complaints, but people were very often unable to contact the office to complain.

Is the service well-led?

Requires Improvement

The service was not well led.

There had been a widespread failure to properly plan the provision of care. Crucial administrative roles were vacant.

There were insufficient checks on people's records to detect issues of concern.

The provider had an action plan to improve the service, but at the time of the inspection this did not prioritise the immediate crisis engulfing the service. Following the inspection action was taken by senior managers to put a robust action plan in place. We will check the effectiveness of this at our next inspection.

London Care (South London)

Detailed findings

Background to this inspection

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

Why we inspected- as part of our monitoring role we received a high number of concerns in a short space of time from people using the service, some of whom made serious allegations of neglect. We passed these concerns to the local authority safeguarding team. We also were contacted by several staff members who shared their concerns anonymously about the service.

We carried out this comprehensive inspection in response to these concerns. The inspection took place on 10 -13 December 2018 and was unannounced. Prior to the inspection we spoke with several senior officers with the local authority.

The inspection was carried out by three adult social care inspectors, a specialist professional advisor who worked as a pharmacist and three experts 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.

We looked at records of care and support for 25 people, and records of medicines management for 12 people. We looked at records of recruitment and supervision for 10 care workers. We spoke with 16 care workers, three field care supervisors, a quality assurance lead, the registered manager and the regional director. We made calls to 34 people who used the service and three relatives.

Inadequate

Is the service safe?

Our findings

People were not safeguarded from abuse as the service left people at high risk of neglect. Care workers had received training in safeguarding adults and were confident in recognising the signs of abuse. Staff we spoke with demonstrated clearly their role and how they kept people safe and secure in their homes. A number examples were given by staff of reporting any safety concerns that arose promptly to supervisory staff. Comments included "I really feel safe with my regular carer" and "I feel very safe with the carer."

There was evidence that when safeguarding concerns were raised these were reported to the local authority and appropriate action taken by the provider.

However, people were at high risk of neglect of their basic needs due to a failure to provide adequate staffing. When people required two care workers to meet their needs, for example to operate a hoist, we saw that this was very often not taking place. One person had not received care from two care workers as required on 24 occasions in 33 days. For another person this had happened on 17 occasions in this period. Care workers had recorded how they had been unable to hoist people, and on some occasions had had to do this with family members. In many cases people's continence pads were not changed, and showers were not provided. This included a person being left in a wet bed, and another person who was left in their wheelchair overnight due to the one care worker being unable to hoist them into bed.

The provider acknowledged that this was a significant problem and we asked to see action plans for how they would address this urgently which they provided. We heard of the concerns expressed by care workers when the service was disrupted due to second care workers not attending, these they said were due to office organisation and shortage of staff at certain periods of the week. A member of staff told us "I take the abuse [from families]. If my parents were neglected like that I would do the same."

This constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had good systems in place for assessing risks to people's safety. This included simple systems for assessing people's risks from falling, how people could be supported to mobilise safely and how the provider ensured a safe environment to provide care. Risk assessments had built in simple plans for managing risks to people. For example, when people were assessed at being of high and medium risk of skin breakdown there were steps required, such as to keep a record of when people had been supported to change position. However, when people were assessed as being of medium risk, this was not taking place even though it formed part of the risk management plan. For one person who was at high risk records of repositioning were not complete; as these books had not been audited this had not been noted by managers. Some people's plans indicated that they had pendants to call for help in the event of an emergency, and it was part of people's plans that this be checked on visits, but there was no record of this taking place.

Where people had hoists to help them make transfers there were assessments in place for how best to hoist

people and how many staff were required to make these transfers. Care workers told us that they received practical training in this which meant they were confident in hoisting people. We couldn't be sure that equipment was safe to use. Although risk management plans indicated that care workers should visually check the equipment was safe, there was no system in place to check that hoists had been professionally checked and serviced. A relative gave us an example of when they had seen a care worker carrying out an unsafe lift. One person told us "You get what you pay for, but they are a bit rough."

In some cases care workers provided support to people with emptying catheters and stomas, but there were no risk assessments in place for these activities.

Medicines were not safely managed as although there were robust policies and procedures, these were not always followed. Procedures included a detailed risk assessment for how to manage people's medicines and processes for how to report errors or refusal of medicines. People's support was assessed based on their level of need, including whether care workers administered medicines or prompted people to administer these. This included highlighting time critical medicines, swallowing difficulties and the presentation of the medicine.

Care workers received training on how to manage medicines safely. A whole day was allocated to medicines which also included continence, pressure area care, catheters and stomas. Care workers also completed workbooks to demonstrate their knowledge which were signed off by trainers. Competency checks were carried out which required care workers to demonstrate their skills.

People's medicines were recorded on medicines administration recording (MAR) charts. These formed part of people's daily log books. MAR charts we viewed contained frequent errors and omissions. For some people there were gaps in signing of more than six occasions in the month; this included two people who received controlled drugs. One person was prescribed an anticonvulsant to be taken twice daily, but in the six weeks covered by the MAR chart this was only recorded as given as prescribed once. Another person was prescribed a once daily medicine which would affect their kidney function; this was highlighted on the MAR chart to be given twice daily and on one occasion it was recorded as given three times in the day. A person was prescribed a statin to be taken once daily, but on 20 occasions in the month it was recorded as given twice in a day.

Procedures clearly stated that log books, including MAR charts were to be returned to the office no more than two months after the first entry to be audited. Out of the 12 records we reviewed, only one had been audited, and this audit had not noted some gaps in recording. Some books as far back as July had not been audited, and errors and omissions such as those we saw were not noted or investigated by senior staff. An audit had been carried out by a quality assurance lead which included a check of medicines management. The provider told us that this was carried out based on who was considered to have the highest risk medicines, but in practice this was based on the records of just four people who were chosen at random. This correctly identified that all four people chosen had gaps in their recording, but this did not appear to have triggered a wider management response.

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

People told us that problems in the branch had impacted on the punctuality of their call times. Comments included "At times they can't get a replacement carer, I often have to wait up to a couple of hours for help", "Sometimes up to two hours late ."

The provider had robust recruitment procedures in place to promote safety and ensure staff were suitable for their role. We found appropriate recruitment checks were carried out for all applicants before they were employed. Information held for each staff member included photographic evidence, completed application forms with employment history, health declarations, references and a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. Only staff who were deemed suitable were recruited.

The provider had policies and procedures in place to prevent and control the spread of infection. Care staff told us they had attended training on infection control and their training records supported this. Comments included "they always wear gloves and aprons; the carers are very good."

Requires Improvement

Is the service effective?

Our findings

The provider was not meeting the requirements of the Mental Capacity Act (2005) (MCA). The Act 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.

In most cases people had signed their plans to indicate their consent. There was a checkbox to indicate when people were unable to sign but had otherwise consented, but there was no further evidence on how this had been verified. People's plans indicated when they may have difficulty making decisions and the support they received from families in making decisions, but there was no process for carrying out a mental capacity assessment for particular decisions or demonstrating how a decision was made in their best interests. In some cases plans stated that family members made decisions for people in their best interests, and in some cases people had signed to consent to their plans even though assessors had recorded that people could not make decisions for themselves. In other cases people's family members had signed plans in their capacity as holders of lasting powers of attorney, but there was no evidence obtained that family members had these.

This constituted a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Policies and procedures as well as staff training on the MCA helped identify anyone who needed advocacy or additional support in making decisions. Care workers told us that training they received helped them understand mental capacity assessments, also the ability of the person to make decisions was respected by staff who understood the principles of the MCA. People were offered choices in all areas of their care and wellbeing. One care worker said, "I always assume a person can make their own decisions. Sometimes I may need to prompt them but it's their choice as to how independent they want to be." Staff were aware that people were supported to make decisions about their health and welfare such as by a relative or appointed advocate through the Office of the Public Guardian (OPG).

The provider had a training and development programme in place to train and develop the staff team. Care staff were supported to keep their knowledge updated and in line with best practice guidance, for example dementia care. Records showed that mandatory training was completed by all staff and refreshed as frequently as required. For example manual handling training was undertaken annually, food hygiene every three years.

A training matrix was in place to monitor staff training and to address training needs at the frequency required, care staff confirmed they attended the training as required and that they could not attend their work if the training was not up to date. Office supervisors had received a limited amount of training and felt additional areas of training were required. Some supervisors who were filling the roles of the care co-ordinators had not had training in rostering and electronic call monitoring systems, despite these systems

being safety critical. Staff turnover in the office was high in recent months with the loss of three care coordinators in a short space of time. The manager and area manager acknowledged that some refresher training was overdue and this was recorded in their compliance and quality checks.

The majority of care staff we spoke with were experienced care workers with lengthy periods of service in care roles, these ranged from ten to twenty five years. Care staff told us of their competencies and confidence in caring for people with complex needs and specifically in using equipment to move people safely. Care staff told us their training helped to ensure they identified and managed the risks effectively encountered in people's homes. Examples were given by staff of informing the sensory department of the local authority to ensure people with impaired vision had the appropriate assistance to help them remain in their home.

The provider had policies and procedures in place regarding staff supervision and support. Support and supervision sessions were expected to be completed every quarter. The registered manager ensured that staff were supported with regular supervision and observation of their working practices but the frequencies of these supervisions and spot checks had lapsed in recent months. The manager and supervisors told us these shortfalls were due to volume of changes to office staff. Experienced staff were used to assist new staff during the induction period and shadow them for the initial weeks. A care worker told us they enjoyed helping new staff on their induction and explaining further what is expected when caring for vulnerable people especially those with complex physical needs. One care worker said, "My supervision gives me the opportunity to say how things are for me. If I ask for more support I get it, lately it is not so frequent." A new care worker told us that their induction had prepared them well for their role as a care staff member with shadowing of experienced staff and guidance from them. Staff got to know people well and this helped people live more independently.

Assessments contained suitable information for recognising people's nutritional needs, including highlighting when people may be at risk from malnutrition. This highlighted any allergies people had, medical conditions which may impact on people's ability to eat and drink, people's ability to prepare food and eat it and any current dietary advice. There was brief information on people's likes and dislikes. Care plans were clear about when people required support to eat and drink and this was recorded accurately by care workers which showed people were supported to have balanced diets. However, there was evidence that missed and late visits had impacted on this area of support. Most people we spoke with told us that they received support with food, but a small number expressed concern at their support in this area. A relative told us "I've come in to visit my [my family member] and he's had nothing to eat all day."

Care staff shared with us examples demonstrating they worked together with GPs, community nurses and occupational therapists where needed to ensure joined up care. Staff told us they felt it important to keep people's relatives informed about their family member's health status if needed. Care plans were clear about the support that was provided by other professionals, such as when district nurses supported people to change dressings or maintain skin integrity. A person who used the service told us ""[my care worker] notices if I am not well. She helps me to keep my independence".

Requires Improvement

Is the service caring?

Our findings

Most people we spoke with told us that they felt their care workers were kind and caring. Comments included, "My regular carers are good, they help me to keep my independence" and "The carers do a blinding job". A small number of people expressed concern about their carer workers, particularly when they received support from people who were not their regular care workers. One person told us "On Wednesday the lady just sat and used her phone, she then wrote in the book that she had helped the client to dress" and another said "Some of the staff go in and they don't even speak to [my family member]."

People's plans were designed in a way which identified how people may have difficulties communicating and how best to promote good communication. There was information on difficulties people had, such as those with memory, mood changes or concentration, and coping mechanisms which could help people.

Plans included personalised details such as people's preferences for food and drink, needs related to their religion and culture and preferred social activities, although at times this information was brief. For example, one person's plan identified that they were a Muslim, and although it stated, 'no pork' there was no other information on cultural or religious observances the person may require support with, or any information on other languages people may speak. There was brief life story work which highlighted people's past employment histories and family backgrounds and some information on people's interests, but less information on people's personalities and what was important to them.

People did not always receive support from a consistent care team. For example, one person who received three double handed visits per day had been supported by 15 different care workers in one week and 14 in the next week. A person with a double handed package with four visits a day had received support from 18 people in seven days and 13 people in the next week. A person who had three single handed visits per day had seven different care workers one week, nine in the next and eight in the week after that.

We received mixed views on people's consistency of care. Comments included "We thankfully manage to keep the same team of carers." And "During the week I do [get the same staff], thank fully. At the weekends it can be anybody and they never stick to the rota" and "I don't always get a rota, so I don't know who is going to arrive" and "I would just like to have a regular carer again". One person said "They want to send different carers every time, I don't want any Tom, Dick or Harry when I am getting undressed, I want regular carers it's not nice, and not respectful"

Staff with the right skills worked together with each other staff assigned to successfully meet their needs. One very experienced care worker told us how they had supported a 99-year-old person for more than 10 years to remain independent in their own home. They said, "As they advanced in years I felt privileged to care for the person right up to their last days, they had confidence in my presence and know I am compassionate and caring." Another care worker with twenty five years' experience told us of responding flexibly to a person's needs who attended frequent hospital appointments and frequently had their visiting times adjusted accordingly. Comments from people included "The care has helped me to regain confidence and I am getting stronger, and getting my independence back." And "they do let me do as much as possible

for myself even though it takes longer. They are very patient and understanding."

Requires Improvement

Is the service responsive?

Our findings

People's plans were clear about how people needed to be supported. Plans identified people's goals, although these were always confined to people's objectives for their care. This included when people wished to develop or regain a skill and the support people required to maintain good hygiene, food intake and a clean home.

Assessments were used to put together a clear plan for each visit which reflected people's needs. Plans had all been reviewed during this year and continued to meet people's needs. We did not see any examples of plans that required updating. Summaries of plans for each visit were uploaded onto an electronic system, which meant that this was printed on care worker's rotas when they received them.

When we reviewed logs of care from August and earlier we saw that care workers were documenting the support they had provided in a way which clearly demonstrated people's needs were met. More recent logs, particularly those from November showed that when calls were attended care workers had delivered care in line with plans. However, when there was insufficient staffing in place, care workers had recorded the efforts they had made to contact the office and arrange for a second care worker and were reduced to recording what tasks they knew needed to be done but were unable to carry out. They had also documented who they had reported their concerns to and the impact on people of not meeting their needs. One care worker documented trying to call the office 11 times to arrange a second care worker but had not been able to make contact. Another told us that they had arrived at a person's house to cover a call but were not able to obtain the keysafe number as they were unable to contact the office.

There was evidence of responsive care. For example, care workers had identified the need for a person to have a hoist in place and had worked with the local authority to arrange this. Care workers gave us examples of when they had referred people to health services and dieticians.

The provider was not meeting the Accessible Information Standard (AIS). The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. Plans did not flag when people may need information in accessible formats and we did not see any evidence of alternative formats available to support communication with people.

There was a process in place for responding to complaints. This included when people and their families had contacted the service and when quality alerts had been raised with the local authority. When this occurred the provider had investigated, including checking log books and call monitoring records and interviewing care workers. Staff were given additional training or supervision or warnings as appropriate. The provider had written to people with the outcome of the investigation and actions that they had taken, such as arranging for a more consistent pool of care workers to support people.

There had been a clear and noticeable increase in the number of complaints received since August. One complaint had been received in April 2018, none at all in May and June, three in July and seven in August.

Some recent concerns had not yet been investigated, and the registered manager told us they were quite behind with these due to the current situation in the branch.

Almost everyone we spoke with told us that they had difficulty contacting the office to make complaints of late or missed calls. Comments included "I can't get through to the office, the phone is not answered or they pick the phone up and put it down", "Last week the carer did not arrive, I spent all day trying to get through on the telephone", and another person said "They only seem to do anything when I threaten to take my complaint further, or make it official".

Most people we spoke with told us they were unable to contact the office, and people spoke of being patronised and dismissed when raising concerns. The phone system was set up to cut out after 10 rings, and many people interpreted this as the office putting the phone down on them. As part of the provider's action plan they implemented changes, including to increase the ringing period and to give people an opportunity to leave a message.

Requires Improvement

Is the service well-led?

Our findings

There had been a widespread failure to plan people's visits in advance. This had followed the provider taking on additional care packages which they were unable to manage. A high number of care workers were on annual leave at the same time. The provider had a rostering system which prevented care workers from being given overlapping calls or being scheduled calls when they were off work. This demonstrated that on a typical day one in eight calls required being scheduled either the day before or on the day of the call. This was usually over 100 calls. The amount of work involved in this was significant. For example, on a Thursday afternoon the system showed that 345 care calls needed to be covered for the weekend. In many cases office staff and the registered manager resorted to covering calls themselves. As part of the branch's action plan, the office staff were required to email the regional director to demonstrate how many calls were still outstanding.

Several office staff reported on the challenges they faced in 2018 due to workload and lack of additional resources. One staff member told of transferring several people who use the service to another organisation because of a decision by the purchasing authority, this caused further disruption to office planning. Care workers we spoke with told us that they were able to take on additional calls but did not have the opportunity to do so.

The provider operated an electronic call monitoring (ECM) system, which required care workers to log in when they had arrived. Use of this system had worsened in recent months, with compliance dropping to 76% in November. The system could not show how many calls were missed, as these only appeared as missed if they were scheduled, which was often not the case. A senior member of staff told us that although the ECM system would alert co-ordinators to when care workers had not arrived, these alerts were not being monitored due to the sheer volume of work in covering calls. The provider told us that the information on the ECM system provided by the local authority did not always match people's regular care times, which made it difficult to monitor these alerts.

Comments from people using the service included "The carers are all pretty good, but the office never get themselves straight", "The office staff are not helpful, they don't answer the phone, or they often hang up, and they never ring back when they say they will", "The office staff can be very patronising towards me" and "We have had a lot of problems with carers not turning up , but they never answer the phone." Other comments included "It is nearly impossible to speak to someone" and "I think they've taken on a lot of work and they can't do it."

Several co-ordinator posts were vacant with the work being covered by field care supervisors. This had also impacted on other systems of audit. For example, we looked at over 20 log books for a period between August and November 2018. These included pages for senior staff members to review log books and financial records for errors and issues of concern. None of these had been audited despite the logs indicating major issues of concern and in some cases evidence of neglect. Of the 12 medicines administration records we reviewed, only one had been audited despite some significant errors. A service wide audit had looked at the records of four people who were chosen randomly. Only two people looked at

were considered at risk of pressure sores, and in both cases, issues were identified with regards to the use of repositioning records. This had not resulted in a further investigation.

This constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider showed us an action plan which had been drawn up by senior managers in response to concerns about the branch's performance. Whilst this was broad in its scope to address all areas of poor performance, we had concerns about how measurable aspects of the actions were. A senior manager told us "There's a lot of extra cover needed and that's not how we should be working... It's frustrating as they have some amazing staff out there."

There was a plan in place for addressing the cover of all calls. This correctly identified areas for improvement but there was a lack of firm timescales for achieving this and it lacked detail on how exactly the designated person could achieve this. In some cases, it stated that some areas were the responsibility of 'branch' but it was not clear who was responsible. It also failed to prioritise the most urgent risks to people using the service.

The provider had acknowledged the problems with the service and prior to our inspection had requested a meeting with the local authority to agree an action plan to address these concerns and had requested a temporary embargo on accepting any more packages of care. The provider had promised us and the local authority that a senior member of staff would be based at the branch, and this was the case throughout our inspection, including when we arrived unannounced.

Following our inspection, we asked the provider to provide us with an improved plan for how they would address the more urgent and serious findings of our inspection. This was completed by senior managers in the organisation and was more detailed in how the immediate crisis would be averted and how the service would move away from covering calls at short notice to having planned further ahead. This included demonstrating a safeguard which would highlight when one only care worker was booked to attend a call which required two workers. The provider gave us the names of additional staff who would be working in the office on this.

The provider had good systems in place for recording the care and support people had received. This was in the form of books which included all necessary charts that care workers may need to complete, and forms for auditors to complete. Care plan and risk assessment documents were overall well designed, although we identified some areas which needed to improve. These documents were designed as a carbon copy, which was both efficient to complete and meant that people received a copy of their assessment and plan as soon as it was carried out. There was a branch monitoring system in place for recording incidents, complaints and safeguarding issues; this allowed senior managers to monitor performance in a wide range of areas. The quality assurance lead demonstrated how the system showed that key measures such as supervision and spot checks were trending down.

People received checks from managers to make sure that they were satisfied with their care. This included checking whether people were happy with the punctuality and performance of their care workers. This was either through telephone calls or visits to the person's house. This typically took place every three months; however, we saw that few of these checks had been carried out in recent months, with 12 of the people we checked having not received a quality assurance check in the past 3 months.

Care workers told us that in most cases they had sufficient time to travel between their calls to arrive on

time. We looked at a sample of five care workers rotas and found that 98% of calls could be reached within 15 minutes of the scheduled time. A care worker told us "The rota is well planned; the jobs are well spaced out. The biggest problem is the covers."

A serious case review had been carried out by the provider in response to several incidents of care workers misusing social media whilst on duty. In response to this they had carried out an information sharing campaign to highlight the risks of using social media on duty and required all staff sign a policy relating to the use of mobile phones.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant person as the registered person did not act in accordance with the Mental Capacity Act (2005)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way as the provider did not do all that was reasonably practicable to mitigate such risks, ensure that equipment used for providing care was safe for such use and did not ensure the proper and safe management of medicines 12(2)(b)(e)(g)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity 17(1)(2)(a)

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, skilled and experienced persons were not deployed by the provider 18(1)

The enforcement action we took:

We issued a warning notice