Genesis Housing Association Limited

Newham Homecare

Inspection report

19 Warton Road
London
E15 2GG

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31 October 2017

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Newham Homecare was inspected on 30 and 31 October 2017. The inspection was announced. The provider was given 24 hours notice as they provide a service to people in their own homes and we needed to be sure there would be staff available in the office. The service was last inspected in March 2017 when it was rated inadequate and placed into special measures. The service had failed to make enough improvements to be removed from special measures and remains inadequate.

The service provides care to people in their own homes, most people lived in supported accommodation although some people lived alone or with their families in the community. At the time of our inspection they were providing care to 78 people.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had failed to consistently improve the quality of risk assessments and medicines management within the service. People remained at risk of unsafe care as risk assessments lacked detail and did not give staff clear information about what they needed to do to mitigate risks. Information about people's medicines was not always up to date and staff did not have enough information about people's medicines to support them in a safe way.

Since our last inspection in March 2017 people had been involved in reviewing and updating their care plans. Although some had a better level of information about people's needs and preferences, others lacked detail. Where people's needs had changed since they had been assessed care plans had not been updated and this meant staff were providing support without clear written guidance about how to do so. Care plans contained insufficient information about people's healthcare needs and dietary preferences. Staff did not have the information they needed to ensure people's healthcare needs were met, or their dietary preferences respected.

Staff told us they did not have to rush, and that they thought there were enough staff to meet people's needs. The provider had not recruited any staff since our last inspection but had completed checks to ensure the staff they were employing were suitable to work with people.

The service escalated concerns about people being abused or neglected and staff had received training about safeguarding adults from harm. However, the provider did not always take action in a timely manner when staff were alleged to have neglected people.

Where people had capacity to consent to their care, this was clearly recorded. However, where people were not able to consent to their care, records were not clear that the principles of the Mental Capacity Act 2005

had been followed.

Staff had received supervision in line with the provider's policy. However, they had not received the training they needed to perform their roles. The provider had identified they needed to make adjustments to how they delivered training to facilitate staff understanding.

The provider had taken action to improve staff understanding of how people's sexual orientation may affect their experience of accessing and receiving care services. However, staff understanding remained mixed.

Some people told us the staff were kind, but others felt they did not demonstrate a compassionate attitude. Although some staff demonstrated an understanding of the importance of knowing about people's pasts and culture to form relationships, other staff told us they did not think this information was relevant.

The provider had improved how it responded to concerns and complaints. They had taken action where people and relatives had raised concerns about the service and had made the complaints policy available in alternative languages. However, some people remained unsure of how to make complaints.

The provider had taken steps to improve the deployment and scheduling of staff. However, the systems in place were not yet effective in ensuring people received their care as scheduled.

The provider's quality assurance and audit systems had identified some, but not all, of the issues we found on the inspection. However, the provider did not follow up on whether the required actions had been taken. The systems in place had not been effective in identifying and addressing issues with the quality and the safety of the service.

The provider had not submitted notifications to us as they are required to do.

We identified continued breaches of six regulations regarding person centre care, consent, safe care and treatment, staffing, good governance and the requirement to submit notifications. 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 overall rating for this service remains 'Inadequate' and the service therefore remains 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.

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. Risks to people had not been appropriately identified or mitigated against.

Information about how to support people to take their medicines was not clear.

The provider was not effectively monitoring staff deployment to ensure sufficient staff were deployed.

People were protected from abuse. Care workers knew to escalate concerns to the office based staff.

Is the service effective?

Inadequate

The service was not effective. Staff had not received the training they needed to perform their roles.

The provider was not consistently applying the principles of the Mental Capacity Act 2005.

Care plans contained insufficient information to inform care workers how to support people with their healthcare needs.

Care plans contained only limited information about how to support people to eat and drink in line with their needs and preferences.

Is the service caring?

Requires Improvement

The service was not always caring. Some people told us they had good relationships with care workers, but others felt that care workers did not display a compassionate attitude.

The provider had taken action to ensure staff were aware of the impact that people's sexual orientation may have on their support preferences, but this had had a limited impact on the understanding of staff.

Care plans contained limited information about people's pasts and information to enable relationships to be developed was not included in care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive. The level of detail in care plans was inconsistent and most did not contain sufficient detail to ensure people received care in line with their preferences.

People told us they were asked for their views on their care.

The provider responded to complaints in line with their policy, however not all people knew how to raise concerns.

Is the service well-led?

Inadequate

The service was not well-led. Audits completed identified some issues with the quality and safety of the service, but not others. There was no follow up to ensure actions had been completed.

Checks on records and staff performance had not been completed and this had not been addressed by the provider.

There was no registered manager in post.

The provider was not submitting notifications to CQC as required.

Newham 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 30 and 31 October 2017 and was announced. The provider was given 24 hours' notice as they provide a domiciliary care service to people in their own homes and we needed to be sure staff would be in the office during our inspection.

The service was last inspected in March 2017 when it was rated inadequate and placed into special measures. The service had failed to make enough improvements to be removed from special measures and remains inadequate.

The inspection was completed 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. This expert-by-experience had experience of caring for someone who received personal care in their own home.

During the inspection we spoke with 10 people who received a service. We spoke with 11 members of staff including the nominated individual, the business and contracts manager, a contracts compliance and systems manager, a practice excellence advisor, a coordinator and six care workers. We reviewed eight care files including assessments, care plans, risk assessments, medicines records and records of care delivered. We reviewed 10 staff files including supervision records and the service's training records. We also reviewed the call monitoring data and various audits, meeting records, policies and procedures and other records relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

At the last inspection in March 2017 we found the service was not safe and identified breaches of regulations regarding safeguarding adults, safe care and treatment and made a recommendation regarding staff recruitment. At this inspection we found some progress had been made with regard to safeguarding adults from harm, but people remained at risk of unsafe care and treatment.

In March 2017 we found that medicines risk assessments were insufficient and did not inform staff of the individual support needs and risks faced by people they supported to take medicines. At this inspection we found the provider had failed to address these concerns. Care plans continued to lack detail and were unclear. For example, one person's care plan stated, "[Person's relative] undertakes medication responsibilities, however, [they] may want carers to take this on – Newham Homecare will follow this up." There was no further clarification regarding whether or not care workers had been asked to take responsibility for this person's medicines.

In a second care file the medicines listed in the care file did not match the medicines administration records (MAR) that staff completed. In addition, there were medicines on the MAR with no record regarding whether or not they had been administered. In a third care file the person's medicines were listed, but there was no information for care workers regarding the side effects that they should be aware of and there was insufficient information to ensure staff knew how to support this person with their medicines. The care plan stated, "Care workers administer [Person's] medication in the morning."

A fourth person's care file contained conflicting information about how to support them to take their medicines and had not been updated to reflect changes in their medicines. The person had swallowing difficulties and the prescriber had advised the person's medicines should be crushed and dissolved in water. The care plan stated, "A number of medications require crushing and dispersing in water. Our care workers are not allowed to crush medication and this is being addressed with the chemist and GP to change to liquid form." The MAR chart showed this person was still receiving medicines in tablet form. There were no clear instructions to inform staff how to support this person to take their medicines in a safe way. The nominated individual told us the GP advised it was safe for this person to take medicines in tablet form, but this information for care workers remained unclear and this meant there was a risk this person was not supported to take their medicines in a safe way. In addition, there were discrepancies between the medicines listed in the care plan and those included the MAR chart. These issues had not been identified or addressed by the provider despite being issued with a warning notice regarding the safety of medicines administration in March 2017.

People had been prescribed medicines on an 'as needed' basis. The medicines audits completed by office based staff included a section to check whether there was clear information for staff about when to offer and administer 'as needed' medicines. The audits had not identified that the guidance for staff was insufficient. For example, one person was prescribed a medicine on an as needed basis. There was no information about the purpose of this medicine, or when it should be offered. The only information available for staff stated, "One or two 5ml spoonfuls to be taken three times a day after food and at night when

required (oral). Shake bottle well before using." There was no further information to inform staff when to offer this medicine or how to decide how much to administer. This meant some people were at risk of not receiving 'as needed' medicines when they needed them.

We asked the provider to provide an update to us on the actions they had taken to address our concerns regarding the safety of medicines administration.

In March 2017 we found risks faced by people had not been appropriately assessed or mitigated by the provider. At this inspection we found the provider had failed to address these concerns and risks to people had not been appropriately assessed or mitigated.

People were identified as requiring support to mobilise and transfer. However, there was insufficient information for care staff to ensure they supported people in a safe way. For example, one person was identified as being unable to walk. Their moving and handling assessment stated, "[Person] is heavily supported by both carers during the week and weekends. There are aids in the bathroom which include handrails and seats (for showering). [Person] needs to be assisted by two individuals to help with [their] moving. This is done together with their parents. Risks are minimised in this way and it helps to keep [person] safe. [Person] needs to be observed at all times." In addition, behavioural risks associated with sudden movements were noted, but there was no guidance for staff about how to support this person with their moving and handling needs. There was insufficient detail for staff regarding moving and handling and mobility needs in all the care files reviewed.

Two care files showed people were at risk of infection because they had wounds that required active treatment. Although it was noted they were under the care of district nurses, the information for care staff about how to mitigate and minimise the risks associated with wounds and pressure care was insufficient. For example, one person's risk assessment regarding the risk of infection from their wound stated risk would be indicated by "Ulcers will be different visually." However, there was no information about what they normally look like for staff to be able to identify this difference. This person's records of care showed staff had identified concerns about pressure area care and were administering a prescribed barrier cream. However, there was no information about pressure risks or how these were mitigated within the care plan and risk assessment.

One person was identified as being at risk of choking. The risk assessment instructed staff, "There is a risk of choking and care must be taken to ensure food is easy to swallow." There was no information about how staff should identify food that was easy to swallow and no guidance on how to identify or respond to choking incidents. Other risks had not been appropriately mitigated, including risks associated with smoking and health conditions including epilepsy and diabetes. This meant people continued to be at risk of unsafe care and treatment as risks had not been appropriately identified or mitigated against.

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

At the last inspection in March 2017 people were not appropriately safeguarded from abuse as the provider was not appropriately escalating concerns raised by people and staff had not received training in safeguarding adults. Staff told us and records confirmed they had received training in safeguarding adults. However, some of the responses of care workers regarding their safeguarding training were unclear. Although all the care workers told us they would report concerns to the office, two care workers told us they could not remember what "safeguarding adults" related to and a third care worker gave an explanation of the Mental Capacity Act 2005 rather than safeguarding.

In March 2017 people had told us they did not always feel safe with their care workers. Feedback at this inspection was more positive. People told us they did feel safe with their care workers. One person said, "I feel safe." Another person said, "Yes, I feel very safe. [Care worker] is very good."

Incident records viewed showed the provider was appropriately identifying and escalating concerns that people had been abused or neglected. However, where allegations had been made against staff of neglect, for example, where they had not attended scheduled visits of care, the follow-up actions had not been completed in a timely or effective manner. For example, one care worker had missed visits on consecutive days. The incident reports stated they would be called in for a supervision and their responsibilities and accountability for their action would be discussed. Their staff file showed they did not receive this supervision until over a month later and although timekeeping was discussed this was in general terms and the specific incidents of neglect were not discussed. After the inspection the provider submitted a file note that showed a conversation had happened with the care worker two days after they had missed the visits. This meant that although there had been improvements in safeguarding adults practice, it was not yet fully embedded in a way that ensured effective action was taken in response to allegations of neglect.

In March 2017 we identified that recruitment practice was not always in line with best practice and made a recommendation regarding this. The provider had not recruited any new staff since March 2017 so was unable to demonstrate they had followed this recommendation. However, the provider had completed an audit of existing staff files and had completed retrospective checks on people's employment history where this was possible.

Care workers told us they thought there were sufficient staff employed and they did not have to rush. People told us they had regular care workers who visited them. One person said, "I have a routine, my carer comes when I expect them." At the last inspection we had identified that visits were often late and monitoring systems for ensuring people received their care were not effective. The provider had completed a significant piece of work regarding staff rotas and scheduling to reduce late visits. A pilot of a new system had been started in October 2017 and was in the process of being rolled out when we inspected the service. The provider used an electronic call monitoring system which required care workers to use people's telephones to log their visits. The provider recognised there were limitations with this system, as many people did not have telephones or did not give permission for care workers to use their telephones. We asked how the provider monitored the punctuality and duration of care visits where the electronic call monitoring system was not used. The provider told us care coordinators logged these calls manually after they had checked the paper logs kept by care workers. We reviewed these paper records for the eight people we case tracked and saw they had all been signed off as checked and audited on 23 and 24 October 2017 despite some of the records relating to as long ago as May 2017. The provider was not able to explain how these calls had been checked prior to October 2017. This meant the provider did not have effective systems in place to ensure staff were effectively deployed to meet people's needs.

Inadequate

Is the service effective?

Our findings

At the last inspection in March 2017 the provider was in breach of Regulation 11 as they were not recording consent in line with the requirements of the Mental Capacity Act 2005. Although the provider had taken some action in relation to this, records of consent remained unclear.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest and as least restrictive as possible.

Records showed where people had capacity they had consented to their care plans. This was indicated by signed consent forms within the files. However, where people lacked capacity to consent to their care relatives had signed these forms and the service did not have records to indicate they had legal authority to consent on people's behalf.

The provider had changed their care plan and assessment document to include a section relating to people's capacity to make decisions about their care and treatment. The quality of information in this section varied. For example, one person's record stated, "[Person's relative] states they cannot make decisions on their own, but there is no power of attorney. The GP has assessed that [unrelated to capacity to consent]. [Provider] to discuss the situation with social worker and seek to understand capacity issues." There was no update within the file. The provider was able to provide an update in relation to the other issues mentioned but not regarding whether or not this person had capacity to make decisions about their care and treatment.

The section relating to capacity for another person stated, "The family provide all key care. [Relative] deals with all her finances. It would be unsafe for her to leave her home without an escort and she would physically find this very this very difficult to do…We discussed POA [power of attorney] but it did not appear that this was in place, this needs to be followed up." A third person's file was similarly unclear and stated, "[Person] has an undiagnosed learning disability and is unable to manage his finances, all their finances are managed by [organisation]." There was no further information in the files and no guidance for staff about the support people might need to make and express their choices. This meant the provider had not addressed the previous concerns about adhering to the principles of the MCA.

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

At our inspection in March 2017 we found care workers had not received the training and support they needed to perform their roles. Care workers told us they had received training since then. The provider explained how they had evaluated the learning needs of their staff and established that online courses were not suitable for their staff team. The provider had delivered training sessions in safeguarding adults in care

workers first languages to ensure they had understood the key messages.

Although records showed the provider had identified specific training needs, particularly regarding moving and handling, at the point of inspection most staff had not completed this training. Twenty-two out of 38 staff were out of date in their moving and handling training, 17 of these staff had not received any training in moving and positioning since 2014. In addition, 35 out of 38 staff had not received fire safety training, 15 staff had never received training in basic life support and 13 staff had never received training in food hygiene. Despite care plans indicating people could present with behaviour which challenged the service, 27 staff had never received training in managing challenging behaviour. Although staff were booked to attend training on nutrition and hydration, 35 staff had not received it at the time of this inspection.

Some people told us they thought staff had the training they needed to perform their roles. One person said, "The care they provide is good and they are well trained." However, other people were less positive about the skills and abilities of staff. One person said, "I think the carer's work is OK. I don't expect full expertise. They are trained up to a certain level." A third person told us "They are not well trained. They don't know how to [support with specific care task]."

All the staff files checked contained a supervision record from within the last three months in line with the provider's policy. Supervision records showed training was discussed with staff in these meetings. Records showed staff were told training was being looked into and they would be booked onto sessions. As staff had not yet completed these training sessions and had not always been booked onto courses requested this meant actions identified to support staff to perform their roles had not been completed.

Other issues raised in supervisions had not been addressed. For example, one care worker had raised a health related concern. However, there was no record that any action had been taken to develop an individual work based risk assessment for this staff member. Although there was a lone working risk assessment in each staff file, this was generic. This staff member had followed the process outlined in the risk assessment and escalated their concern through supervision but no further action had been recorded. This meant the provider had not taken action to ensure staff had the support they needed to perform their roles.

In addition to formal supervision meetings, care coordinators completed spot checks of the performance of care workers. Records showed these had been completed by one care coordinator. During the inspection we were told they had left the service in July 2017, however, after the inspection the provider told us they had left in September 2017. The spot checks had not been completed since July 2017. This meant the provider had not maintained the systems in place to ensure staff were performing their roles as required.

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

People receiving care had a range of health conditions and some people required support to access healthcare services. In March 2017 we identified the information within care files regarding people's health conditions and the support they needed to maintain their health was insufficient. The provider had not addressed these concerns when we returned in October 2017.

People had a range of health conditions, including epilepsy, diabetes, heart disease and a history of strokes. The provider told us there was information about these conditions available to staff. However, this was not specific to the individual. For example, there was no information on what an individual's seizures looked like, or how they presented if their blood sugar levels were high or low.

One person was living with a range of significant and life limiting health conditions, including diabetes. There was a risk assessment regarding diabetes. It identified that the risk was that the person might take the wrong dose of insulin. The indicators were described as, "Will become hypoglycaemic and require hospitalisation." There was no guidance for staff to support them to identify hypoglycaemia. The mitigation was described as "Currently under review by memory clinic who wish to provide [person] with a diabetic nurse for two / three months to ensure correct administration of insulin. This was reviewed today [3/5/17] by the memory clinic." The risk assessment and plan had not been updated by the time of the inspection in October 2017 which meant staff did not have clear information about how to support this person with their healthcare needs.

At the last inspection we made a recommendation that the service seek and follow best practice guidance on ensuring people's dietary needs and preferences were met. It was not clear the provider had followed this recommendation. Most people who received care from the provider lived in supported accommodation where they received their meals. However, care workers were required to support some people to prepare and eat their meals. Care plans informed care workers either to follow people's instructions regarding meal choices or that family members would prepare food for them. Care files did not contain details regarding people's dietary needs and preferences. Although care records showed staff prepared meals for people, they did not capture what people ate so we could not tell if people were supported to eat and drink in line with their preferences. People told us care workers supported them to access meals provided by their supported accommodation services.

Requires Improvement

Is the service caring?

Our findings

In March 2017 we made a recommendation about ensuring that people's support plans and information about the service were made in a format that was accessible to them. This was because a high number of people using the service did not read, or speak English. The provider had taken action to ensure that key documents about the service, including complaints information and how to raise concerns about abuse were available in the different languages spoken by people who used the service. The provider ensured that a staff member who could speak the same language as people and their relatives completed needs assessments, however, care plans were only available in English and were only accessible to people with a good level of English language comprehension.

In March 2017 we also made a recommendation about supporting people who identified as lesbian, gay, bisexual and transgender (LGBT). The provider had made some progress in this area. Records showed people were asked about their sexuality and if they chose to disclose this information it was recorded.

Staff told us they had received training on supporting people who identified as LGBT. One care worker said, "All the people I work with have said they're heterosexual. It should be stated in the care plan and they might have their own preferences. It affects their preferences and we should respect that." However, another care worker who also told us they had attended this training session said, "I actually don't get myself involved in such a person." A third care worker was asked how they knew the people they supported did not identify as LGBT. They said, "I am with two people. I make shower, breakfast, dress and make the bed. They are not gay." These responses showed that not all staff had understood the importance of ensuring they were sensitive to the impact people's sexual orientation and identity may have on their care preferences.

People told us they were asked about their preferences in terms of the gender of their care workers, and these preferences were respected. One person said, "I did have a choice when I first was given the option. It's never varied from that. They have never tried to send a male staff." Care plans contained information about people's preference for the gender of their care workers. Likewise, care plans contained information about people's religious faith. Where people were supported to attend places of worship this was recorded. Care workers told us they did not support anyone who's faith or religious beliefs affected their care preferences.

Feedback from people about the attitude of their care workers was mixed. Although some people told us they had established strong relationships with their care workers, others found care staff to be task focussed in their approach. One person said, "Oh they're lovely girls. I really like them." However, another person said, "They [staff] don't seem that bothered."

Care files contained a section where details of people's pasts could be recorded to help care workers have information to form the basis of a relationship with the people they supported. However, the information contained in this varied and in some cases it was blank or just contained information about their medical diagnoses. Care workers told us they were not provided with information about people's pasts. One care worker said, "[Information about people's pasts] is not in the care plans. I have conversations with my clients, that's how I get to know them. I always inform the office of the information I find out that way, but

they don't note it down. One of the people I support has a daughter, but no one in the office knew because they hadn't written it down when I told them."

Other care workers told us they did not think they needed to know about people's pasts to be able to support them. One care worker said, "You have to know what he or she looks like and then take it from there. You have been informed of their needs and what you are meant to do." Another care worker said, "We don't get information [about people's pasts]. We don't get information about husbands or wives. We don't get information about that. The next of kin might be written there. So they can check in. To check we are doing our jobs." This meant not all staff understood the importance of knowing about people's life history and the positive impact this knowledge can have in forming relationships.

Requires Improvement

Is the service responsive?

Our findings

In March 2017 we found a breach of regulations about person centred care. This was because people were not involved in writing or reviewing their care plans and care was not delivered in line with people's preferences. At this inspection we found the provider had failed to fully address these issues.

After the last inspection staff had met with people to involve them in re-writing their care plans. People told us they had met with staff to discuss their care needs. One person said, "They come in and they talk to me." Another person told us, "I'm involved in planning my support."

Two out of the eight care plans reviewed contained a high level of detail regarding people's choices and preferences for care, providing care workers with detailed information about how to deliver care and where they would find the equipment they needed to perform care tasks. However, records of care delivered for one of these people showed this person's needs had changed and their care workers were providing support that was not captured in the care plan. Their care plan had not been updated to reflect the change in their needs.

The other care plans reviewed did not contain sufficient information to ensure care workers had information about how to deliver care in line with people's needs and preferences. For example, one person's care plan stated, "Help [person] get out of bed. Support her with shower; she has a bath seat which she can sit on independently. She prefers to use a bucket and flannel while sitting in the shower. Assist [person] to brush her teeth. Dress [person]. Assist [person] to comb her hair." There was no detail to ensure care workers were able to provide the right kind of assistance to this person. Another person's care plan informed staff to, "Assist [person] to have a shower and shave." There was no further information about how to support this person to have a shower in line with their needs and preferences. A third care plan stated, "[Person] showers each day and requires assistance. [Person] should be enabled to do as much for himself as he can." There was no guidance about what this person was able to do for himself, or what assistance should be provided.

Care workers told us they received information about people's needs from checking the care plans. However, one care worker expressed frustration that the information was not kept up to date, and was not updated to reflect the knowledge acquired by care workers. They said, "They [office based staff who write the care plans] did not talk to us [care workers] once about what went in the care plans. Not once was I asked. I've noticed they could be clearer and a bit more specific for that client. One person's needs have changed three times and I don't think it's been updated."

We noted in several of the care plans reviewed, sections contained notes regarding the quality of the care plan. These appeared to be a commentary on the quality of the contents of the document. One plan included comments that the information about the person's communication abilities was not sufficient and needed to be expanded. Another plan noted a number of follow up actions that should be completed. However, the plans had not been updated to reflect whether these tasks had been completed. This meant that although all of the plans were dated within the last six months, they were not up to date and were not being used as live documents to ensure care workers had up to date information about people's needs and

preferences.

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

At the last inspection in March 2017 we made a recommendation about seeking and responding to feedback from people and their relatives. Since then, the provider had completed further telephone feedback surveys and held a meeting with people and relatives to seek their views on how the service was performing. Records showed the provider had considered negative feedback received as complaints, and had taken action to address people's concerns. They had made changes to the telephone system for the office and were introducing changes to how staff rotas were structured.

People gave us mixed feedback about whether they knew how to make complaints about the service. Although several people told us they would contact a supervisor or the manager to raise concerns other people did not know how to make complaints. One person said, "I don't really know [how to make a complaint] no. Sometimes I get vexed and I shout. The staff know I am right in what I'm saying so they don't really say much." Another person said, "I have a relative who can deal with that, she knows what to do, I can't really say that I know for myself."

The provider had a robust complaints policy which had been translated into different languages spoken by people who used the service. The policy included timescales for people to expect a response and information about how to escalate concerns if they were not happy with the provider's response. Records showed the provider had investigated and responded to complaints in an appropriate manner and was making changes to systems of work to address concerns that had been raised by more than one complainant.

Inadequate

Is the service well-led?

Our findings

At the last inspection in March 2017 we found the governance and leadership of the service was inadequate as audits and quality assurance mechanisms had not identified or addressed concerns with the quality and safety of the service. The provider had not taken effective action to address these concerns.

The previous registered manager had left the service shortly after our inspection in March 2017. Although the service had a new manager in post, and senior level managers from the provider were involved in auditing and supporting the service, there was no registered manager in post when we inspected.

Staff told us they were aware there had been changes in the management and they found the new management team supportive and more responsive to their requests for help. One care worker said, "[Team manager] is doing really well. She's taken a lot of pressure off us and is doing it herself. Her communication is really good. She tells us what's going on and she's really clear with us." Another care worker said, "There's too many changes. They are really hardworking. I'm sure this time they are working hard and I'm sure it's getting better. The new manager is much better."

The provider had implemented a range of quality assurance systems to monitor and improve the quality of the service. The practice excellence advisor completed a monthly audit where they reviewed key documents as well as two care files and two staff files. They also sought feedback from people and care workers as part of this audit. These audits identified issues with the quality of records. However, follow up to ensure actions had been completed was ineffective. We found the actions had not been completed during our inspection. For example, where audits had identified risk assessments were not sufficient, or that staff had not received medicines supervision, these had not been completed. This meant the mechanisms for improving the quality and safety of the service had not been effective.

The practice excellence advisor also submitted a weekly report to the task and finish group of the provider regarding actions taken to improve the service. The task and finish group comprised of the nominated individual, senior operations staff and operational leads within the provider organisation. These reports were high level summaries of what actions had been completed and what remained outstanding. It was noted that some issues were "parked." These issues were not reconsidered at a later date. The focus of these reports was on staff training and rostering and there was no consideration of the quality of the care plans or experience of people receiving a service.

The provider told us it was part of the care coordinator's role to monitor daily notes and complete spot checks on care workers performance. Records showed spot checks had been completed from April until July 2017 but none had been recorded since. The provider told us a coordinator had left the service in July and since then the completion of spot checks had lapsed. After the inspection the provider told us this coordinator had left in September 2017. This had not been addressed by the time we inspected the service at the end of October 2017.

Likewise, coordinators and supervisors were responsible for collecting and reviewing daily records of care.

This had not been completed regularly. All the care notes reviewed had been audited on 23 and 24 October 2017. Although there were markings on the notes to indicate where concerns had been raised, for example, where care workers had recorded a change in someone's condition, and this had been highlighted, there was no record or action log to demonstrate what had been done with this information. The audits of medicines records had not identified or addressed discrepancies between people's care plans and medicines records. Nor had they identified that guidelines for medicines prescribed on an 'as needed' basis were insufficient.

The provider had dedicated significant resources to implementing an improved schedule for care workers to help ensure people received care at times they preferred. The provider had started this piece of work in July 2017 and was in the process of implementing it when we inspected at the end of October 2017. The provider recognised they had challenges in monitoring the punctuality of calls where they were unable to use electronic call monitoring systems. They had not addressed this issue and continued to rely on coordinators logging calls manually based on timesheets. As coordinators were not routinely collecting or checking the daily records of care there were not effective systems in place to ensure people were receiving their care in a timely way.

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

In March 2017 the provider had not submitted notifications to us as required. Providers are required to inform CQC of certain types of event in order that we monitor services effectively. Records showed the provider had not notified us of four safeguarding alerts they had raised.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not personalised and did not contain sufficient information to ensure people received support in line with their needs and preferences.

The enforcement action we took:

We issued a Notice of Proposal to remove the location from the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity to consent to their care the provider had not followed the principles of the Mental Capacity Act 2005.

The enforcement action we took:

We issued a Notice of Proposal to remove the location from the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people receiving care and medicines support had not been appropriately identified or mitigated against.

The enforcement action we took:

We issued a notice of proposal to remove the location from the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance System and processes had not operated effectively to identify and address issues with the quality and safety of the service.

The enforcement action we took:

We issued a notice of proposal to remove the location from the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the training they needed to perform their roles.

The enforcement action we took:

We issued a notice of proposal to remove the location from the provider's registration.