Metropolitan Care Services Limited

Barking

Inspection report

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Date of inspection visit:
15 June 2017

Date of publication:
27 July 2017

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

This inspection took place on 15 June 2017 and was announced. The provider was given 48 hours notice as it is a domiciliary care service providing care to people in their own homes and we needed to be sure someone would be in. This was the service's first inspection since they registered with CQC in November 2016.

Barking Metropolitan Care Services Limited is a domiciliary care service providing personal care to people in their own homes. At the time of the inspection they were providing personal care to 22 people.

There was 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.

Relatives did not feel people were safe using the service. Risk assessments lacked information about how risks people faced during care were mitigated. This included risks around people's health conditions and medicines. Medicines were not managed in a safe way. Staff were not knowledgeable about safeguarding adults from avoidable harm or abuse. Recruitment of staff was not completed in a way that ensured they were suitable to work in a care setting.

Staff did not receive the training or support they needed to perform their roles. Relatives told us they were worried staff did not know how to do their jobs. The service did not involve people or their relatives in the assessment and care planning process and was not recording consent to care in line with legislation and guidance. Care plans did not contain information about people's dietary needs and preferences and relatives told us people were not supported to eat appropriate meals. Care plans did not contain enough information about people's health conditions to inform staff how to support people to maintain their health. Some relatives worried they would not be informed if people's health condition changed.

People's relatives and staff told us the quality of their relationships was affected by frequent changes in care workers. Care plans did not contain sufficient information about people's preferences or life histories to form the basis of positive, caring relationships. The service did not explore people's relationship histories or sexuality and what impact that may have on their support preferences. Relatives told us they thought care workers treated people with dignity and respect.

Care plans were brief and were not personalised. They did not contain information about how people wished to receive care and there was no information on people's preferences. People and relatives told us they did not choose what time care workers visited them and the times were often not in line with their preferences. People and relatives knew how to make complaints and told us when they had made complaints they were happy with how they had been resolved. However, the provider had not recorded any complaints made.

People's relatives told us they did not think the service was well run. The provider had not identified any of the issues with the quality and safety of the service which were found during the inspection. The provider had not completed any audits or checks to monitor the quality of records. The checks they had carried out on people's experience had not identified the issues found during the inspection.

We have made one recommendation about ensuring the service is accessible to people who identify as lesbian, gay bisexual and transgender. We have identified breaches of six regulations relating to person centre care, consent, safe care and treatment, good governance, staffing and fit and proper persons employed. 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. Relatives told us they did not feel people were safe when receiving care.

Risk assessments did not contain enough information to tell staff how to mitigate risks.

Medicines were not managed in a safe way and staff did not know how to respond to medicines errors.

Staff knowledge and understanding of safeguarding adults was poor.

Is the service effective?

Inadequate

The service was not effective. Staff did not receive the training or support they needed to perform their roles.

The service was not seeking consent in line with legislation and guidance.

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

Care plans did not contain enough information about people's healthcare needs to ensure people were supported to maintain their health.

Is the service caring?

Requires Improvement

The service was not always caring. Relationships between people and care workers were negatively affected by frequent changes in care workers.

People were not supported to express their views and be involved in their care plans.

The service did not explore people's relationship histories or preferences with them.

Care workers described how they showed respect to people and

relatives told us people were treated with kindness and compassion by caring staff.

Is the service responsive?

Inadequate

The service was not responsive. The provider was not completing needs assessments with people or their relatives.

Care plans lacked details about how to support people and contained no information about people's preferences.

People and relatives told us support was not provided at a time that was in line with their preferences.

Relatives told us they had made complaints and these had been resolved. The provider had not maintained any records of complaints made.

Is the service well-led?

Inadequate

The service was not well led. The provider had not identified or addressed issues with the quality and safety of the service.

The provider had not completed audits or checks to ensure that records were up to date and in line with best practice.

People and relatives did not think the service was well run.

Some staff found management approachable and responsive.

Barking

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 15 June 2017 and was announced. The provider was given 48 hours notice because they are a domiciliary care service and we needed to be sure someone would be in.

The inspection was completed by one inspector.

Before the inspection, we reviewed the information we already held about the service. This included details of its registration with the Care Quality Commission. We sought feedback from the local authority who commissioned services from them. As part of the inspection we spoke with one person who received a service and five relatives. We spoke with five members of staff including the registered manager, the nominated individual and three care workers. We reviewed four people's care files including assessments, care plans and records of care. We reviewed four staff files including recruitment records, supervisions and training. We reviewed various other documents and policies relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

Four of the five relatives we spoke with told us they didn't feel their relative was safe. One relative said, "I always feel tense when I'm not there." A second relative told us, "I've never left [relative] alone with the care workers. Just in case." A third relative said, "If my relative was on her own I would worry. It's so difficult. It's difficult to rely on them." Relatives told us they were particularly concerned that care workers did not know how to support people with their moving and handling needs. One relative said, "They don't know what they're doing with the hoist. It can be dangerous."

The moving and handling risk assessments lacked detailed instructions for care workers to follow in order to mitigate the risks associated with specific manoeuvres or the use of equipment. For example, one person's care plan listed various pieces of equipment including a specialised bed, hoist, and sling. However the only instructions to care workers stated, "Manual assistance is required to support [person] to sit up in bed." The description of the task stated, "To complete all personal care tasks including washing, dressing and grooming in bed. Support with change of incontinence pad and support with preparing and feeding." There was no information for care workers on how to complete these manoeuvres or tasks in a way that kept people safe.

A second person's moving and handling risk assessment stated, "Two carers is required to support service user with all the transfers as required as service user is immobile and currently need maximum physical lift and support to manage transfers without a hoist." The description of the moving and handling task stated, "The task involved supporting [person] with all transfers as required either by pushing, pulling, carrying, moving or lifting or putting down." This suggested that care workers were manually lifting this person without equipment. This is not safe for people or care workers. The registered manager was asked about this and they said, "It's just her legs, they are deteriorating. I think there's a mistake there, she uses [various pieces of equipment] and two care workers at every visit." Records of care showed a physiotherapist had visited this person and records stated, "Physiotherapist came in to assess [person]. Do not lift her without equipment." After this date records showed this person was only cared for in bed. After the inspection the provider submitted a revised risk assessment but this still lacked detailed instructions. The updated document stated, "Two carers is required to support [person] with all her personal care in bed as she is immobile and currently need maximum support to manage her p/c [personal care]" This was not sufficient information to inform care workers how to move and handle this person in a safe way.

Risks people faced were not consistently identified or addressed by the service. Three people whose care files were reviewed were identified as being at risk of developing pressure wounds. However, there were no specific risk assessments or guidelines to inform staff about how to mitigate the risks of developing pressure wounds. Also, one person was identified as having epilepsy but there were no seizures guidelines in place. Another person had diabetes and records showed they had an episode of low blood sugar levels while care workers were attending. There was no risk assessment in place regarding the management of their diabetes and no information for care workers about how to identify or respond to changes in blood sugar levels. This meant the service had failed to identify or mitigate risks and people were at risk of harm.

Records showed the service supported people to take medicines. The service had created its own medicines administration records (MAR). However, these were not sufficient to ensure the safe administration of medicines as the staff were recording they had administered "dosset box" rather than the individual medicines administered. One person's medicines care plan was blank and contained no information about which medicines staff were administering. Their MAR showed staff frequently recorded "o" for doses of medicines. The registered manager told us this stood for "other" but there was no supporting information to explain what "other" meant. The provider submitted an updated medicines care plan for this person. It stated, "[Person's] son is total control of her medication as she is the one that dispenses the medication before the start of calls and most times administered the medications." Records of care showed staff gave this person medicines when they had not been administered by the relative. There was no clear information for staff about when they might have to administer medicines and which medicines they might be. This meant there was a risk the person did not receive their medicines as prescribed.

The provider submitted a second person's updated medicines care plan after the inspection. This stated, "[Person] is currently taking medication four times a day for his condition. Medication is administered by carers and [relative]." There was a list of medicines, but the strength, dose, route and time of medicines was not recorded. The MAR contained gaps in records and it was not clear staff had administered medicine in a safe way. Staff told us they could not identify individual medicines they supported people to take. One care worker was asked if they knew the names of the medicines they supported people with. They said, "No, no the chemist sorts it." Two care workers who confirmed they gave people medicines were asked what they would do if a tablet was dropped on the floor. Neither of them was confident in what action to take. One care worker said, "I never had that happen. I don't know. I'm not giving them the one that dropped." The second care worker said, "It's a hard question. You can't open the other one. It's not happened. I don't know what to do now. Maybe I call my manager or the GP." This meant staff were not confident in medicines administration and there was a risk that people would not be supported appropriately with their medicines.

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

Recruitment of staff was not completed in a way that ensured staff were suitable to work in a care setting. Application forms were poorly completed and gaps in applicant's employment histories were not explored. There were no records of the interview or assessment process and there was record of how the provider had decided that staff were suitable to work in a care setting in any of the four staff files viewed. One staff member was using a criminal records check from a previous employer. This meant the service had not carried out appropriate checks on this staff member to ensure they were suitable to work for the service. References had been collected but in two cases the name, role and relationship of the referee had not been recorded and a third person's character reference had been provided by their partner. The staff files did not include appropriate documentation to show that staff had the right to work in the UK. The provider took immediate action to gather the records to show that staff had the right to work in the UK.

The above issues with recruitment and selection process are a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy regarding safeguarding adults from avoidable harm and abuse. This included the details of the local authority safeguarding team in which the office was based, but not for the local authority area in which all the people who received a service lived. Safeguarding is led by the local authority where the alleged abuse took place. This meant the policy did not include appropriate information to ensure staff knew how to escalate concerns to the correct agencies.

Records showed that safeguarding adults and children was included in the provider's training to staff. However, this had not been effective as staff understanding of safeguarding was poor. One care worker said, "There was a section on the online training about that. Is it to do with lifting and all of that?" Another care worker said, "[Safeguarding] is about the way you can handle. If I enter the house, if I switch the switch it might be a hazard, or if I leave the medication. It's to avoid the harmful things or hazards." A third care worker said, "It's like when we are leaving a client we need to make sure clients are safe and secure." This meant staff did not have sufficient knowledge of safeguarding adults to ensure people were protected from avoidable harm and abuse. The registered manager told us there had been no safeguarding concerns since the service had started operating.

Inadequate

Is the service effective?

Our findings

Relatives told us they did not feel care workers had been trained for their roles. One relative said, "They [care workers] don't fill me with great confidence." Another relative told us, "Some [care workers] do know what they are doing. Some are learning on the job." Staff gave us mixed feedback about the training they received. One care worker said they had received lots of training, however, a second care worker said they were relying on the training they had received from a previous employer. A third care worker said, "With the training, I just had shadowing for a week and some online training. I had to learn how to use the hoist from the relatives." Training records did not include practical training on moving and handling people. A relative told us this showed in how they supported their family member. They said, "Virtually every day I'm telling them they've got it wrong. Usually they have the sling inside out."

Two of the staff files reviewed contained a training certificate for "Mandatory training refresher." The certificate showed that the course content included 38 topics including health and safety legislation and guidance, moving and handling theory, infection control, safeguarding, food hygiene, first aid, information governance, lone working, fire safety and equality, diversity and inclusion. The certificate stated the course duration was seven hours. The registered manager told us this was the provider's core induction training and that it took place over two days. There were no records to support this and the course was entitled a refresher which suggests it was intended to recap existing knowledge rather than provide foundation knowledge required by staff new to working in care. The training had been completed in April 2017 despite two of the staff having worked for the service since January 2017 providing care where knowledge of medicines and moving and handling was required.

The registered manager told us they only provided a refresher as all their staff had a background in care work. None of the four staff files reviewed showed a work history that included care work. Staff files also contained certificates showing they had completed online training in medicines and moving and handling theory. The moving and handling course included 15 topics and the medicines training 37 topics. The certificates showed these courses had been completed on the same day. This meant staff had completed training in 52 areas on the same day. Staff responses to questions about medicines and safeguarding showed this training had not been effective as they did not understand what actions they should take. This meant they were not applying knowledge when supporting people.

The provider had a policy regarding supervision for staff. This stated that staff should receive supervision a minimum of six times per year, and this should be a place to discuss relationships with people who use the service, staff performance and training. During the inspection only one staff file contained any records of supervision. The notes were very brief and did not include detailed discussion of relationships and although with regard to training it was recorded "Training helps" and the column for actions was completed with "yes" it was not clear if any training needs had been identified. After the inspection the provider submitted supervision records for two more staff. These both stated staff would like "to spend less time in supervision." There was no detailed discussion of people or their needs and training was only referred to in general terms. One care worker said, "We normally have supervision once a month. They ask if we are OK, ask if we wear our badges, how are the jobs going." The wearing of identification badges was not included in any of the

supervision records viewed. A care worker whose supervision records were submitted after the inspection was asked if they had supervision. They said, "I don't know what you mean." A third care worker was very clear they had never received any supervision. This meant there were not opportunities for staff to discuss people and reflect on how they provided their support.

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

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. We checked whether the service was working within the principles of the MCA.

At the start of the inspection the registered manager told us that some people using the service lacked capacity to consent to their care and their relatives were legally appointed decision makers. The registered manager told us they did not have copies of the records required to confirm these relatives had legal authority to consent to care on their relative's behalf. Care plans contained no information about people's capacity to consent to their care, or make decisions about their care. Considerations about capacity and consent were not included in the assessment. The provider submitted updated needs assessments after the inspection but these still did not explicitly refer to people's capacity to make decisions. There was a reference to "confusion" which stated that all four people whose files were reviewed were not confused, three of them stated "Not confused as she is able to hold an adult conversation." This is not an appropriate assessment or record of whether people have capacity to consent to their care.

None of the care files viewed were signed by people, or legally appointed decision makers, to indicate their consent. One person told us, "[Provider] more or less told me he was bringing the worker around. I didn't want them. I phoned [nominated individual] and told him to stop sending them." This meant the service was not working within the principles of the MCA as people had not provided consent to care and consent had not been appropriately recorded.

Staff understanding of the MCA was poor. One care worker told us, "I've not had training on that [MCA]." Another care worker said, "Yes, I've heard of that [MCA]. The people are mental. Where I'm going, I have this one. It means I know the situation and how to handle her or him." This showed that care workers did not understand what the MCA was about or had not had training to ensure they followed the principles of the MCA.

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

Care workers told us they offered people choices while they provided care to people. One care worker said, "In the morning, I will ask if they want a shower or a bath. It's their choice." Another care worker told us they worked with one person who could not express their choices. They explained, "Her husband makes all the choices, he gets everything ready but we still chat to her, check if she's OK and talk her through what we are doing. If she's really communicating 'No' we'll get her husband to help and we will try again after he has spoken to her." However, relatives we spoke with told us care workers did not offer people choices. One relative said, "[Person] likes to have a shower a couple of times a week but they don't offer that. She has to ask and sometimes they'll suggest she just has a wash instead." This meant people were not being offered choices about their care, and choices they had made were not respected.

Care plans showed care workers were supposed to support some people to eat and drink as part of their support package. However, care plans contained no information about people's dietary preferences. One person's care plan stated, "Support with preparing, serving and feeding breakfast [lunch and dinner]." In their life history it said, "He does not feed himself and he requires carer to feed him." Later the plan stated, "Carers to prepare, served and feed me four times daily." There was no information about what food this person liked or how they liked to be supported to eat their meals.

Records of care contained information about what people had eaten during care visits. However, one relative told us care workers did not always understand or follow their family member's requests regarding food. They explained, "One time [person] had been given a beef dripping sandwich. She had some leftover in the fridge. She had asked for a cheese sandwich and got a dripping sandwich which she couldn't eat. Who would eat a fat sandwich?" Another relative told us, "They [care workers] are supposed to get her tea ready. But she often makes her sandwich herself. What she needs is them to make the hot drink. She'll have made the sandwich and left it in the kitchen. They'll bring the sandwich through and record that they've given her tea." This meant there was a risk that people were not always supported to maintain a balanced diet or eat and drink enough.

Care files contained limited information about people's health conditions and needs in relation to their health. One care file contained a list of diagnoses, however this person's relative said, "When I looked at the file there were some things that were surprising to us. Some diagnoses that I think I would have known about." One person's care file stated they had epilepsy but there was no information about whether or not they had seizures or information about their seizures for staff to follow. Another person was diagnosed with diabetes. Their care file contained no information about identifying or responding to changes in their blood sugar levels. A relative told us, "[Person] is diabetic and it's really important they have their meals on time. They don't always come on time and I worry something might happen."

Some relatives were confident that staff would tell them if they thought people were unwell. One relative said, "Yes, they would tell [another member of the household] if he was unwell." However, other relatives we spoke with were not so confident. One relative said, "I don't think they would [tell me if my relative was unwell]. It makes me very tense." This meant there was a risk that people were not supported to maintain their health as care workers did not have clear information about people's health needs and the support they needed to maintain their health.

Requires Improvement

Is the service caring?

Our findings

People, relatives and staff told us the strength of relationships was affected by constantly changing care workers. A relative told us, "We requested specific care workers, or at least a reduction in the number of care workers, but that didn't happen. It's always new people." Another relative said, "I had to speak to them because we were getting so many different carers. We have at least one regular per day now." Another relative told us, "[Relative] never knows who is coming, sometimes [relative] has five different ones [care workers] in a week."

One of the care workers we spoke with told us changes to the people they worked with affected relationships. They said, "People get used to us. Then it changes. It means you can't get to know people. People are always asking why it can't be someone they are used to. One person refused me because I didn't know her. That's fair enough really." However, other care workers did not appreciate the impact being a strange face might have on people receiving care. One care worker said, "When we learn how to look after people we can go straight in to new people." Inconsistent rotas and changing care workers meant people did not have the opportunity to build up positive relationships with care workers.

Care plans did not contain any information about people's preferences. Although some of the files reviewed contained a form which stated that people had said they were happy with the care they were provided with, all the relatives and people we spoke with told us they had not been asked their views or involved in making decisions about their care. One person said, "No one met with me before. Someone came, I think it was the owner. He came and told me this one would be coming. It was not based on what I said. I didn't want it." After the inspection the provider submitted updated care plans. These still did not contain information on people's preferences for their care, although they did now include whether or not people had stated whether they preferred care workers of a specific gender. A relative told us they had asked if care workers who spoke the same language as their family members could attend but this was not possible. This meant the service had not actively sought people's views or helped them to make decisions about their care.

Care files contained a section called "Life history – pen picture." These were poorly completed and did not provide care workers with information that would help form the basis of positive, caring relationships. One person's life history section was completed with a copy of the summary of referral information from the local authority. Another person's contained their date of birth, then continued, "My son is whom I live with, he is my next of kin and my primary carer. He means a lot to me we have a very strong bond." There was no further information about their life or preferences. A third person's life history contained their date of birth and details about their relatives. The only information about their life before they received a service stated, "Before my illness I was self-sufficient and living in my own house [in a different area]." This meant staff did not have any information about people and their lives to help form the basis of a positive relationship.

Care plans did not contain information about people's personal and significant relationships. The assessments submitted after the inspection did not show that people's sexual identity was explored with them to see if it had an impact on how they wished to receive care. When asked if they supported anyone who identified as lesbian, gay, bisexual or transgender one care worker said, "No, I never work with gay

people. I don't know if anyone is." This meant there was a risk that people who identified as LGBT were not involved in expressing their care preferences and there was a risk they did not receive care that reflected their preferences.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring services are accessible to and supportive of people who identify as lesbian, gay, bisexual and transgender.

Although care plans did not contain any guidance for care workers about how to respect and promote people's dignity care workers described the things they would do clearly. One care worker said, "We need to reassure the person. Talk with them. Make sure the family have left the room. I will close the door." Relatives told us they felt care workers were kind and compassionate in their attitude. One relative said, "The carers when they turn up are very caring." Another relative said, "They [care workers] are lovely people, they're good to [relative]. Chatty and more than respectful." A third relative said, "They respect our culture. We do ask for [culturally specific request]. As long as they are polite and we feel we can ask for that it's ok."

Inadequate

Is the service responsive?

Our findings

The provider's policy stated "Service users will be assessed prior to consideration for a care package from the agency." The policy also stated, "Service users or their personal representatives will be encouraged and supported to be fully involved in the assessment of their care, treatment and support needs." Feedback from people and relatives, and records available in the service showed the provider was not adhering to their policy. People and relatives told us they were not involved in the assessment or care planning process. A relative told us, "No, they didn't do an assessment. I got a call to say they'd be there in the morning. They came with the information from social services but they didn't check it with us. I've had no one come and do a home visit."

Two out of the four care files reviewed had no needs assessment completed. The registered manager told us they had relied on the referral information from the local authority as there had been a need to put a care package in place quickly. After the inspection the provider submitted assessments for these people. The assessments completed rated people's dependency levels in various areas of care, but provided no details on what this meant for the individual. Comparison with the local authority referral information showed that no additional information about people's support and care needs and their preferences in terms of how those needs should be met had been added. The information submitted did not show people had been involved in completing the updated assessments.

The provider's policy stated that care plans, "Should state in clear and factual language the detailed care treatment and support instructions required to instruct staff to meet the individual service user's needs identified by the individual assessment process." The provider had not followed this policy. The registered manager told us they wrote the care plans or relied on the care plans supplied by the referring local authority. Care plans contained only basic summaries of the support to be provided and contained no information about people's care preferences. For example, one care plan submitted described the support required at a morning visit as "Morning call (8am to 9am) x2 carers 60 minutes. Support with personal care (full body wash in bed, dressing, grooming and change of beddings and laundry. Support with preparing and serving breakfast." There was a table later in the file which included a column to describe how care outcomes would be met. This did not contain information on how to meet needs. For example, in order to meet the need of "maintain personal hygiene" the instruction stated, "Carers to assist with washing and dressing four times daily." There was no information about how to actually provide assistance with these tasks.

The registered manager told us they attended initial care visits so they could ensure that care workers knew what to do when visiting people's homes. Some care workers told us this was the case. One care worker said, "Most of the time when it's a new person the manager comes with us." However, another care worker said, "Sometimes we are going in without any information. I worry about what I will find." Care workers told us they relied on the handover from the registered manager rather than the care plan. One care worker said, "You have to call the office, or the office will call us to find out what to do." Another care worker told us, "When you go to a new person you have to ask them what to do and they have to tell you what to do and what the situation is. You have to call the manager and ask what to do and they explain to you what to do." A

third care worker said, "Sometimes I know about them [people] before I go. The folders don't really tell us much. I have to ask the family."

All the relatives we spoke with told us they had not been involved in care plans and only one had seen a copy of the care plan in their relative's home. Relatives told us that this meant people did not always receive support that reflected their needs and preferences. The timing of visits was an issue for everyone we spoke with. One relative said, "They were always early. My relative isn't going to be ready for them until 9:30 at the earliest. We had to say that a few times." Two other relatives told us they had concerns that the bed time call was taking place too early. One relative told us, "They put her to bed as early as 5pm. She has all her faculties, she doesn't want to be put to bed like a child." Another relative told us they had cancelled their evening visit as they were being supported to go to bed very early and this was not in line with their preferences.

People and relatives told us the provider changed the time of their calls without consulting with them. One person said, "They started at 10:00, but when a new carer came it changed to 10:30 but he didn't arrive til 11:00 or even 11:30 and I didn't want to wait til then. They just changed the times and didn't ask." One relative described how the morning visit was time critical due to the person's health needs. They told us they were never informed if the care worker was running late and were very worried that if they were away their relative's health could deteriorate if the call was late. Another relative told us, "The times have settled a bit but we never get the full hour in the morning or full time in the afternoon. It's an in-out job. It's a bit frustrating." A third relative told us, "With the timings, they are not exact, sometimes 20 minutes early, sometimes 15 minutes late. They never stay the full time. They go after half an hour if they've finished the tasks."

Records of the handwritten log sheets completed by carers during site visits were reviewed. These showed care workers recorded the full length of time of a scheduled visit and that the time of calls varied by between 15 and 30 minutes from the scheduled time. However, the provider's electronic call monitoring data showed that every single visit for every single person over a two week period was completed exactly on time for exactly the correct amount of time. A relative told us, "It's very worrying, the timesheets don't match the copies in the home. I am signing things blind. I don't mind if they go when they have finished the tasks, but I know the timesheets are a work of fiction." This meant there was a risk that people were not receiving the support they required to ensure their needs were met.

The issues above about needs assessments, care plans and support not reflecting people's preferences are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had not received any formal complaints since the service started operating in November 2016. They said they had received some informal complaints about timekeeping. The provider's policy did not distinguish between formal and informal complaints and stated, "The recording of complaints will not be confined to 'serious' or 'substantial' complaints." The provider had not maintained a record of complaints made. Three of the relatives we spoke with told us they had made what they considered to be formal complaints about the service. They were all satisfied with the outcome and stated that the provider had apologised and was taking steps to ensure the issue they had complained about did not recur. The lack of records regarding complaints meant the provider was not keeping records of complaints and so could not analyse complaints for themes or ensure that lessons were learnt and applied from complaints.

Inadequate

Is the service well-led?

Our findings

Relatives told us they did not think the management of the service was good enough. One relative said, "The systems around the girls aren't helping them to do their jobs well." Another relative told us they hadn't had any contact with managers within the service. They said, "There have been no checks by them. It feels like they have a ways to go." A third relative told us, "I do not have confidence in management. They don't appear to know what they are doing." A fourth relative said, "I wouldn't be going to them if I was paying. The only meeting with the manager chap was on the first day when it was all a bit chaotic."

Staff told us they found the registered manager was approachable and they could speak to her to raise any concerns they had. One care worker said, "The manager, she's a lovely lady. She's available. I can call her if I'm struggling with a new client." Another care worker said, "They are good managers. Anytime we call them they answer the call. They listen, they don't argue, they don't ignore us and they make changes." However, a third care worker said, "I feel like they don't really know what they are doing. [Registered manager and nominated individual] are doing a lot of their own. It feels like they have too much work on their hands."

The service was relatively new, and had only been operating for six months at the time of inspection. The provider submitted a copy of their quality and quality assurance policy and their auditing policy and procedure. These laid out the processes that the provider should follow to assure themselves they were providing a high quality service. The provider was asked if they had completed any audits or checks on care plans, records of care or medicines records. The registered manager told us, "There are no checks on the records log book, I do check the MAR charts but I don't document it. We monitor the call log information but it's not recorded." During the inspection issues with the quality of the recruitment records were identified. The registered manager and nominated individual were asked if they had ever checked or reviewed the recruitment files. The registered manager responded, "Truthfully, no, I have never checked."

During the inspection we identified significant concerns with the needs assessments, care plans, medicines records and recruitment records within the service. None of these issues had been identified by the registered manager or the provider. The provider was given the opportunity to submit additional information but the quality of documentation remained insufficient to ensure that people received safe care and treatment.

The registered manager completed spot checks of records in people's homes. These contained a section where the quality of care plans and records was considered. None of the spot checks reviewed identified the issues with the quality of documentation found on inspection. The feedback from people was that they understood and had copies of their care plans and were happy with the support they received. This included a spot check completed with a person whose relative provided contradictory feedback to us where they stated they had never received any checks on their service. The spot check feedback did not correspond with the feedback received during the inspection that timekeeping and lack of information about care plans were issues for all the people and relatives we spoke with. The lack of quality systems in place meant there were risks to people using the service that had not been identified or addressed.

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

The provider told us they completed service user surveys to gain feedback about people's experiences of care. However, these could not be located during the inspection. The provider managed to locate one survey which included the feedback, "Your carers are very caring and kind."

Two care workers told us they had regular staff meetings, although one told us these did not take place. The two care workers told us these were useful meetings where they raised concerns about people's homes and travel time. Records of staff meetings were reviewed. These showed that neither the registered manager or nominated individual attended the meetings. Meetings took place every three months and showed staff were reminded to wear personal protective equipment and discussed the hours of work, training and supervision.

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 9 HSCA RA Regulations 2014 Person-centred care People's needs were not assessed and care plans did not contain sufficient information to ensure people's needs were met. Regulation 9 (3)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not seeking or recording consent to care in line with legislation and guidance. Regulation 11 (1)

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

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not identify or mitigate risks faced by people receiving care. Medicines were not managed in a safe way. Regulation 12 (2)(a)(b)(g)

The enforcement action we took:

We have imposed a condition on the provider's registration and issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were ineffective and had not identified or addressed risks to people or the service. Regulation 17 (1)(2)(a)(b)

The enforcement action we took:

We have imposed a condition on the provider's registration and issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not provided with the training and support they needed to perform their roles. Regulation 18 (2)(a)

The enforcement action we took:

We have issued a warning notice