Enterprise Care Group Ltd

Enterprise Homecare

Inspection report

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Date of inspection visit:
29 November 2017
30 November 2017
01 December 2017

Date of publication:
14 February 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place over three days on 29, 30 November 2017 and 01 December 2017. We gave the service 24 hours' notice.

Enterprise Homecare is a domiciliary care service providing personal care and support to people living in their own homes. The length of visits for care and support vary depending on the assessed needs of people, with calls ranging from 15 minutes or more. At the time of this inspection, 202 people were in receipt of service. However, not everyone using Enterprise Homecare receives regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

We last inspected Enterprise Homecare in March 2017. The service was rated 'requires improvement' overall and 'inadequate' in the key question of well-led. At the last inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of safeguarding people from abuse; receiving and acting on complaints; and good governance.

Following the last inspection, we met with the provider and sought assurance that sufficient improvements would be made and sustained, to ensure the quality of the service improved to attain a rating of at least 'Good' at this inspection. However, this has not been the case. During this inspection we found continued systemic failures and multiple breaches of regulations. We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of safe care and treatment; dignity and respect; person-centred care; complaints; staffing; fit and proper persons; and good governance. We have also made a recommendation with regards to consent and mental capacity.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the continued and multiple breaches of regulations identified during this inspection, demonstrated that systems and process were not operated effectively to ensure compliance.

We looked at people's care records to ensure the care and support which people needed was being delivered safely and that risks to people's health and wellbeing were appropriately managed. At the last inspection we acknowledged some improvements had been made in this area but during this inspection, we found these improvements had not been sustained.

We found where a person who used the service was deemed to be a 'high risk' for a particular care related activity, such as risks associated with moving and handling, eating and drinking or pressure area care, there was little or no information about how the service sought to mitigate such risks. Risk assessments were too

subjective and generic and not based on a formalised assessment or scoring tool. We also found that reviews of risk were not completed in a timely manner.

We reviewed how the service sought to ensure the people's medicines were managed safely. At the last inspection this had been an area of concern. During this inspection we found improvements had not been sustained and medicines were not always managed safely. Issues identified included the timeliness of administering 'time critical' medicines, the availability of a medicines support plan in a person's own home, procedures for when medicines were seen to not be taken and the competency and training of staff.

We looked at how the service sought to ensure newly recruited staff were suitable to work with vulnerable people. We looked at a sample of recruitment records and found a variety of issues including incomplete application forms with some sections completely blank, unaccounted employment gaps and missing employment references. This meant the service was not able to consistently demonstrate the suitability of candidates to work with vulnerable groups before an offer of employment was made.

At this inspection we saw that the provider had invested in mobile telephones for staff to improve call monitoring. We looked at a number of records in relation to call monitoring and saw that call logging had improved. Electronic call monitoring records we looked at reflected that staff were not always staying for the full commissioned time with people, however we were assured that visits had taken place.

Electronic visit schedules were sent to all care workers via their mobile phone handsets and important information, for example about risks posed to people receiving a service, was included. We evidenced that information was not always added to the system once identified and there was no electronic audit trail with regards to people's changes in need. We were not always assured that staff were provided with the most current information in relation to the person's health condition and risks.

Enterprise Homecare provided a service to people who lacked capacity. For example, people living with a diagnosis of dementia. However, we were not assured that people were always supported to have maximum choice and control of their lives and we were not assured that staff always supported people by the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We checked to ensure staff were receiving regular supervision sessions. Staff supervision provides a framework for managers and staff to share key information, promote good practice and challenge poor practice. We found the completion of supervision sessions to be sporadic and not in line with company policy. When performance issues were identified, these were not always addressed.

Enterprise Homecare served a diverse and multi-cultural community in and around central and south Manchester and the client base was reflective of this. However, we found equality, diversity and human rights had not been embedded into everyday practice. One person who used the service was living with a visual impairment but we found the service had failed to provide information in an accessible format.

People were not always involved in decisions about how their care package should be organised. Records were not sufficiently detailed to demonstrate how and when people may have been involved, or indeed, if they had chosen to not be involved.

The service was unable to demonstrate effectively that care and support was delivered to people in a person-centred way. We found an unacceptable variation in the quality of care plans and plans were too task orientated and lacked meaningful information about the person.

In order for any service to be considered 'well-led', good governance is fundamental. At this inspection we found continued systemic failures, with no tangible improvements. In particular, in respect of the overarching governance of this service.

We found no progress had been made with regards to improving audit, quality assurance and questioning of practice. We looked at records that were described as 'quality assurance' but these were not fit for purpose and did not demonstrate how the registered manager maintained oversight of the service. Furthermore, we found governance arrangements in respect of the registered provider to be non-existent and no evidence could be provided to demonstrate how they maintained oversight of the quality of services being delivered from this location.

The overall rating for this service is 'Inadequate' and the service continues to be in 'special measures'. This is the third consecutive inspection where one or more of the five key questions has been rated as 'Inadequate.' We are therefore reviewing our enforcement options. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people who used the service were adequately assessed, risks were not always mitigated, and reviews of risk assessments were not always completed.

The service had failed to make sustained improves to ensure people's medicines were managed safely.

Procedures for the safe recruitment and selection of staff were not always adhered to.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act 2005 were not adhered to. The service did not effectively consider the needs of people who may lack capacity. In particular, people living with dementia.

Some people who used the service did not consider all staff to be suitably trained to carry out their role.

Staff supervision and questioning of practice was not effective.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People who used the service told us they considered the vast majority of staff to be caring. However, some people told us they were not always treated with dignity and respect.

Equality, diversity and human rights was not embedded into everyday practice and the ethos and culture within the service was reflective of this.

People and their loved ones or lawful representatives were not always involved in decisions about care.

Is the service responsive?

Inadequate

The service was not responsive.

Care and support was not delivered in a person-centred way and was too task orientated.

The management of complaints continued to be ineffective.

Is the service well-led?

Inadequate

The service was not well-led.

Improvements had not been made or sustained to ensure the safety and quality of services being provided were complaint with regulations.

Overarching governance remained inadequate at both registered manager and provider level. In particular for audit, quality assurance and questioning of practice.

Enterprise Homecare

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 29 and 30 November and 1 December 2017. We gave the provider 24 hours' notice of the inspection as we needed to make sure someone would be in the office on the days of inspection. The inspection team consisted of two inspectors for the three days of inspection. The inspection included visits to the home care agency's premises and to people in their own homes. An assistant inspector contacted six people who used the service and four staff by telephone and spoke with them to obtain feedback about the quality of the service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. As part of our on-going monitoring of this service since our last inspection, we also spoke with local authority contracts and commissioning team to gather their views of the service.

During our inspection we spoke with the registered manager, two care co-ordinators, a training and recruitment officer and six care workers. At the time of our visit the service was providing personal care and support to 202 people. There were 84 members of staff employed at the time of our inspection.

We spent the first day of the inspection at the provider's registered office, speaking with staff and looking at records. These included care plans and associated documentation, staff recruitment files, staff training records, supervision records, various policies and procedures and other documents relating to the management of the service.

On the second day of inspection we visited eight people in their own homes and spoke with them to gather their views on the service. Five visits included meeting staff who were there to provide support for the person, speaking to relatives and a person's representative. We looked at paperwork kept on file in people's homes relating to their care.

Inadequate

Is the service safe?

Our findings

We asked people whether they considered the service provided by Enterprise Homecare to be safe and we received a mixed response. Comments from people who used the service included, "I've had two missed calls, no phone call, no apology, nothing but I didn't complain."; "Yes, I normally feel safe. I'm mostly happy but not happy when they don't turn up; this happens on average twice per month. If I phone to tell them I'll get an explanation and apology but if I don't then nothing happens." and, "They make me feel safe; I am anxious and they know that so they reassure me."

During the course of our telephone interviews with people who used the service, one person disclosed to us that on occasions, they felt bullied and intimidated by two particular care staff. The nature of the allegation centred on the derogatory manner in which the carers spoke with this person and an allegation of theft. We raised our concerns with the registered manager who started an immediate investigation and removed the care staff. Community health professionals involved in this persons care were also informed and a safeguarding alert was raised with the local authority.

We looked at people's care records to ascertain that the care and support people needed was being delivered safely and that risks to people's health and wellbeing were appropriately managed. At the last inspection, we acknowledged some improvements had been made in this area but during this inspection, we found these improvements had not been sustained.

We looked in one person's care plan and saw a risk assessment had been produced on 21 January 2016. At that time, risks associated with mobility, manual handling and falls were deemed to be a 'moderate' risk. However, there was insufficient information contained within the care plan to demonstrate how this risk was mitigated. We also saw that during June 2017 and July 2017 this person had experienced a significant decline in their mobility and had suffered a fall. The service had made a request to the local authority social care department for a review, but the care plan and risk assessment had never been updated to reflect this significant change and there was no information recorded to support how these newly emerging risks had been mitigated.

In a second person's care plan, we saw a risk assessment had been produced on 15 July 2016. At that time, risks associated with mobility, manual handling and falls were deemed to be a 'high' risk. It was also documented this person had epilepsy and was at risk of losing consciousness for a few minutes when fitting. However, there was insufficient information contained within the care plan to demonstrate how these risks were managed. In particular, there was no information about how to manage the risks associated with epilepsy or seizures. Similarly to the situation described above, we found that in October 2017, the service had contacted the local authority social care department to request an urgent review. This was because this person was now unable to stand, had no balance and that this was causing difficulties for their loved one and the care staff. However, as before, the care plan and risk assessment had never been updated to reflect this significant change.

In a third person's care file, we saw a pressure care risk assessment had been completed in 2014 but had

never been reviewed; this was despite the risk document stating that a review should have been completed on a monthly basis.

We then reviewed more widely how the service responded to a particular incident or significant change to a person's assessed care needs. We found the service maintained a substantial file of hard copy emails that had been sent to the local authority adult social care department, requesting reviews of people's individual care needs. However, many of these emails had simply been sent in isolation and did not always translate into an updated risk assessment or wider care plan review. We also checked the care plans that were kept in people's own homes and found no evidence to support that risk assessments had been reviewed for those individuals.

We also found risk assessments to be too subjective and generic and were not based on a formalised assessment or scoring tool. We spoke with the registered manager about this who acknowledged that a high, medium or low risk assessment outcome was simply based on the opinion of the member of staff completing the assessment at that time.

We could not be assured that risks to people who used the service had been assessed, monitored and mitigated in a meaningful way.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to safe care and treatment.

At the last inspection we identified that the company's medicines policy did not reflect the fact that staff were administering medicines. At that time we were provided with an updated policy which accurately reflected the steps staff needed to follow when assisting and administering medicines to people they supported. We also noted at the previous inspection that during the initial assessment, a list of medicines prescribed to an individual was recorded in the support plan held in the office, but this was not replicated in the support plans we saw in people's homes. We brought this to the registered manager's attention at the time who assured us that this would be put in place and staff would have the correct medicines information for the people they supported with this aspect of care. However, during this inspection, we found this had not been done. For example, when we visited people in their own home, we did not see a list of current medicines in their support plan and staff were not provided with accurate information in relation to the medicines that people were receiving.

Staff had received training in medicines at the time of their induction and they received annual refresher training. However, we saw no records to evidence that staff had undergone ongoing competency checks in this area. We were informed by the registered manager staff were shadowed to monitor competency levels but these assessments of competency were not recorded. This meant that the provider could not evidence staff administering medicines remained competent and safe to do so.

During one of our home visits to people in their own homes we looked more closely at how medicines were managed. Our visit took place on a Thursday before lunch and we could see that the morning medicines had been correctly administered, as had medicines for Wednesday morning and Wednesday teatime. We saw however, there were two tablets still in the blister pack for Wednesday lunch. These had not been given. We checked that the person had been at home and had received a visit at this time and they told us that they had. The visit log also indicated that a care worker had been. This indicated that this person had not been supported to take their medicines as prescribed. We also saw five tablets loose in the bottom of a box where blister packed medicines were stored. We identified these were not from the current week's supply of medicines but it was not clear how long they had been there.

We looked at people's medicines which had been prescribed to be administered within a certain timeframe. For example, before food, an hour after food or at bedtime. Where such medicines are not administered as prescribed, this could have a negative impact on the wellbeing of the person.

We saw that one person needed a morning visit at 8.00am in order for staff to administer a particular medicine. However care visits were not always within the specified times, particularly at weekends. One Saturday morning call had been logged as late as 10.38am .

We were not provided with sufficient assurance that improvements for the safe management of medicines had been sustained. In particular, that people were consistently provided with their medicines at the right time and that care workers were deemed competent at administering medicines.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safe care and treatment.

We looked at how the service sought to ensure newly recruited staff were suitable to work with vulnerable people. We found application forms were present, proof of identity had been obtained, and checks carried out with the Disclosure and Barring Service (DBS). However we found a combination of issues in four of the six recruitment records we reviewed. These included incomplete application forms with some sections completely blank, unaccounted employment gaps, and missing employment references. When reviewing the notes taken during employment interviews, no explanations had been sought or recorded.

This meant the service was not able to consistently demonstrate the suitability of candidates to work with vulnerable groups before an offer of employment was made.

This is a breach of Regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 with regards to fit and proper persons employed.

At our last inspection the provider made us aware of their intention to invest in mobile telephones for staff to improve call monitoring. At this inspection we saw that these had been introduced. The mobile phones give each care worker a live rota on their handsets with real-time task lists and service user data, for example around risks posed to individuals and specific medicine instructions, to care workers. The system also allows the managers and co-ordinators to see if a care worker is running late for an appointment and alerts are notified to the office when a scheduled call is missed or late.

We looked at a number of records in relation to call monitoring and saw that since the introduction of the mobile phones for staff, call logging had improved. There were fewer instances where the office were inputting the start and end times of calls. Not all of the electronic call monitoring records we looked at reflected that staff were staying for the full commissioned time with individuals. However we were assured that visits had happened and that people were safer as a result of the improved call logging.

At the last inspection the service was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safeguarding people from abuse. This was because office based staff had failed to follow the correct procedures when a safeguarding concern was raised with them. However, through talking to the registered manager, office based staff and care workers, we were satisfied that staff demonstrated sufficient working knowledge of the types of abuse and the procedures to follow if they suspected that a person was at risk of, or was being abused. This was also evidenced by the timely manner in which statutory notifications were sent to CQC by the registered manager when an allegation of abuse had been raised. We also found the service had an up-to-date safeguarding and

whistleblowing policy in place.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service if they considered the care they received from Enterprise Homecare to be effective and whether they felt staff were trained and competent to carry out their role. Comments included, "Not all of them have the right skills and knowledge, one of them made me move so she could hoover where I was sat but I have a lot of pain due to my [medical condition] so [person] should have hoovered around me as I'd found a comfortable position, I ended up in pain again so [person] could hoover."; "It depends which carer turns up on what day. My regular carer is great but others I don't rate. I'd consider moving services but it's 'better the devil you know."; and, "Some carers seem well trained but others carry on like they don't know what they're doing."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Enterprise Homecare provides a service to people within their own home, therefore any decision to deprive a person of their liberty within the community must be legally authorised by the Court of Protection.

We found MCA training was provided to new staff as part of their induction, but not all existing staff had completed this training. Additionally, staff we spoke with were not consistent in demonstrating an underpinning knowledge around how best to support people who lacked capacity. Comments from staff included, "I don't know about helping with decision making; I think some of the clients are passed that stage anyway."; "When people start to get more confused we encourage them to make decisions and report it to the office."; "If they don't have capacity to make choices, I put different options in front of them and they can point or look at the one they want."; and, "I don't recall having training about mental health or capacity. Some clients do have memory problems but I just do my best to support them."

By looking in care plans, we could see Enterprise Homecare provided a service to people who lacked capacity. For example, people living with a diagnosis of dementia. However, we were told by the registered manager that the service did not complete any form of mental capacity assessment because these were completed by the local authority before a package of care was commissioned, or a referral would be made by the service to the local authority in the event of any concerns with people already using the service.

Whilst we acknowledged that the local authority has a role in completing formal assessments of capacity, this does not absolve the service of all responsibility where a person who uses the service lacks capacity. In particular, where changes to mental capacity might occur during the lifespan of a commissioned package of care. For example, in one person's care plan, it had been documented that a family member had raised concerns about their loved ones deteriorating mental state and there were emerging issues about capacity to consent.

In line with the principles of MCA, the service must ensure that where a person lacks capacity, decisions are made in their best interest and by the least restrictive means. Prior to a referral being made to the local authority and in the absence of a formal capacity assessment, we saw no documentary evidence to support whether the service had considered the principles of the MCA.

We also found little or no supporting information where it was identified a person was represented through a Lasting Power of Attorney. This meant we could not be assured that any decisions being made on a person's behalf were always done so lawfully.

We recommend that the provider consults national and local best practice guidance in respect of the Mental Capacity Act 2005 and its application within a community setting.

We looked at induction, training and continuous development staff received to ensure they were fully supported and qualified to undertake their roles. We saw newly recruited staff completed an induction period which included shadowing opportunities and completion of mandatory training such as moving and handling, health and safety and safeguarding. New staff were also required to complete a workbook at the end of each session to demonstrate their understanding and competence.

The service employed a member of staff who had responsibility for the delivery of mandatory training. However, this was a part-time role and for the remainder of the time, this member of staff functioned in the role of a supervisor. We were told the provider was moving to online e-learning for the vast majority of topics, but classroom based training would still be delivered in relation to core training such as moving and handling. Comments from staff about access to training included, "There is enough training and we help each other out."; "We do lots of training but there could always be more."; and, "I feel OK and confident as I've been a carer for years but there's not enough training for new staff."

We checked to ensure staff were receiving regular supervision sessions and that annual appraisals were completed. Staff supervision provides a framework for managers and staff to share key information, promote good practice and challenge poor practice. By checking records and through talking to staff, we found the completion of supervision sessions to be sporadic and not in line with company policy which stated supervision should carried out at least once every three months, and at least twice in the home of a person who used the service.

Where a supervision session was completed in person's home, we saw that a supervisor would shadow care workers and complete a monitoring form. However, where issues had been identified, it was not always clear what management action had been taken. For example, in November 2017 a monitoring form had been completed which detailed a number of performance issues observed during a home visit. Issues identified included the carer not speaking to the person who used the service and poor communication; incorrect meal being prepared and served; no cutlery being provided; and missing uniform items. As no management actions had been recorded on the form, we asked the registered manager for an explanation but none could be offered. We also found inconsistences in the frequency of such monitoring visits. We found one member of staff had only ever been shadowed once in eight years of service.

This meant that current procedures for supervision and questioning of practice were not effective and could not be relied upon.

This is a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 with regards to staffing.

Where support with eating and drinking was part of an assessed care need, we saw that people received a sufficient amount of support to meet their nutritional and hydration needs. Comments from staff included, "We always write down what [people] have eaten and drank and we sometimes get texts to say [people] need extra monitoring of food and drinks."; and, "We monitor if [people] eat and drink and check cupboards and fridges for food, we check it's nutritional. Records are updated at every visit."

By looking at daily records in people's own homes', we saw examples of how people's urgent healthcare needs had been met. For example, care staff would often be the first person many people who used the service would see first thing in a morning and often at this time, people would express they had felt unwell during the night. In such circumstances, we saw care staff had contacted a relevant healthcare professional to seek further advice or to arrange a home visit. We also saw that where appropriate, people were supported to ensure their routine healthcare needs were met. This included support to make appointments with the GP, dentist or podiatrist. However, In one person's care plan we saw they had been deemed a high risk of pressure sores but we found no evidence that contact had been made with this person's GP or the district nurses.

Requires Improvement

Is the service caring?

Our findings

The vast majority of people we spoke with considered staff to be caring. Comments included, "I have a good rapport with them [staff]; they don't have enough time though, they are so busy, they are always under pressure, so they rush. They are kind and compassionate."; "I get around 20 minutes per visit. They do listen to me talking and are very caring towards me."; and, "They listen to me and they make time for me."

Enterprise Homecare served a diverse and multi-cultural community in and around central and south Manchester and the client base was reflective of this. We therefore looked at the service's approach to equality, diversity and human rights (EDHR) and how people from different backgrounds were supported. Whilst we saw the service had an equality and diversity policy and customer guide which outlined a number of commitments in respect of equality and diversity, we saw no tangible examples of how this was applied in practice. Furthermore, it was not clear to us how the ethos and culture of the service sought to ensure people received care and support that was non-discriminatory. In particular, how the needs of people with a protected characteristic were considered. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination on the basis of age, disability, race, religion or belief and sexuality.

During a home visit to one person who used the service, we learnt this person was visually impaired and they required written information to be presented on yellow paper with black lettering. However, this person's visual impairment had never been considered by the service and all care related documentation provided by Enterprise Homecare was on white paper. This meant this person was not able to read any of the documentation and they told us how disempowered this made them feel. Another person who used the service told us they objected to care staff continuously referring to them as 'darling' and 'sweet pea.' This person told us they would prefer to be called by their name but this did not always happen.

We found people who used the service were not always treated with dignity and respect and insufficient consideration was given to people with a protected characteristic.

This is a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 with regards to dignity and respect.

We looked at how people were supported to routinely participate in the planning and review of their package of care, including involvement of loved ones or lawful representatives. We found there was an inconsistent approach to this and relevant people were not always involved. Records were not sufficiently detailed to demonstrate how and when people may have been involved, or indeed, if they had chosen to not be involved. People we spoke with confirmed they had not always been consulted when changes were made to their package of care. Comments included, "I was involved in my old care plan; I know they did a review but didn't involve me at all, then they changed it without asking me and it now has things missing."

We asked people if the care staff encouraged and promoted their independence and offered choice when delivering care. Comments included, "Oh yes they look after me properly, they always ask permission, I

choose my food and my clothes. They make my food but I make my own drinks, they encourage me to wash myself but they do help."; "They discussed my care plan with me when I was in hospital but it's wrong, it says I wear pads and I don't. The care plan hasn't changed since last year but I have changed."

Inadequate

Is the service responsive?

Our findings

At our last inspection in March 2017, we identified various issues with regards to the quality of care plans and associated documentation. During this inspection, we found insufficient improvements had been made. In particular, we found the service had failed to adhere to its own policy for ensuring that care plans were 'person-centred.'

When reviewing people's care plans, we found unacceptable levels of variation. For example, some care plans contained a one page 'About Me' document whilst others did not. The vast majority of care plans were too task orientated and there continued to be insufficient information which captured a person's life history, personal preferences, likes and dislikes, and people who were important to them.

We found the service was over reliant on 'citizen assessments' completed by the local authority. The local authority would often share these assessments with the service before a care package they commissioned commenced. However, we saw numerous examples of where the citizen assessments had been completed well in advance of the care package starting which meant the information could not always be relied upon to be accurate and reflective of a person's current needs. This was of concern because information contained within the citizen assessment would often simply be copied by Enterprise Homecare onto an initial assessment form which then formed the basis of a person's new care plan .

The continuance of similar issues identified at our last inspection, demonstrated a failure to learn lessons from past experiences which meant care and support was not delivered in a person-centred way.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to person-centred care.

At our last inspection we found the management of complaints to be ineffective. This was a breach of Regulation 16(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, whilst we found some improvements had been made in respect of the way complaints were now logged on a spread sheet, we found paper based records to be disorganised. The complaints file contained documentation that was related to safeguarding issues, not complaints, which made the file difficult to navigate. It was also not always clear if complaints had been resolved, what information had been communicated to the complainant and if any, what lessons had been learnt.

We asked people who used the service about their experience of making a complaint and we received a mixed response. Some people told us they were apprehensive about complaining in case this impacted on the care they received; others told us they had complained in the past but had not received any feedback . People also told us that when they telephoned the office, they were not certain their complaints would be taken seriously. Information about how to make a complaint was contained in the customer guide and the framework for handling complaints was detailed. However, the issues we have identified demonstrated the service was not following its own published procedures for dealing with complaints.

On this basis, it was evident that systems for identifying, receiving, recording, handling and responding to complaints remained ineffective.

This was a continued breach of Regulation 16(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to receiving and acting on complaints.

Due to the time constraints of commissioned packages of care with Enterprise Homecare, there were little to no opportunities for staff to engage with people who used the service to enable them to access community based activities. However, one person who used the service told that because staff were frequently late on a Sunday morning to assist with personal care, this meant they were unable to attend church as often as they would like .

At the time of our inspection, Enterprise Homecare did not provide end of life care. Within the City of Manchester, if a person in receipt of a homecare service requires end of life care, the care package is usually transferred to another provider.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Following our last inspection of Enterprise Homecare in March 2017, we met with the registered persons and sought assurance that sufficient improvements could be made and sustained, to ensure the quality of the service improved to attain a rating of at least 'Good' at this inspection. However, this has not been the case so we are reviewing our enforcement options.

In order for any service to be considered 'well-led' good governance is fundamental. At this inspection we found continued systemic failures, with no tangible improvements, in respect of the overarching governance of this service. In particular, we found no progress had been made with regards to improving audit, quality assurance and questioning of practice. We looked at records that were described as 'quality assurance' but these were not fit for purpose and did not demonstrate how the registered manager maintained oversight of the service. Furthermore, we found governance arrangements in respect of the registered provider to be non-existent and no evidence could be provided to demonstrate how they maintained oversight of the quality of services being delivered from this location.

We reviewed how the service sought the views and opinions of people who used the service and/or their representatives, for example, through the use of questionnaires. We reviewed 15 completed questionnaires and found positive remarks in three, with 12 containing negative feedback. However, no evidence was provided to demonstrate how the service had evaluated and acted upon this feedback in order to continually evaluate and improve services. We also saw the registered manager maintained a 'customer monitoring' matrix and the company policy stated that feedback would be sought every three months by telephone and a face-to-face meeting at least every six months. However, completion of such customer monitoring was sporadic and did not always occur at the frequency described in the company policy.

Comments from people we spoke with included, "They've sent questionnaires out recently. I'm not sure what they've done about it."; "Friday and Saturday morning issues have still not been resolved. We understand that carer's can be delayed but we're having to ring Enterprise."; and, "Sometimes they are 30 minutes to one hour late." At the last inspection we identified that care provided at weekends was rushed and calls were frequently late. Comments on returned questionnaires issued by the provider in October 2017 confirmed this was still the case. One person indicated they did not feel rushed by care workers but added, "Weekends are different." Another said care workers were on time during the weekdays but 'very often late at weekends.' The registered manager had not addressed the issue of inconsistent care since the last inspection.

We looked at how accidents and incidents were recorded and audited and found a variety of different accident forms were in use which meant there were inconsistences and variations in the way information was recorded. This meant it was not always clear what steps had been taken to reduce the likelihood of such events occurring again in the future. Furthermore, there was no overarching analysis of these events in order to identify trends or contributory factors.

The service had a selection of policies and procedures covering a variety of topic areas such as safeguarding, medication, infection control, accident reporting, providing person-centred care and recruitment and selection. However, the registered persons failure to adhere to the company's own policies in respect of medicines, recruitment and selection and providing person-centred care, as evidenced elsewhere in this report, further demonstrates a failure in governance.

We therefore found the registered persons had continued in failing to ensure effective governance systems and had failed to continually evaluate and seek to improve governance and auditing of practice.

This is a continued breach of Regulation 17(1) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to good governance.

When we asked employees of Enterprise Homecare whether they considered the service to be well-led we received a mixed response. One member of staff told us, "I don't think it is a supportive open culture." Another commented, "The culture is, 'you do your work and we do ours', they don't encourage, they could do more. They take complaints on but don't communicate if they have resolved it; there is a lack of communication." A third member of staff said, "The culture at work is good. When they make changes though it's always for the benefit of the company not for staff or clients. Staff need to log in and out on the phones in order to get paid. A fourth person told us, "It's a lovely culture, [registered manager] is always there for people, [registered manager] is fine. And a fifth member of staff said, ""I personally do feel supported. [registered manager] is approachable; they listen."

We spoke with staff about the continued roll-out of the Electronic Call Monitoring (ECM) system. Staff understood the benefits of such a system and recognised this was a valuable tool in assisting them to do their job. However, a number of staff told us they thought ECM was also being used punitively and the performance aspect that was linked to pay was not always fair. We were also told that insufficient travel time in-between care calls continued to be challenging as often the time given to 'travel' was unrealistic and impacted on the next call which was inevitably late. Staff also told us that the use of zero hours contracts by the provider meant there was always an amount of uncertainty and anxiety which impacted on morale.

At the last inspection we identified that office staff and the company accountant were inputting start and end times of calls when care workers were unable to log in or out of any scheduled calls and inflating the duration of some visits. At this inspection we looked at four client visit lists for week ending 28 November 2017 and saw that two client visit lists contained entries made by the company accountant. Both of these entries detailed scheduled visits of two hours. For one of the visits we looked at the corresponding care worker schedule, however the two hour call was not included on their schedule and we saw that the individual had received both a 30 minute morning and 15 minute lunch call as planned. It was not clear why the two hour entries had been made and we were not assured that the practice had stopped.