Allfor Care Services Limited

Allfor Care Alpha Care Recruitment West and Home Care Service Limited

Inspection report

15 Maswell Park Road
Hounslow
Middlesex
TW3 2DL

Tel: 02088982867
Website: www.allforcare.co.uk

Date of inspection visit:
18 February 2020
19 February 2020
21 February 2020

Date of publication:
30 April 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Allfor Care Alpha Care Recruitment West and Home Care Service Limited is a domiciliary care service providing personal care and support for people in their own homes. The service supports younger people with autism and complex physical impairments. The majority of people receiving support had their care funded by a local authority. At the time of the inspection the service provided support for approximately 93 people.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The provider did not record and investigate when an incident and accident occurred involving a person receiving support so lessons were learnt to prevent reoccurrence of similar incidents and accidents.

When a risk had been identified during an assessment of a person's needs a risk management plan had not always been developed to provide care workers with adequate information to reduce the risks. Risk management plans for some people had not been regularly reviewed to ensure these were up to date.

Improvements had been made in the monitoring of how medicines were recorded but issues were still identified in relation to the guidance provided for care workers to make sure they had all the necessary information to support people with their medicines safely.

Records relating to people using the service were not always clear about the care and support they needed, so staff had all the information they needed to care for people.

The provider had a range of audits in place, but these were not effective as they had not always identify areas where improvement were required so these could be addressed.

People told us they felt safe when receiving care. The provider had a process in place for the receipt, recording and investigation of complaints so people and relatives can be confident their complaints would be taken seriously.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The provider operated safe recruitment processes and there were enough care workers allocated to meet people's care needs. Staff received the training and supervision they required to equip them with the skills to

provide care in a safe and effective way.

An assessment of people's care and support needs was completed before they started to receive care from the service.

People using the service, relatives and care workers felt the service was well run.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 19 March 2019) and there were multiple breaches of regulation which included regulations in relation to person centred care, the need for consent, safe care and treatment and good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made in relation to supporting people to consent to their care (regulation 11), but the service was still in breach of the other regulations.

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider still needs to make improvements. Please see the Safe, Responsive and Well Led sections of this full report. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

Enforcement
We have identified repeated breaches of regulations in relation to safe care and treatment, person centred care and good governance at this inspection. 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 provider had not sent notifications to the CQC relating to two incidents that involved the police as required by law. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are considering our regulatory approach regarding this breach of regulation.

The provider was not displaying their rating on their website. This was a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory approach regarding this breach of regulation.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Allfor Care Alpha Care Recruitment West and Home Care Service Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and ann Expert by Experience who carried out telephone interviews with people receiving care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 18 February 2020 and ended on 4 March 2020. Telephone interviews were

carried out on 3 March and 4 March 2020. We visited the office location on 18 February, 19 February and 21 February 2020.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and five relatives about their experience of the care provided. During the inspection we spoke with the registered manager and deputy manager. We received feedback from one care worker. We reviewed a range of records which included the care plans for 13 people and multiple medication records. We looked at the records for four care workers in relation to recruitment and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and other information provided.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had not always acted to assess, monitor or mitigate risks to the health, safety and wellbeing of people using the service. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 in relation to managing risk.

• The provider had risk assessments and information in place for the majority of risks but some relating to people's specific health risks and support needs did not provide enough information for staff to mitigate identified risks.
• General information sheets were in the care plans about people's medical conditions, but these did not relate to the person's own experience of the conditions. Risk management plans were not in place for conditions including seizures, dizziness, breathing problems, and risks associated with pressure relieving mattresses, oxygen therapy machines and catheter care.
• The care plan and skin risk assessment for another person identified that in February 2020 they did not have any skin issues, but a district nurse had raised a safeguarding concern relating to a grade three pressure ulcer at the same time. Therefore, the information in the risk assessment and the care plan was not accurate.
• The record of a multi-disciplinary meeting relating to one person's care indicated a risk assessment was required for a new piece of equipment which was being used to maintain their safety when supported to access the community. The need for the risk assessment was identified in July 2019 but this was not in place at the time of the inspection. Therefore, care workers had not been provided with guidance on how the person should be supported safely.
• Where people at times behaved in a way that challenged staff when accessing the community and using transport, risk management plans were not always in place or the ones in place had not been updated to include any changes. For example, the road safety management plan for one person consisted of standard text with the person's name written into spaces so did not reflect the specific risks and action which should be taken to reduce identified risks.
• The care plans and needs assessments for people identified as not having an awareness of possible danger when accessing the community and traveling in public did not always have risk management plans to provide care workers with guidance on how to support them safely. Where risk management plans were in place they did not relate to the person's specific support needs and were generic.

•The environmental risk assessment for one person indicated there were no fire risk in their home but the care plan indicated the person smoked and was also unable to mobilise without support from care workers. There were no control measures in place to reduce the risk of fire.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risk was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At our last inspection the provider did not always ensure the outcomes from incidents and accidents were reviewed to identify learning which could be used to reduce the risk of reoccurrence. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 in relation to learning lessons when things go wrong and issues occur.

• Incident and accident records were completed by care workers, but they had not been reviewed to identify learning that could be used to reduce the risk of reoccurrence. For example, we saw one incident record which related to a person experiencing behaviour that could be challenging. The section on the record form used to identify a possible trigger for the incident stated, "I don't know" and the only action was to inform the social worker. There was no review of any issues which may have led to the incident, learning from it and how the person could be better supported in the future to avoid triggering similar incidents.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure lessons were identified and appropriate action taken to help reduce the reoccurrence of similar concerns, incidents or accidents. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had a process in place for the administration and recording of medicines, but this was not always followed which resulted in the administration of medicines not being recorded accurately. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Though some improvements had been made at this inspection the provider was still in breach of regulation 12 in relation to the administration of medicines.

• The medicines record for one person indicated the person wanted to manage their own medicines but then stated the care worker was to remove the medicines from the dossett box and place in a cup. The care worker was then to give the tablets to the person with water. The medicines to be taken during the day outside of care visits were to be removed from the packaging and left out for the person to take. Care workers completed the medicines administration record (MAR) indicating they had administered all the medicines throughout the day including the ones that had been left out, even though they had not seen the person physically taking the medicines.

• The guidance provided for care workers indicated they should remove medicines out of the packaging for the person but there was no indication on what they should do with them once removed. The records provided conflicting information as to whether the person required the care workers to administer medicines or they could manage their medicines. The care plan did not explain if the medicines were not to be taken immediately, where they should be placed for the person to access them. The care plan also indicated the person may forget to take their medicines but there was no guidance provided to identify what care workers should do to ensure the medicines were taken as prescribed.
• If the care visit was carried out by a care worker that was not familiar with the way this person had support with their medicines, they would not have had the appropriate knowledge to do this safely.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure care workers were provided with accurate information to ensure medicines were administered as prescribed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Information about prescribed medicines was included on the MAR. There was also a photograph of the medicines labels provided by the pharmacy attached to the MAR which provided information on how and when medicines should be administered.
• A medicines risk assessment was completed to identify if the person required support to take their medicines and if there were any risks identified. A medicines agreement form was also completed to indicate if the person required support with medicines and if they had consented to this.
• Care workers completed administration of medicines training annually and their competency was also assessed.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe when receiving support in their home. Their comments included, "Yes, the carer is very good" and "They look after me." Relatives also confirmed this and said, "[My family member] has dementia, and [they do] trust them" and "Definitely safe. [My family member] has dementia. I have no issues with the care [they] receive."
• The provider had systems for responding to any concerns relating to the care and support provided. We reviewed the records for safeguarding concerns which included copies of investigation notes, information from the local authority and the outcome of any investigations and referrals with any actions.
• Care workers showed they understood how people should be protected from abuse.

Staffing and recruitment
• People confirmed that in general care workers arrived when planned and they were contacted if the care workers were running late. Their comments included, "They let me know if they are going to be late. They come on time [usually]" and "More or less [on time], depends on the traffic. Yes, the carer phones [if running late]." A relative told us, "Yes, absolutely. The odd time [they have] been held up. [They] always text or call, but very rarely [they are] late."
• One relative told us that when the regular care worker was off there was sometimes an issue with the service finding appropriately trained care workers to cover. They said, "That has been something we have been struggling with. They don't always have the backup one available. It's not often, but if the care worker is not well or stuck somewhere I want someone who knows my family member. A very long time it has been going on. Sometimes I can't go out because of the carer shortage. They never send a back up one."
• The number of care workers required to visit a person was identified during the assessment of care needs and any reviews and the duty rota was drawn up accordingly.
• The provider had a recruitment process to help ensure care workers were recruited safely and had the skills for the role. The registered manager confirmed two references would be obtained from either previous

employers, education providers or character references.
• As part of the interview process, applicants completed a literacy and maths test. Before new care workers started to work they completed an induction and shadowed an experienced care worker. Recruitment records we reviewed demonstrated the provider's process was being followed.

Preventing and controlling infection
• Care workers received personal protective equipment (PPE) to use when providing care. The registered manager told us care workers were provided with gloves, aprons and shoe covers to use during visits.
• Records showed care workers had completed training in relation to infection control.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

At our last inspection the provider had not always ensured people's care was being provided in line with the principles of the MCA. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement was being made at this inspection and we judged the provider was no longer in breach of regulation 11. However, they had not yet completed all the improvements they had intended to make.

• The deputy manager explained the new computerised care plan system was being used to create people's care plans. When the information relating to a person's care needs was added to the system and it was identified that the person may not be able to consent to an aspect of their care, a mental capacity assessment form was generated.
• We saw the provider was still in the process of completing records to assess and document people's mental capacity to make decisions. The deputy manager told us as existing care plans were being added to the system a person's capacity to consent would be assessed and the forms would be completed. They showed us examples where mental capacity assessments had been completed for one person in relation to personal care and other parts of the support they receive. These assessments were being introduced as the care plans were being transferred to the computerised system during the next couple of months.
• Care workers completed training on the MCA. Care workers demonstrated an understanding of the MCA and how it impacted on decision making when providing care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's care needs were assessed before they used the service to identify the support needs and to ensure the service could meet their care needs. The registered manager explained when a referral was received from the local authority, a needs assessment was carried out within two days.
• If an assessment could not be carried out the registered manager told us an experienced care worker was sent to the initial visits. A field supervisor worker would also attend the initial visits to identify the person's support needs and develop the care plan and risk assessments.

Staff support: induction, training, skills and experience
• Staff completed a range of training and had regular supervision with their line manager. People told us they felt the care workers were appropriately trained. Their comments included, "Yes, most of them. I don't think I have a really bad one. Some are better than others" and "Yes, they have the right skills." One relative commented, "Yes, they are trained very well. Never had any complaints" but one relative told us, "At the moment [regular care workers are trained]. When it's a care worker who doesn't know anything, I have to train them. I was sent a care worker who did not know how to use a hoist. They looked terrified."
• Care workers completed a range of training including moving and handling, pressure area care, diabetes awareness and catheter care. The training records showed care workers were up to date with their training and this was confirmed by the care workers we contacted.
• New care workers also completed the Care Certificate and had their competency in relation to providing safe and appropriate care assessed. The Care Certificate is a nationally recognised set of standards that gives new staff to care an introduction to their roles and responsibilities.
• The registered manager explained they aimed to carry out four to six supervision meetings with care workers each year including an appraisal. We saw evidence of regular supervision meetings between care workers and their line manager and annual appraisals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to access healthcare services and a range of agencies to receive timely care. The registered manager explained the service worked with GPs, occupational therapists and district nurses.
• Senior staff attended meetings with local hospitals to plan people's discharge into the community. A joint appointment with an occupational therapist would be carried out to ensure all the appropriate equipment was in place in the person's home.
• The pharmacist would be contacted to ensure a person was provided with medicines in appropriate packaging for example a blister pack to support the person to manage their own medicines.
• Care plans identified how the person should be supported with their oral care needs.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us care workers supported them with meals. Their comments included, "Any time they ask me 'what food would you like?' I tell them and they do it and give it to me" and "They help, prepare my stuff for me. Yes, they ask me [choice], I have a variety."
• The care plans identified if the person required support to make and/or prepare meals. They also identified if the care workers needed to assist a person to purchase food when being supported to access the community.
• Care workers completed a food and hygiene course as part of their mandatory training, so they could prepare food for and with people safely.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• During the inspection, we found that the provider did not always ensure people were always appropriately treated and their health and safety were always fully considered while they received care. The provider had not always considered people's safety in that risk assessments were not fully completed to help ensure people were safe and they were not always acting in a caring manner as there were a number of repeated issues in the way the service was provided.
•The service was also not always caring in that people were at times not protected against the risk of poor care because learning did not take place where there were incidents and accidents and medicines were not always managed safely. The provider had also not ensured people received all the information they needed in a format they understood so they could be fully involved in their care.
• Notwithstanding the above people told us they were happy with the care they received. One person commented, "Yes, very happy, they are very good." A relative commented, "They have been with my family member for about two years. They communicate with me a lot. They will let me know anything serious." Some relatives did tell us on occasion there were issues with communication from the office when a visit was not going ahead on time.
• People felt the care workers provided support in a kind and caring manner. Their comments included, "Yes. They make me laugh all the time. [The care worker] is very good" and "Definitely. They always try to put a smile on my face and make me feel happy, have a little joke with me. They basically try to keep me smiling and cheer me up."
• Care plans identified the person's preferred name as well as their religious and cultural preferences. The care plans produced using the computerised system included information on the gender and sexuality the person identified with. The information also included the type of clothing the person preferred.
• Care workers completed equality and diversity training as part of their induction and regular training refreshers so they had a good understanding of people's diverse needs.

Supporting people to express their views and be involved in making decisions about their care
• People told us they were involved in decisions about their care. Their comments included, "Yes, they come to my home. Like I said, they are a good agency and definitely tick all the boxes for me. I am happy with the care I receive from them" and "[My care plan is reviewed] every six months. I think I am due for another one. Last one was in November."
• We saw care plans had been signed by the person receiving support or their representative to show they had agreed to them. Where a person with capacity to consent to their care had indicated they wished a family member or another person to sign the care plan on their behalf, this was also recorded in the care

plan.

Respecting and promoting people's privacy, dignity and independence
• People told us they felt care workers respected their dignity and privacy when they provided care. Their comments included, "Yes. They give me a wash. They close doors, pull curtains. They let themselves in, I have a keysafe. They knock on the door of the bathroom" and "They make sure the door is shut and I don't sit facing the window, and my back is to the window. My regular carer goes ahead and gets on with it because I have confidence in her." A relative commented, "Yes, absolutely. I have sometimes been there on weekends and they do treat my family member well, ask what they want, double check with them what they would like for food. They are very good with my relative."
• A care worker told us, "I always make sure that I provide care and treatment in a way that ensures people's dignity and I treat them with respect at all times. This includes making sure that people have privacy when they need and want it, treating them as equals and providing any support they might need to be autonomous, independent and involved in their local community."
• People felt care workers supported them to be as independent as possible when providing care. They told us, "Yes. If I tell them I want to do something they let me do it" and "Yes, it is good for me." A relative said "Yes, they do, they don't do things for her if they know she can do it. They encourage her to do things they know she can do."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider did not ensure the information provided in care plans was always accurate and consistent to enable care workers to provide appropriate care for the person. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

• The care plan for one person stated they received oxygen therapy to help with their breathing and they needed a specialist piece of equipment to help with their breathing. The care plan did not contain comprehensive information and instructions about how to ensure the equipment needed for the oxygen therapy and to help the person breathe, was cleaned and maintained.
• Where a person had a specialist mattress in place used to reduce the risk of skin breaking down there was limited information for care workers as to how they should check it was working correctly. The daily records of care they completed for each visit did not indicate that they had checked the mattress to ensure it was working appropriately.
• The daily records of the care provided for one person indicated the care worker supported the person to have a shower, but this information was not included in the care plan. Care workers were not provided with guidance in relation to how this care should be provided to meet the person's needs.
• In addition, there were notes from multi-disciplinary team meetings in the care plan for this person but the information and changes to how care should be provided had not been added to the care plan. For example, changes had been made to the type of equipment care workers should use when supporting the person in the community to maintain their safety, but this was not reflected in the care plan. Therefore, care workers had not been provided with up to date information on how to support the person.
• Care plans for people who behaved in a way that could challenge the service were not person centred. These were also not clear about the triggers care workers needed to observe and manage to help support the person's specific needs in relation to their behaviour.
• Care plans identified if people needed to be supported by care workers to access activities and events within the community to reduce the risk of social isolation but the care plans did not always provide information on the activities the care workers could support the person to access. Care plans for some people identified a person's area of interest but not how they could be supported to maintain those

interests .

The provider did not ensure information in care plans was accurate and provided care workers with information on how they should support people to meet their care needs. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

At our last inspection the provider did not ensure information was provided in a format that was appropriate to meet people's communication needs. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

• The communication needs of people receiving support from the service were identified during the initial needs assessment and were recorded in the care plan. For example, we saw one person used alphabet charts and another person used Picture Exchange Communication System (PECS). Other people's care plans identified they used vocalisations and gestures to communicate.
• Care plans and social activity information for people were provided in a standard text format and did not include any pictorial or accessible versions. This meant people were not provided with information in a format which met their communication needs to enable them to be involved in making decisions about their care whenever possible.

The provider did not always ensure information was provided in a format which met people's communication needs. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager explained information could be translated to a person's preferred language and the way to request this was described in the provider's service user handbook. Also, there was a diverse group of staff employed by the provider who could support with translation to other languages.

Improving care quality in response to complaints or concerns
• People confirmed they knew how to raise a complaint or concern and where a person had raised a complaint they told us it had been resolved to their satisfaction. One person told us, "Yes, I'd phone the office. I haven't needed to."
• The provider had a complaints policy and how to raise concerns was included in the information provided to people when their care visits started. The registered manager told us complaints were acknowledged within 24 hours of receipt and resolved within 28 days. This was confirmed by records we saw.
• During the inspection we reviewed the responses to complaints that had been received via the local authority. These included copies of care plans, time sheets and statements relevant to the complaint which had been used to investigate the complaint.

End of life care and support

• At the time of the inspection the service was not supporting anyone with end of life care.
• The registered manager explained an assessment was completed if a person was identified as requiring end of life support. This assessment included the person's support needs, any risk assessment that needed to be completed, what professionals were involved in the person's care and any additional equipment that was required.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

At our last inspection the provider had a range of quality assurance checks in place, but these were not always effective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

• The provider had failed to make improvements to the breaches of regulation relating to safe care and treatment, person centred care and good governance which were identified at the last inspection. Some improvements were noted following the previous inspection. However, the provider had not implemented effective actions to make improvements to the service.
• An audit based upon the CQC inspection process was completed every six months. The audit included a pre-printed list of documents which should be used to provide evidence of compliance with relevant standards and an action plan. A completion date and who was responsible for the action was not always completed to ensure the work was undertaken. The audit was not robust as the checks that were recorded had not identified the shortfalls and issues which have been noted in this report. For example, the audit check for incident and accident forms related to the care workers completing the forms and placing them in the folder. There were no checks to ensure an analysis had taken place, lessons had been identified and action taken to reduce the risk of reoccurrence.
• The provider had not identified, managed and mitigated risks to people. This was also identified at the previous inspection and improvements had not been made. During the inspection we identified a range of issues including risk management plans for specific risks and for meeting people's care needs. These had not been identified by the provider using their existing processes. In addition the medicines audits had also not been effective in identifying areas for improvement, so these could be addressed.

This meant the provider did not have effective quality assurance processes to assess, monitor and improve the quality of service people received. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager explained an electronic call monitoring system had been introduced in December 2019 to enable care workers to record their arrival and departure times for visits, so that punctuality could

be improved. A staff member had been allocated to monitor the planned visits and identify when a care worker was late in registering their arrival. They would then contact the care worker and find out why there was a delay and ensure to person receiving care was informed.
• Since the last inspection, some improvements had been made to the audits of MAR charts to help ensure care workers were recording information on the administration of medicines as prescribed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The provider did not give us accurate information about the number of people using the service and did not have full oversight of their service. The numbers of people receiving person care as stated in the PIR and given to us prior to the inspection was significantly different. After checking with the main local authority who commissioned packages of care from the provider, and placing the evidence in front of them, the registered manager confirmed they had 93 care packages. The registered manager told us they believed their interpretation of the term personal care was not the same as the local authorities' which resulted in the difference in the number of people identified as receiving the regulated activity.

This meant the provider did not maintain accurate and up to date records of the care packages they provided. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During the inspection we saw there had been two incidents that involved the police attending to resolve an issue. Providers are required to send the CQC a notification when there is any police involvement in relation to a person receiving the regulated activity. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.
• The registered manager confirmed they had not sent notifications relating to the two incidents to the CQC at the time they occurred. The meant the registered manager had not complied with their regulatory requirements.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are considering our regulatory approach regarding this breach of regulation.

The provider was not displaying their rating on their website. This was a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory approach regarding this breach of regulation.
Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and relatives we spoke with felt the service was well run but some raised concerns regarding issues with communication. People's comments included, "I think it's got a bit better now. Communication could be better" and "Yes. The carers are really good and overall I am very happy with the service I receive." Relatives told us, "I think it could be better run, but I can't really comment. At times I have felt a bit frustrated, but that was earlier and now people are reacting better" and "I think, as a caring service, they are very good. They are excellent. The service is by far the best, they are outstanding."
• A care worker told us, "Yes. The service is very well led. I have always received support from the registered manager and from the senior staff. They are available weekends and nights on the phone. If there is any issue they solve it quickly and in good way."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• There was a range of policies and procedures in place which were regularly reviewed and updated when required.
• The responses to complaints demonstrated the registered manager responded to them in a timely manner and identified where improvements could be made. They were opened and transparent when they gave feedback to people or relatives who had complained.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The registered manager told us a survey form was sent to people receiving support and their families every three months. Telephone quality monitoring calls were also regularly carried out to obtain feedback on the care provided.
• Regular meetings were held with care workers and office staff to discuss any issues identified about providing support and good practice.

Working in partnership with others
• The registered manager confirmed they worked closely with the local authorities that commissioned care packages from the service.
• The service had information on local services such as day centres which people could be directed to if it was identified as suitable to meet the person's needs.
• Information was obtained from voluntary organisations to help identify ways of supporting people's needs for example information from The Challenging Behaviour Foundation was accessed for guidance on how to support people.

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 The provider did not ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c)

The enforcement action we took:

A Warning Notice was issued requiring the provider to comply with the Regulation by 13 April 2020.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users. The risk to health and safety of service users of receiving care and treatment was not assessed and they did not do all that is reasonably practicable to mitigate any such risks. The provider did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

The enforcement action we took:

A Warning Notice was issued requiring the provider to comply with the Regulation by 13 April 2020.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

The provider did not have a process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks.

Regulation 17 (1)(2) (a) (b)

The enforcement action we took:

A Warning Notice was issued requiring the provider to comply with the Regulation by 13 April 2020.