Reline Care Ltd

Barking Enterprise Centre

Inspection report

50 Cambridge Road
Barking
Essex
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05 December 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The service was inspected on 1, 2 and 5 December 2016. The inspection was announced. The provider was given 48 hours' notice as they are a domiciliary care service and we needed to be sure staff would be available to speak with us. The service was last inspected in September 2014 when it was compliant with the outcomes inspected.

Barking Enterprise Centre is a large domiciliary care service providing personal care to people in their own homes. At the time of our inspection they were providing care to 155 people, most of whom were older adults.

The service had a 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 2008 and associated Regulations about how the service is run.

The service was not protecting people from abuse and neglect as incidents were not correctly identified as safeguarding issues or referred onto the local safeguarding authorities.

Risks to people were not appropriately mitigated. The measures in place to reduce risks were not robust and did not tell staff have to ensure people were safe.

Medicines were not managed in a safe way. Records were unclear and staff did not have sufficient information to ensure they supported people to take their medicines as prescribed.

People told us the service did not have enough staff and this led to them missing care visits or their care visits being late. The service was not following its recruitment policy and discrepancies in information provided by applicants were not explored.

The training provided to staff was not effective and staff did not have the knowledge they required to perform their roles.

Most people provided consent to their care and treatment in line with legislation and guidance. However, the provider did not follow the appropriate legislation and guidance, or maintain appropriate records, when providing care to people who lacked capacity to consent to their care.

People told us they did not consistently receive the support they needed with eating and drinking. Care plans did not contain details of people's dietary needs and preferences.

Care plans were task focussed and did not contain information about people's preferences, or how their religious and cultural background or sexuality affected their preferences for care. We have made a

recommendation about ensuring care plans reflect people's religion, culture and sexual identity.

Records of care showed that people were not consistently receiving care in line with their needs and preferences.

Management audits were ineffective as they had not identified issues with the quality of care plans, risk assessments or records of care. Although individual concerns had been addressed lessons learnt had not been applied to the whole service.

The service was not submitting notification to CQC as required.

People and staff gave us mixed feedback about the approachability and availability of the registered manager. Some people and staff found her open and approachable, others told us she was difficult to get in contact with and did not listen to feedback.

The service completed regular monitoring and collected feedback from people about their views on the service. The service had a robust complaints policy and records showed that complaints were responded to in line with the policy.

People told us some care staff displayed a caring attitude and treated them with dignity and respect. People told us other care staff were not caring.

We found breaches of eight regulations. You can see what action we told the provider to take at the back of the full version of this report.

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.

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. Instances of neglect and abuse were not raised as safeguarding issues and staff did not identify neglect as a type of abuse.

Risk assessments were not robust and did not contain sufficient measures to mitigate risks faced by people receiving a service.

People told us there were not enough staff and this meant they missed care visits or received them late.

Recruitment was not completed in line with the provider's policy and discrepancies in staff applications were not explored.

Medicines were not managed or recorded in a safe way.

Is the service effective?

Inadequate

The service was not effective. Staff training was not effective at ensuring staff had the knowledge required to perform their roles.

The service was not working in line with legislation and guidance regarding consent and care for people who lacked capacity.

Care plans did not contain information about people's dietary needs and preferences. People were not consistently supported to eat and drink or to maintain a balanced diet.

People's healthcare diagnoses were included in their care plans. However, there was limited information about the impact people's health had on their care.

Is the service caring?

Requires Improvement

The service was not always caring. Although some people told us staff had a caring attitude, others said staff were not caring.

Care plans contained brief personal histories with information about people's pasts and significant relationships.

Some people told us they felt they were treated with dignity and respect, others did not feel they were treated kindly.

Assessments included questions about people's sexuality, religion and culture. However, these were not completed and were not used to ensure care met people's preferences.

Is the service responsive?

Inadequate

The service was not responsive. Care plans were task focussed and did not contain information about people's preferences.

Records did not show that people's care plans were followed.

The service collected feedback regularly and responded to complaints made in line with their policy. People told us they continued to receive a poor service as the service had not learned from people's feedback and complaints.

Is the service well-led?

Inadequate

The service was not well led. People and staff gave us mixed feedback about the openness and availability of the registered manager.

Audits were completed, but they were not effective as they had not identified issues with the quality of records and plans found during the inspection.

Quality complaints were dealt with on an individual basis and lessons learned were not applied to the overall quality of the service.

The service was not submitting notifications to CQC as required.

Barking Enterprise Centre

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 1, 2 and 5 December 2016 and was announced. We gave the provider 48 hours' notice as the location provides a domiciliary care service and we needed to be sure the people we needed to speak with would be in the office.

The inspection was conducted by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we already held about the service in terms of notifications submitted to us and feedback from people who used the service. We sought feedback from the local Healthwatch and local authority commissioning teams.

During the inspection we reviewed the care files of nine people including needs assessments, care plans, risk assessments, medicines records and records of care delivered. We reviewed six staff files including recruitment records, supervision, appraisal and training records. We looked at other documents relevant to the management of the service including incident reports, safeguarding records, complaints, monitoring records and various policies and procedures. We spoke with 10 people who used the service and four family members of people who used the service. We also spoke with eight members of staff including the registered manager, the deputy manager, a field care supervisor and five care workers.

Inadequate

Is the service safe?

Our findings

People told us they felt safe with care staff. One person responded to being asked if they felt safe by saying, "I would say so, yes." A relative told us, "Yes, my relative is safe." Care workers told us they would report any concerns they had about people being abused to the office. However, when asked about the different types of abuse none of the care workers identified neglect as a type of abuse or recognised that other care workers might abuse people in their care. One care worker said, "Safeguarding means to protect the service user from abuse, from relatives, friends and other service users."

The registered manager was asked how they would respond if one staff member made an allegation of abuse against another care worker. The registered manager told us they would treat it as a whistleblowing concern and complete an investigation. They told us they would report it to the local authority safeguarding team if they found the allegation had been upheld. This is not the correct process to follow, as investigations must be delegated from local authority safeguarding teams for investigation.

Records of complaints and feedback from people who used the service were reviewed. These included reports that single workers had covered calls where two staff were required, reports of missed visits, an allegation of a "medication mix up" where a person was given the wrong medicines and multiple people complaining that care workers arrived very late to their visits. Records showed the service had responded to these allegations by increasing monitoring of care packages and workers, and changing call times. In some cases the local authority had been aware of concerns, but not in all cases. None of these incidents had been appropriately identified as neglect by the service and escalated to the appropriate safeguarding authority. A note in one person's care records showed they had reported an allegation of domestic violence to their care worker. The care worker had reported this to office based staff. The registered manager was asked if this had been raised as a safeguarding concern. The registered manager told us, "I know it was not raised."

The above issues are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files contained various risk assessment forms relating to risks faced by people receiving care. These included risks associated with people's mobility and the use of equipment to support them to move around their homes. The measures in place to reduce and mitigate risks faced by people were not sufficient and did not provide clear instructions for care workers to follow to provide safe care. For example, one person had been identified as being at risk of falls, being unstable on their feet and requiring assistance with transfers. Their care plan referred to the involvement of an occupational therapist and a plan to move their bed downstairs to reduce the risks associated with using the stairs. This person's risk assessment contained conflicting information. In one section it stated, "Carers will have to support him downstairs." Later, the document stated, "Carers should not assist him to use the stairs as it is quite risky." It was not clear if care workers were supporting this person to use the stairs. In addition, there was no guidance for care workers on how to support this person to use the stairs in a safer way.

Another person was identified as being at risk of falls and requiring assistance with getting into and out of

bed. Their risk assessment did not contain information for staff on how this risk was mitigated or how support was provided. Regarding 'moving around inside the home' the risk assessment stated, "Just observe / supervise in case of falls." Regarding 'getting into or out of bed' the risk assessment said, "Independent with occasional leg up." These were not clear instructions for staff or measures which mitigated the risks associated with this person's mobility. A third person was identified as requiring a high level of support with their mobility, their care plan stated the hoist provided was incorrect but there was no information for care staff on how to provide safe care while awaiting the correct hoist. The care plan said, "The hoist is not the correct size so she is waiting for the correct sized one." This was also the case for a fourth person, where the care plan stated the hoist was not used as there was not room for it in the person's home. The care plan stated, "She has a hoist but the carers don't use it because of the limited space in the house. The carers are using a commode chair to transfer her." This person's assessment said they were unable to mobilise at all but there were no instructions for staff about how to safely support this person from their bed into the commode chair. This meant people were at risk of not being supported with their moving and handling in a safe way as there was insufficient information for care staff to follow.

Information about risks posed to people's skin was unclear and inconsistent. For example, one person's risk regarding their skin was described as 'low' but the plan went onto state, "She is at high risk of skin breaking down as she is always sitting down." There were no measures in place to mitigate this risk. Another person's care plan did not identify any support needs relating to their skin, however, the referral information included that the person suffered with leg ulcers. A third person's assessment noted, "She has scratches on her skin at time of assessment. No professionals are aware of it." There was no record that action had been taken to make professionals aware of it and no risk assessment or care plan related to ensuring this person's skin health was maintained. In a further care plan the person was identified as being at high risk of skin breakdown, but the section of the document relating to control measures was blank. This meant there were insufficient measures in place to mitigate the risks associated with skin breakdown and pressure care.

The service supported people to take medicines. Care plans were unclear regarding the level and nature of support people required to take their medicines as prescribed. For example, two people were assessed as not requiring support with their medicines but the records of care delivered showed that care staff were recording that they had supported the person to take medicines. There were no records regarding what medicines these people had been supported to take. Where the care plan did include support with medicines, information was unclear and records did not demonstrate that people had been supported to take their medicines as prescribed. For example, one person's medicines care plan contained a list of their medicines, including three different doses of warfarin. Warfarin is a medicine used to thin the blood and requires staff to have received specialist training to administer as doses can change frequently and must be adjusted according to blood test results. The plan noted by each warfarin dose, "Advised not to take for now." Due to the level of risk associated with the administration of warfarin, we asked the service to find out what support was being provided to take warfarin. The service contacted the care worker who advised the person self-administered their warfarin and a number of pain relieving medicines. The care worker advised they only administered medicines contained in the compliance aid (blister pack) the person received from their pharmacist. However, this was not clear from the records of medicines administered. The records did not list the individual medicines administered and the records for September and October 2016 were coded by staff to state that the person had either taken their medicines already or wished to take them later. It was not clear from the records what medicines the person had taken or whether they had taken their medicines as prescribed.

The medicines administration records (MAR) used by the service were not fit for purpose. MAR must detail which medicines are prescribed, when they must be given, the dose and any special instructions, such as giving the medicine with food. The MAR viewed did not contain this information. The registered manager

advised that care workers only supported people who received medicines in compliance aids, and the care workers signed to indicate the contents of the compliance aid had been administered. This was not sufficient as records must show which medicines had been administered. It was not possible to understand exactly what the care worker had done or account for all the medicines that had been managed for people.

The MAR viewed were also incomplete. One person's record showed medicines had been recorded as administered on only four occasions during October 2016. Another person's record contained multiple gaps in signatures for their night time medicines. The records showed there were six occasions in July 2016, 11 occasions in August 2016 and four occasions in September 2016 when no record was made that their night time medicines were administered. This meant the records did not support that people were supported to take their medicines as prescribed.

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

In response to our concerns regarding medicines records and risk assessments the provider showed us a new template they would use to record medicines and submitted a plan to update and review their risk assessments and medicines plans.

The provider had a robust policy regarding the recruitment of staff. This included pre-interview skills assessments, interviews, the collection of employment and character references as well as checking if staff had criminal records. Staff files checked showed the provider was not following their recruitment policy. Records showed there were gaps in employment history, discrepancies between employment histories provided in CVs and application forms and inconsistencies regarding references. For example, three people's CVs and application forms stated they had no background working in the care sector, however the references completed referred to experience working in a care setting and the employability of candidates. This was despite the referee being named as a character rather than employment referee in two of these cases. Although the service carried out checks on the criminal histories of candidates, the inconsistencies regarding employment history and references meant recruitment was not completed safely. This was because discrepancies regarding job histories and experience had not been explored with candidates.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they did not think the service had enough staff. People told us their care workers were often late, or missed their visits altogether and this was particularly a problem at weekends. One person said, "Staff are not on time on the weekends or at night time." Another person said, "On the weekend they are not on time and you can't get hold of the office to ask them when the carers are going to arrive." A third person said, "I doubt [they have enough staff], that's the trouble on the weekends." A relative told us, "[Relative] has to chase them up on Sundays, they never turn up in the evenings and on the weekdays sometimes."

Three of the five care workers we spoke with also told us they did not think there were enough staff. One care worker said, "No, there's not enough staff." Another care workers said, "No, I could never say that [there are enough staff]. They call me for extras." Both of these care workers told us this meant they sometimes had to attend visits which required two workers on their own. Another member of staff said, "We are very short on care workers." The registered manager told us they worked out the staffing needs for the service by looking at the number of hours the care staff worked and if they saw that care workers were completing a high number of hours they would recruit additional staff. The registered manager told us they considered a

high number of hours to be 60 hours per week. The registered manager told us there had been an issue with staffing numbers during the summer of 2016 but they believed they now had sufficient staff. This was not supported by the feedback from people and their relatives which remained that staffing levels were not sufficient to ensure the service had enough care workers to meet people's needs.

The above is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Staff gave us mixed feedback about the quality of the training and support they received. One staff member said, "I've had training in medicines, moving and handling and all different things. It was useful." However, another member of staff told us they did not find the training engaging enough. Records showed care workers had to contribute to the cost of the training the provider required them to complete before starting work. Care workers had raised in a staff meeting that this was putting some new staff off applying to work for the service as it would cost them money to start working. The registered manager told us where new staff struggled to cover the cost of training it was deducted from their salaries after they started working.

Records of training for 35 care workers were reviewed. These showed staff completed the care certificate when they joined the service. The care certificate is a recognised training qualification that gives staff the foundation knowledge required to work in a care setting. The training certificates showed that staff covered 15 units of the care certificate on one day. For example, one worker was considered trained on medication level 2, the Mental Capacity Act (2005), dementia awareness, end of life awareness, pressure sore awareness, catheter and stoma care and moving and handling on a one day course. This led to concern that none of the topics had been covered in sufficient detail. Five care staff were asked about their knowledge acquired through training. They were unable to explain the Mental Capacity Act (2005) or different types of abuse when asked by the inspector. This was despite the records showing they had received training in these areas. Training records showed that seven of the 25 staff had not completed re-ablement training and 15 care workers had not completed training in end of life care.

When staff joined the service they completed a period of shadowing. However, records were not clear whether competence at the care tasks was assessed, or whether care tasks had been observed by supervisory staff. Shadowing records were undated so it was not clear if care workers had completed all the tasks in one session, or over a period of time. This meant it was not clear that staff received the support they required to perform their roles.

The above is a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed staff received supervision, spot checks on their performance and appraisals in line with the provider's policy. The policy required staff received supervisory input a minimum of four times a year. Records showed where concerns were raised about care worker performance, for example, if a complaint was made about them, the provider took appropriate action. For example, following a complaint about a member of staff the provider interviewed the staff member, supported them to attend refresher training and increased the amount of monitoring they were subject to. In addition, the provider sought feedback from other people the staff member supported to establish if this was an isolated incident or if other people had concerns.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People 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. We checked whether the service was working within the principles of the MCA.

Records showed that where people had capacity they signed their care plans to indicate their consent. However, one care file had been signed by the person's relative despite the assessment stating that the person had capacity. Two of the care plans reviewed stated the people they related to lacked capacity to consent to their care. The care plans had been signed by relatives, however, there was no record to demonstrate these relatives had the legal authority to make decisions on the person's behalf. In order for it to be legal for another person to give consent they must have been granted a lasting power of attorney by the person, or been appointed as a deputy by the Court of Protection. The registered manager told us, "We have no record they [relatives] have legal power to consent." This meant the provider was not working within the principles of the MCA.

The care plans of people who lacked capacity to consent to their care contained a section where details of the support they required in relation to their capacity could be completed. This was blank in both files reviewed. In addition, we asked staff if they understood how the MCA applied to their work. One care worker said, "I don't think I've had training in that." Another care worker said the MCA was, "About making sure they are emotionally and physically OK." This meant staff did not have an appropriate understanding of the MCA to apply it in their roles.

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

People told us that staff supported them to prepare some of their meals. One person said, "She [care worker] makes my breakfast when she comes." A family member told us care workers supported their relative with breakfast. Care plans contained a section where details of people's eating and drinking needs and preferences could be recorded. However, these were poorly completed and did not contain details of preferences. Eight of the nine care files said that people either had no dietary preferences or the section of the plan was blank. In the ninth file it stated, "Not particularly." This meant staff relied on people being able to communicate their preferences for food choices clearly during care visits.

In addition, two people's care plan stated they required a soft diet. For one person this was explained as being because the person could not chew. Their care plan stated a relative supported them with their meals. However, for the other person there was no information about any risks associated with their swallowing or any reason for them requiring a soft diet. This meant staff did not have enough information to provide people with a balanced, nutritious diet in line with their needs and preferences. A relative told us that care workers did not always take time to prepare meals in line with their family member's preferences. They told us, "A carer came in the other day and my relative asked her to make her a tin of soup. The carer opened a tin of tomatoes and left that. The carer is meant to stay with her for half an hour, but she'd gone after ten minutes." We raised this as a concern with the local authority who commissioned this person's care.

Records showed that most people were supported by their family members to attend health appointments. Records of care showed care workers logged when they had concerns about people's health. Care plans contained details of people's health diagnoses where this had been included in the referral information. However, there were limited details about what people's health conditions meant in terms of how they received their support. For example, one person's care plan made repeated reference to them having a

specific health diagnosis, but did not tell care workers how this affected the person or how they should support the person with this health condition. This meant there was a risk people were not consistently supported to have their healthcare needs met.

Requires Improvement

Is the service caring?

Our findings

People and their relatives gave us mixed feedback about the attitude of care staff. One person said, "[Care worker] was very caring and I found that I could not have received better care and attention from her, it was excellent." Another person said, "She appear to [care], she does seem to be caring. When she thinks I haven't got anything that I need she gets it for me." However, other people were less positive about the attitude of care staff. One person said, "Apart from [specific care worker] you can just forget about them." They continued, "They are not able to communicate much, they don't understand when my relative talks to them." Another person said, "They aren't really caring. All they want to do is do their job and go."

Care plans contained a brief summary of people's lives before they started to receive a service. These included details of significant relationships, activities people enjoyed and their occupations. For example, one person's summary stated, "I used to do a clerical job. I paid a lot of money to be able to learn how to type." It continued to name their family members and their relationships.

Staff told us how they maintained people's dignity during care. One care worker said, "I cover them up, wash them half and half, that's how I do it. I explain what I'm going to do, wash this part, then that part." People and relatives said they thought staff treated them with dignity and respect. One person said, "Yes, they treat me with dignity. I always say to them I'm disabled not stupid." A family member told us, "Yes, they treat my relative with dignity." However, another person said when asked if staff treated them with dignity, "Probably, I say five out of ten." This meant not everyone felt care staff treated them with dignity and respect.

Care plans contained sections where details of people's religious and cultural beliefs could be recorded. Although people's religions had been recorded, there was no further information regarding whether this affected how they wished to receive care. The registered manager told us they provided shoe covers for care workers if this was culturally appropriate for people. A care worker told us, "A lot of the people I work with are [specific religion]. They prefer to have carers of the same gender, and I take my shoes off." In all nine of the care plans viewed, the section relating to culture was marked "not applicable" or left blank. This meant the service was not consistently taking people's culture and background into account when planning their care.

The care plans also contained a section where people's sexual orientation could be recorded. In seven of the nine plans reviewed this was blank, in two the people were recorded as being heterosexual. None of the care workers we spoke with knew whether anyone they supported identified as lesbian or gay. When asked how they knew whether people identified as lesbian, gay or heterosexual one care worker said, "Well, I'd know. I don't know if it's in the care plan." A member of staff talked about how the assessment process could be quite intimidating for people and they did not always want to share personal details with staff. They said, "Staff come in with this annoying bunch of papers. We just get the info we need and leave it." This meant staff did not have information about people's lifestyles and preferences that are needed to support the development of relationships between staff and people receiving care.

We recommend the service seeks and follows best practice regarding incorporating information about

people's culture, religious beliefs and sexuality into care plans.

Inadequate

Is the service responsive?

Our findings

People told us care workers made records of their visits and they had copies of their care plans in their homes. One person said, "Most of the time when they come they look in the book and write what they have done." Another person told us they had been involved in writing their care plan. They said, "Initially I was [involved in writing my care plan]." However, people also told us that care workers did not always follow their care plans. A relative told us, "There was an issue where they were not [completing aspect of care plan] so I wrote in the book for them to do it, and now they do." A person who used the service told us that care workers did not always respond to their requests for support, they said, "It hurts me very much when I ask them to do something for me and they don't want to do it."

People were consistent in their feedback that the service failed to provide personalised care as care workers could not be relied upon to come at the scheduled times. One person said, "They say that they are arranging it [care visits] but they don't call. The timing has always been an issue. The timing is an ongoing issue." Another relative told us their family member required a care worker of the same gender, but this did not happen and they received care from a care worker of the opposite gender.

The service used an electronic call monitoring system to record when care workers arrived at and left people's homes. The electronic call monitoring information for five people was reviewed. This showed that one person who had requested support only from male care workers received support from female care workers. The records also showed that people's care visits consistently did not take place at the scheduled time, with some visits occurring up to two hours before or after the scheduled time.

Care workers made records of care delivered on log sheets kept in people's homes. These were reviewed and did not show that care plans were being followed. For example, one person's care plan stated they should be supported to have a shower and to use their exercise equipment daily. The logs for November 2016 showed they had been supported with a shower on eight occasions and to use their exercise equipment on two occasions. This meant people were not receiving personalised care in line with their needs and preferences.

The assessments and care plans of nine people were reviewed. The assessments did not identify preferences, with the sections relating to specific preferences marked as not applicable or left blank in all files viewed. The only information available to care workers was contained in a section called "Care Plan Summary." This information was brief and did not contain information required by staff to ensure that care was provided in line with people's preferences. Information contained in the care plans was task focussed. For example, one person's care plan stated, "Carers must assist [person] to use the toilet and personal care. Carers must support [person] with the transfer of going downstairs. Carers now give him a shower in the new shower downstairs." There was no information for care staff regarding this person's preferences during the shower, for example, water temperature or washing products used. There was also no information for carers about the level of support the person required. It was not clear if the person was largely independent but required staff to pass him washing products and help with hard to reach places, or whether he required staff to wash him.

Another person's care plan stated, "Assist with getting up. Assist with getting dressed. Assist with transfers. Assist with wash and cream all over the body. Assist with breakfast. Assist with medication." This did not tell care workers what they had to do to support this person. The assessment of a third person identified they required an interpreter, however the person's communication plan made no reference to the need for a care worker who spoke the same language, or the provision of an interpreter. The person's care plan stated, "Carers to assist [person] to get out of the bed. To assist her downstairs to the bathroom. Give her a strip wash, dry her body, apply cream, dress up, change pad and move her to the front room where she has her eye drops instilled. Tidy up, make bed, ensure she is left comfortable." There was no further information to enable care workers to provide personalised care that met this person's preferences.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used two systems of monitoring to check that people were satisfied with the service and to receive feedback. These were monthly telephone calls to people or their relatives, and quarterly monitoring visits. Records showed people had raised concerns about missed and late visits of care through these systems. Records showed that when issues were raised through these monitoring checks the provider took action to address the issues. For example, records showed that care workers were changed and increased monitoring put in place to ensure people received care visits as required. However, people told us that these changes were not always effective. One person said, "One of the care workers used to come late so [registered manager] changed the time." The person had not wanted the time changed, but for their care worker to visit at the correct time.

People told us they contacted the office if they wished to make a complaint. One person said, "I would ring the company if I had a complaint." Another person said, "I have no complaints, just a couple of times when they haven't turned up and they haven't let me know, I rang the office and someone turned up around lunchtime." People told us that contacting the office with complaints was not always an effective way to achieve change. Three people told us they had faced difficulties contacting the office to raise complaints. A relative told us, "I waste my time making complaints, the carers are not good enough, you cannot rely on the carers."

Records showed formal complaints were dealt with in line with the provider's policy. The registered manager had completed investigations and taken action against staff where this was appropriate. Records showed that most people were satisfied there had been an improvement in their service following a complaint. However, records showed one person had terminated their contract with the provider as complaints had not been resolved to their satisfaction. Another person who we spoke with told us they had stopped receiving a service from the provider as they had not addressed concerns raised.

The registered manager completed audits of feedback collected and complaints. This had identified a peak in concerns being raised about timekeeping and missed visits in August and September 2016. The audits for October and November 2016 showed a reduction in concerns being raised. The November 2016 audit showed no complaints or concerns had been raised. However, this does not correspond with the feedback received from people during inspection where people told us concerns had not been fully addressed. This meant it was not clear that the complaints process and feedback mechanisms had led to the service learning from people's experiences, concerns and complaints.

Inadequate

Is the service well-led?

Our findings

Three people we spoke with told us they did not know who the registered manager was. One person said, "No, I have not heard of [registered manager]" Another person said, "She [registered manager] is OK. Sometimes she comes and when I register something with her she takes it on board." Another person told us they found contacting the registered manager difficult. They said, "You can't get hold of her when you need her."

Feedback from staff was also mixed. Some staff told us the registered manager listened to them and was responsive to their suggestions. One member of staff said, "She [registered manager] listens. That's what I like about her, she takes things on board." However, other staff told us they did not think the registered manager listened or was responsive to change. A staff member told us, "I don't feel comfortable to raise issues with the registered manager. Things just get brushed under the carpet."

The registered manager completed a monthly audit of the telephone monitoring completed by other office based staff. Themes were identified, however, there was no action plan created to address issues identified. Issues were addressed on a person by person basis which meant that overall issues of quality had not been addressed.

Office based staff, including a field care supervisor, coordinators, the deputy manager and registered manager completed checks of records completed by care workers. However, these checks were not consistently completed and there was no oversight of the completed checks. For example, the audit of one person's log had indicated care workers had not recorded information about when the person went away and returned home. However, there was no action recorded against this observation. In two of the audits checked the section relating to checking records in the person's home had not been completed. In four of the audits checked they had identified that medicines records were not being appropriately completed. However, there were only actions recorded against two of these audits. A further audit had found no issues with the records, but our review found that log book entries were brief and did not demonstrate the care plan had been followed. Gaps were found in medicines records that had not been identified by the audit. This meant the audits were not effective as they had not identified issues with the quality of records identified during the inspection.

The registered manager told us they checked that care plans were accurate by going to visit people and discussing their needs with them. There were no formal mechanisms in place for the quality of care plans to be checked and reviewed by managers in the service. Records showed the care plans in place were poor quality and task focussed but this had not been identified by the management of the service. Likewise, there was no management oversight of the recruitment process. This had been delegated to a specific member of staff who had since left the organisation. This meant the inconsistencies identified in staff employment histories and references had not been identified or addressed by the management of the service.

Although records showed there were effective responses to individual issues raised, this was not used to form a strategic plan for the whole service and lessons learned from one case were not used to drive

improvement across the service. Despite the effective response to individual issues, concerns remained that the registered manager was not routinely identifying and escalating issues for external investigation through safeguarding teams.

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

Providers are required to notify CQC about certain events. These include safeguarding alerts, serious incidents and deaths of people receiving a service. The registered manager had not been submitting incident and safeguarding notifications as required.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 (1) Consent was not consistently provided by people. Where people lacked capacity to consent to their care the service did not have appropriate records in place regarding legally appointed decision makers or best interests decision making.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment (2)(3) systems were not operating effectively to prevent the neglect of people through missed and late visits. Systems to investigate allegations were not appropriately escalating concerns to the appropriate authorities. Staff understanding of abuse was not sufficient.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed (2) Recruitment processes had not operated effectively to ensure staff were recruited in a safe way.

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 18 Registration Regulations 2009 Notifications of other incidents (1) Notifications had not been submitted to CQC as required.

The enforcement action we took:

We issued a warning notice against the registered provider and the registered manager.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care (1)(b)(c)(3)(b) Care plans were task focussed and contained insufficient information to meet people's needs and preferences. Records of care were poorly completed and did not show care had been carried out in line with people's needs and preferences.

The enforcement action we took:

We issued a warning notice against the registered provider and the registered manager.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (2)(a)(b)(g) Risks were not appropriately identified and measures in place to mitigate risks were not clear. Medicines were not managed in a safe way, records were unclear and incomplete.

The enforcement action we took:

We issued a warning notice against the registered provider and the registered manager.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (2)(a)(b) Audits completed had not identified that care plans and risk assessments were not sufficient. Monitoring of the quality of the service

	was not consistently completed and did not lead to improvements across the service.

The enforcement action we took:

We issued a warning notice against the registered provider and the registered manager.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1)(2)(a) Insufficient staff who had not received the training they required to perform their roles were deployed.

The enforcement action we took:

We issued a warning notice against the registered provider and registered manager.