Eboney Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place 13, 17, 19 and 23 November 2015 and was announced.We gave the registered provider 24 hours' notice of intended visit to ensure someone would be available in the office. After considering the risks we found at Eboney Home Care Ltd we revisited the service on 18 December 2015 to carry out further checks and visited people in their home on 21 December 2015. This latter visit was unannounced.

The last inspection took place in January 2014 when the service was found to be compliant with our regulations.

At the time of our inspection there were 23 people receiving personal care from the service.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Staff told us recruitment checks including references and Disclosure and Barring Services checks had been carried out, however, some staff told us they had visited the office one day and then asked to start the next day by shadowing other staff. This meant robust checks were not carried out before staff had direct access to people in their own homes.

We found staff were giving people their medicines from a dossette box without knowing what they were giving people and staff were also giving people medicines known as PRN (as and when required) without recording what had been given to the person.

The registered provider carried out an environmental risk assessment to see if there were any risks in people's homes to staff or to people themselves.

Staff induction included a period of shadowing without the member of staff undertaking any specific training.

We found not everyone had given their consent to have their care provided by Eboney Home Care. The registered provider and the registered manager agreed to address this issue.

The registered provider in following their baseline assessment document asked people about eating and drinking including their favourite food and special diets. However these were not translated into care plans for staff to deliver appropriate care in people's homes.

People told us the staff respected their homes and did what was asked of them to ensure their homes were kept the way they wanted.

We found staff had not been supported and given guidance about providing consistent care to people.

The provider did not have in place care plans which met people's needs. In the absence of robust care planning we found that relatives and carers employed by families in other ways had written detailed task lists for Eboney Home Care staff.

Staff we spoke with said they would give people a choice and gave some examples. For example one staff member described giving people a choice of meals. Another member of staff stated people chose what they wanted to wear.

We looked at the records held by the provider and found they were not fit for purpose.

We found when people's daily records were returned to the office they were not routinely audited. This meant the registered manager and the registered provider were not aware of some of the incidents which occurred in people's homes.

We found the registered provider in the delivery of their service had not always taken into account the guidance provided to question and support their practices.

The provider had carried out a survey to measure the quality of the service. People's responses were largely positive.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staff told us recruitment checks including references and Disclosure and Barring Services checks had been carried out, however, some staff told us they had visited the office one day and then asked to start the next day by shadowing other staff. This meant robust checks were not carried out before staff had direct access to people in their own homes.

We found staff were giving people their medicines from a dossette box without knowing what they were giving people and staff were also giving people medicines known as PRN (as and when required) without recording what had been given to the person.

We found the risk assessments carried out by the provider did not consider the risks identified by the local authority commissioners of care.

Inadequate

Is the service effective?
The service was not effective.

Staff induction included a period of shadowing without the member of staff undertaking any specific training. We found staff were providing care to people with specific needs without having had training.

We found not everyone had given their consent to have their care provided by Eboney Home Care. The registered provider and the registered manager agreed to address this issue.

The registered provider in following their baseline assessment document asked people about eating and drinking including their favourite food and special diets. However these were not translated into care plans for staff to deliver appropriate care in people's homes.

Inadequate

Is the service caring?
The service was not always caring.

People told us they staff respected their homes and did what was asked of them to ensure homes were kept the way they wanted.

We found staff had not been supported and given guidance about providing consistent care to people.

We found people and their relatives were not actively involved in their care plans.

Requires improvement

Is the service responsive?
The service was not responsive.

Inadequate

Summary of findings

The provider did not have in place care plans which met people's needs and there were no reviews of people's care in place.

In the absence of robust care planning we found that relatives and carers employed by families in other ways had written detailed task lists for Eboney Home Care staff.

Staff we spoke to said they would give people a choice and gave some examples. For example one staff member described giving people a choice of meals. Another member of staff stated people chose what they wanted to wear.

Is the service well-led?

Inadequate

The service was not always well led.

We looked at the records held by the provider and found they were not fit for purpose.

We found when people's daily records were returned to the office they were not routinely audited. This meant the registered manager and the registered provider were not aware of some of the incidents which occurred in people's homes.

We found the registered provider in the delivery of their service had not always taken into account the guidance provided to question and support their practices.

Eboney Home Care Limited

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 registered 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 13, 17, 19 and 23 November 2015. These dates included visits to the office, to people's home address and talking to staff. After considering the risks we found at Eboney Home Care Ltd we revisited the service on and 18 December 2015 to carry out further checks and visited people in their home on 21 December 2015. This latter visit was unannounced.

The registered provider was given 24 hours' notice because the location provides a domiciliary care service. We needed to be sure that someone would be in.

The inspection team consisted of two adult social care inspectors.

Before the inspection we looked at information available to us including documentation submitted by the provider regarding their registration, and any notifications. No concerns had been raised with us by the local authority safeguarding team, local commissioning teams or Healthwatch.

During the inspection we looked at 21 people's records. We visited 12 people in their own home and spoke to their relatives. We also spoke with a further two people and their relatives by telephone. We spoke to the registered provider, the registered manager and the care coordinator in the office. We spoke with seven staff by telephone. We reviewed nine staff files and requested information from the registered manager about the service. We also spoke to two other professionals who had contact with the service.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

In the PIR the registered provider told us, 'We have a robust recruitment procedure in place to ensure as far as is possible that we recruit the people who are right for the positions to be filled." During our inspection we looked at staff recruitment and found prospective staff members had completed an application form. There were discrepancies in staff recruitment records for example staff start dates were before the dates of the Disclosure and Barring (DBS) service dates. On some staff files there was no evidence of DBS checks being carried out. On one file we found it was written, '[Staff member] has DBS check from previous employer'. Staff confirmed to us recruitment checks including references had been carried out however, some staff told us they had visited the office one day and then asked to start the next day by shadowing other staff. This meant robust checks were not carried out before staff had direct access to people in their own homes.

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

We saw where the registered provider had carried out DBS checks which had revealed an offence the registered provider had carried out a risk assessment to make a judgement if a person was safe to work with vulnerable people.

We saw in the assessments carried out by local service commissioners people required support to take their medicines. When we visited people in their home some people told us they needed this help. We saw people had dossette boxes in their home and the staff recorded when people had taken their medicines. The Royal Pharmaceutical Society of Great Britain in their guidance, 'The Handling of Medicines in Social Care' states, "Care staff know which medicines each person has and the social care service keeps a complete account of medicines." We spoke to the registered manager and the registered provider about how staff knew which medicines they had given to people. They told us people would be given the medicines from the dossette box but were unable to specify if staff could identify for example which tablet they had given. People also told us staff gave people medicines which were not in dossette boxes for example medicines known as PRN (as and when required medicines). We found there were no PRN plans or records of these medicines to guide staff to the frequency and dosage that should be given. Staff confirmed to us they had given these medicines to people. This meant staff were giving people PRN medicines without appropriate guidance being in place to follow.

When we visited people in their homes we saw they had been prescribed topical medicines. Staff had recorded in people's daily notes they had applied topical medicines. We found there was no guidance provided to staff about these topical medicines and staff told us they had applied them. One relative spoke to us about their family member's topical medicines and said, "Sometimes the girls put it on and sometimes they don't." This meant in the absence of appropriate care plans people may not have received their prescribed topical medicines regularly or as prescribed.

We found the disposal of peoples medicines had not been carried out in line with the registered provider's policy which stated, "Medicines for disposal should not be flushed down the toilet or added to the household waste at the service user's home. Medicines must be taken to the prescribing pharmacy at the earliest opportunity." Staff told us they flushed medicines down the toilet. This meant staff were not following the registered provider's policy on the safe disposal of medicines.

The registered provider carried out an environmental risk assessment to see if there were any risks in people's homes to staff or to people themselves. The registered provider also carried out risk assessments in relation to people. We found these risk assessments did not consider risks to people which had been identified by the commissioners, for example we found one person was at risk of reoccurring infections but this was not identified and the actions required to ensure the person was safe were not specified. Another person was at risk of falls and actions the staff were required to take to prevent further falls were not in place. This meant the registered provider had failed to identify and mitigate risks to people.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with people about hygiene practices in their own homes. People confirmed staff wore gloves when delivering personal care but no one had seen staff wearing aprons. One person told us they had experienced staff coming into

Inadequate

Is the service safe?

their home dressed up prior to going out for the evening. This meant people were not protected from the risks of cross infection associated with staff going from one person's home to another.

We looked at the staff rotas and found there were two different areas to be covered - Stanley and Consett; in each area there were a number of rounds. People told us the right number of staff usually turned up, for example if two staff members were required then two arrived together. One relative told us they had experience one occasion when only one staff came to deliver care and there were meant to be two. We spoke with the registered provider and the registered manager who were not aware of this missed visit. Two other people spoke to us about one missed visit each. Despite these missed visits we did not find any pattern of missed visits were due to the service having insufficient staff.

On the staff training matrix we saw out of 10 staff eight had received training in safeguarding vulnerable adults. The remaining two members of staff told us they had staff training in the near future. Staff confirmed to us they would contact the office if they had any concerns about people. This meant that whilst not all staff had received training staff knew they had to contact their line manager if they had concerns. One member of staff told us they would also contact the local authority safeguarding team if they had any concerns.

The registered manager told us there were no ongoing disciplinary or whistle-blowing investigations.

Inadequate

Is the service effective?

Our findings

One relative described the service as, "Very good" and went on to tell us they "Have had a few hiccups." Another relative described the service to us as a, "Comedy of Errors." One person said they were, "Not impressed" and they wanted to change care companies. Another person told us, "Up to now everything is fine."

Staff told us about their induction and told us they shadowed people before they started to visit people on their own. We looked at staff induction records and found there were staff who had not received an induction. Staff also told us they did not receive training during their induction period as training was arranged twice a year. This meant staff who joined the service between training dates were not trained by Eboney Home Care to deliver care to people. We found staff did not receive an effective induction to the service.

In the PIR the registered provider told us, 'All staff receive Job-specific training'. One member of staff confirmed to us they had not received moving and handling training but had delivered care to people who required the use of a hoist. The registered provider had in place a training matrix. On the training matrix we found one person who had diabetes but staff had not received any training in diabetes, similarly staff had not received training in dementia despite delivering care to people with dementia type conditions. None of the staff had received risk assessment training.

We asked the registered provider how staff had learned to change colostomy bags and catheter bags. The registered provider and the registered manager told us staff had been trained by their current training provider but were unable to give us any evidence on the day of the inspection. They later sent us information that they used a previous training provider but could provide no evidence to support this. Staff told us they had learned how to change catheter or stoma bags from watching other staff. This meant the registered provider had not ensured staff had received appropriate training.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The guidance provided by the Royal Pharmaceutical Society of Great Britain states as a principle, "Care staff who help people with their medicines are competent." We saw the registered provider had in place a 'Staff Training – Competency to Administer Medication to a Service User' document last updated 1 April 2014 and found this had not been used to assess if staff were competent to give people their medicines. We spoke with the registered provider and the registered manager who told us they had not yet implemented the document and staff competency was addressed using spot checks and supervision. We looked at the spot checks and the staff supervision and found neither included staff being competent to give people their medicines. This meant staff giving people their medicines had not been assessed as having the skills and knowledge to carry out this task.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they preferred to have fresh food and did not like microwaveable meals. Staff therefore worked with each other to prepare the person's meal. One staff member confirmed this happened and the person used a slow cooker. We saw staff had received training in food hygiene.

We looked at staff supervision records. A supervision meeting takes place between a staff member and their manager to discuss any concerns, look at their progress and future training needs. We found staff had supervision meetings recorded on their files. One staff member told us they worked for the registered provider for a number of months and had not had a supervision meeting.

One person told us staff members have long nails and wear nail varnish. Another relative described a carer as accidently hurting a person due to their nails. We fed this back to the provider who told us they frequently have told their staff about the issue.

We found there was no travelling time set aside between visits and we asked the registered manager how do they ensure people receive care at the time they requested. They told us if staff were required to start their day in a person's home they would visit for example at 7.50am rather than 8am. This meant staff had a head start to get to the next person's home on time and staff would ask the person to leave early if they could. Staff confirmed these arrangements to us.

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

Inadequate

Is the service effective?

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. We checked whether the service was working within the principles of the MCA. The registered provider told us the service works within the MCA and in the PIR stated, "We at all times consider the best interests of the service users and in the case of an emergency consider all available options and do our level best to continue to provide care to reduce any risk to the service user." We found during our inspection staff had not been trained in the MCA and the registered provider's 'Baseline Assessment of Needs for Daily Living' did not include any reference to a person's capacity. However it did include areas of a person's life where their capacity would be relevant, for example their finances and their understanding for the need for care. At the same time staff had not been given guidance on what to do where a person with a dementia type condition verbally challenged them and told them to leave their property. One staff member had recorded they had left as requested whilst another staff member told us they busied themselves until the person could be spoken to but did not leave their home. We found staff had a lack of insight into the person's capacity and how this might impact on their behaviour. In addition we found the lack of guidance and training resulted in an inconsistent approach to the management of the person's care.

We spoke with the registered provider about people giving their consent to receive care from the service. Both the registered manager and the registered provider told us consent had been obtained by the commissioner of the service. However they showed us how they had contracts in place for people and either people or their relatives had signed a contract agreeing to the service delivering the hours required. The registered provider stated they would address the issue of consent.

The registered provider in following their baseline assessment document asked people about eating and drinking including their favourite food and special diets. However these were not translated into care plans for staff to deliver appropriate care in people's homes. This meant staff had not been given guidance and information on how to support people's nutrition and hydration requirements.

We looked at communication in the service. We saw in one person's baseline assessment their communication was described as poor. Relatives and another professional told us about how this person communicated and what was required by staff to support the person's communication. We were told by one relative when we visited their family member the person was deaf and we needed to face the person and speak loudly. We found this communication method was not described in the care plan. Two relatives, independent of each other, told us they would like better communication in the office. We discussed communication between relatives and the registered manager or the registered provider and asked them to consider how communication could be improved.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service caring?

Our findings

People spoke to us about the punctuality of the service. One relative said they are "Pretty punctual" and they "Rush all the time and not allowed travelling time." They went onto describe how this impacts on their caring role and how their family member does not like to be rushed. They told us they find a couple of the carers are very caring, and those who seem less caring do not do it, "Out of malice". When we spoke to people they were consistent in their praise of one carer who was prepared to go the extra mile for people, one relative felt reassured they would always make contact if there was an issue with their family member. Another relative of a different person described the staff member as a "Good carer".

People told us the staff respected their homes and did what was asked of them to ensure homes were kept the way they wanted.

Staff were able to tell us about the care they provided to people in their own homes and people's likes and dislikes. This meant staff were familiar with people's wishes.

In the registered provider's 'Charter of Rights' we read, "Each client has the right to a Care Service that does not discriminate on the basis of race or ethnic origin, creed, colour, religion, political affiliation, disability or impairments, marital status, parenthood, sexual gender or sexual orientation." The registered provider had in place in their baseline assessment document questions which recognised people's diversity. For example they asked the question if there were any foods forbidden by the person's religion, faith or culture. The registered provider also had in place a service user personal and social profile with questions on ethnicity, religion and belief and sexual orientation. However we found these were not always completed, this meant the registered provider was unable to establish if people were in receipt of appropriate care as needs had not been fully identified and planned for.

At the time of inspection the registered provider told us they were not caring for anyone who was at the end of their life. The registered manager emailed to us the registered provider's End of Life Policy. We found the policy and associated documents to be comprehensive.

When we spoke to staff they told us about the people they had cared for and the care they had provided. Staff described their approach to people and the challenges they had faced. In one person's daily notes we found one staff member had recorded they had left a person's home because the person had been hostile towards them. Another staff member told us they had left the room and then come back to speak to the person whilst another staff member said they had spoken to the person concerned and let them know their behaviour was unacceptable whilst continuing on with their work. We found there was a lack of a coordinated approach to this person. We spoke with the registered provider and the registered manager and asked what guidance had been given to staff to support this person. They acknowledged the staff had not been given any guidance. This meant arrangements were not in place to enable staff to care for this person.

Each person we visited and their relatives described adverse scenarios in the delivery of care which impacted on their well-being. For example one family member felt unable to leave their relative in the care of the service due to staff not being sufficiently trained. Another relative described the staff as not delivering care to meet people's care needs. We spoke to staff about this and they told us they did not have the time to do a specific task, although they told us they did offer the people concerned a choice. Another family member told us they had been contacted by a relative to state a person had not been ready for them to collect. We spoke to the registered manager and the registered provider about this who said it was often down to the person refusing to get ready.

We found relatives acted as natural advocates for their family members. Relatives described to us a mixed experience of acting in this role. One relative found the staff carried out the specific requirements they had laid down to care for their family member. Another relative told us they did not get a suitable response. One person who was able to self-advocate told us they could not be "Bothered anymore."

In the PIR the registered provider told us they strive to keep the numbers of care staff to a minimum for each person in order to achieve continuity of care. Relatives told us this was variable. For people with the most complex needs who required specifically trained staff relatives were able to identify to us a small number staff who cared for their family member. For one person whose needs were becoming increasingly dependent their relative gave us a list of eight staff. We saw the service introduced new staff to

Requires improvement

Is the service caring?

people before they started providing the care. Relatives and people who used the service confirmed this happened. This meant people who used the service had met the staff before they received care from them.

Also in the PIR the registered provider stated. "Service users are actively involved in the development of their individual care plan to ensure that it meets their needs and requirements and that it is responsive to any changes in their needs." One staff member told us they completed the assessment of people's needs by looking at the information provided by the local authority and visiting them in their own home. We found the registered provider's baseline assessment failed to detail who was involved in the assessment of the person's needs. In the absence of the registered provider having in place detailed care plans for people we were unable to find evidence of people's involvement in their care plans.

Inadequate

Is the service responsive?

Our findings

We looked in people's care files in the office and found each person's file in the section entitled 'Care Plan' were assessments and provision plans carried out by local adult commissioning services. We saw the registered provider carried out their 'Baseline Assessment' of people's needs. The registered manager told us these assessments were carried out once they had agreed with the respective commissioners they were able to meet the times people needed the service in their own home.

We found the baseline assessments did not reflect people's needs as described by the commissioning assessments and plans. For example in one person's plan the commissioners had assessed, '[Person] needs support to clean their teeth however needs to be encouraged to do this independently if possible'. The commissioners support plan stated the person needed their teeth cleaning and was to be given medication on a particular day. The registered provider's baseline assessment did not include any reference to these aspects of the person's care. In one person's commissioning care plan staff were expected to carry out monitoring arrangements of a person's condition, this was not translated in the person's assessment to a care plan. Staff were therefore not given sufficient guidance on how to care for a person. One person explained to us staff had told them to '"Keep them right" as they did not know what they were doing. Their relative told us the person did not like to ask and cause "Any bother". The person explained to us the staff asked them what they wanted doing but they could not remember. This meant in the absence of appropriate care plans people's needs were not guaranteed to be met.

In another person's plan the commissioners stated the person required help to administer topical medicines. We found this was not considered by the assessor from Eboney Home Care. This meant the registered provider had failed to carry out an appropriate assessment of people's needs to produce an appropriate plan of care.

We visited seven peoples' homes and found a one page document in six homes which listed the person's GP, next of kin, below which tasks were listed for each day of the week. In one person's home there was no such document. Two people received additional care at the weekend and when another carer was not available; there was no additional information given to staff about what actions they should take during these periods. We asked the registered provider and the registered manager if this was the Eboney Home Care plan for people and they confirmed it was. After asking for copies of people's care plans they explained the care coordinator completed the document and put them in people's homes. These were not stored in the office and were destroyed once they were completed. The registered manager said the care plans for people were in their files and showed us the local authority commissioner's plans. This meant the registered provider had not got in place person centred care plans which reflected people's needs for staff to follow.

In the service user guide we read, "Care Planning is continuously reviewed because people's needs change and we have to respond to these changes to make sure that we are delivering the right care." We asked the registered provider and the registered manager how often do reviews of people's care plans take place. They told us care plans had not been reviewed. When we spoke to staff they told us how people's conditions and how their care needs had changed, for example one person had been cared for in bed for a number of weeks due to deterioration in their health. We found the changes in the person's condition had not been resulted in a reassessment of their needs and guidance given to staff.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the absence of robust care planning we found that relatives and carers employed by families in other ways had written detailed task lists for Eboney Home Care staff.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had in place a complaints policy and told us they had not received any complaints. We spoke to one relative who told us they had received a letter of apology from the registered provider concerning aspects of the service. The registered provider and the registered manager explained the circumstances and told us it was not about the care but the lack of subsequent actions taken. They agreed if they had to write a letter of apology then the circumstances could be described as a complaint. We could not be assured people's complaints had been appropriately dealt with.

Inadequate

Is the service responsive?

Staff we spoke with said they would give people a choice and gave some examples. For example one staff member described giving people a choice of meals. Another member of staff stated people chose what they wanted to wear.

Relatives spoke with us about the after-hours call service and one person described the contact as, “Almost impossible.” Whilst relatives realised the on call service was likely to be a member of staff delivering care to people they wanted a more timely response to address their needs. We fed this back to the registered provider and the registered manager. The registered manager thought it might be that the person on call was busy when the call was made.

Inadequate

Is the service well-led?

Our findings

Staff told us they had heard good things about Eboney Home Care and had chosen to work for the service. One staff member said they were a, "Family orientated firm" and there were some "Warm characters who worked for the service." Another member of staff said the people in the office were, "Really friendly" and they felt "Like they could speak to them" and "Go in the office and have a cuppa." One professional fed back to us that people they had recently visited had not expressed any dissatisfaction with the service and found the management, "Bent over backwards" to support people

At the time of our inspection the service had a registered manager in post. We spent time in the office and observed the culture of the organisation. We found the office culture contained banter usually led by the registered provider. Staff who came into the office were spoken to and asked about the people they supported.

The registered provider had in place a 'Charter of Rights'. These were described in the service user guide which said, "We respect the right of each client to lead as independent and fulfilling life as possible. We have set out a Client's Charter of Rights which we believe should be the minimum entitlement for each client." The registered provider then set out a set of standards. The standards included a person's right to refuse a member of staff access to their home. We found where staff induction was based on shadowing another worker the charter of rights had not been used by the registered provider during the staff induction period to ensure staff adhered to the values of the organisation.

We found the records stored in the office were in lockable filing cabinets. We looked at the records held by the provider and found they were not fit for purpose. The baseline assessments in place failed to address people's individual needs. There were no clear service care plans in place which gave guidance to staff on how to care for people and there were no routinely held reviews about people's care to ensure the records of care were contemporaneous.

Staff wrote about each visit to a person's home, however it was difficult to track if the content of their diary entry matched a person's care needs due to a lack of care plans in a person's home.

We found people's medicine records were undated and there were no plans in place which related to people receiving medication other than from a dossette box. We were unable to trace what PRN medicines had been given to each person and what topical medicines had been administered. This did not conform with best practice guidance.

We asked the registered provider and the registered manager about when the daily records were brought back into the office from people's homes. They told us it was on a regular basis but described this was dependent on how full the file may be. We discussed with the registered provider and the registered manager issues which carers had documented in the daily records, for example a medicine's error, when staff members had left people early due to their behaviour or when two carers failed to arrive. Neither the registered provider nor the registered manager were aware of these issues. This meant documents were not routinely audited and deficits in the care provision or risks to people had not been addressed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the registered provider carried out spot checks on the staff. The service had a pro-forma in place to measure the quality of the service as delivered by staff. Not all staff had a spot check in place. Staff we spoke with confirmed they either had been checked or had yet to have a check carried out on their work.

Other professionals told us the service worked well with them and tried to accommodate people's needs by being flexible. This included the registered provider and the registered manager undertaking specific training for one person to be able to care for them. Staff we spoke with described one person's specific needs and knew of the involvement of another end of life service but was unable to say when they visited and what they did. One staff member told us the same person needed a more appropriate bed but was unsure what to do about it. We found given the needs of the person the absence of partnership working did not lead to coordinated support for the person concerned.

We saw the registered provider had carried out a survey asking people about the quality of the service. Relatives we spoke to confirmed they had received a questionnaire. The responses were largely positive. One person responded

Inadequate

Is the service well-led?

with, ”All good, some very good” and ”Was very concerned with stories of home care, but have been very satisfied with current care and quality.” Another person had written about the staff, ”One or two of them I could do without, the others are very good.”

Guidance to support the delivery of a home care service included the Royal Pharmaceutical Society of Great Britain ‘The Handling of Medicines in Social Care’ which was published in February 2007 and the NICE guidance - ‘Home care: delivering personal care and practical support to older people living in their own homes’ which was published in September 2015. Further guidance is available to services on the CQC website which describes how registered providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall. We found the registered provider and the registered manager in the delivery of the service had not always taken into account the guidance provided to question and support their practices. This meant service provision had not been reviewed and improved in the light of recommended best practice.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were at risk of being cared for by staff who were not trained to meet people's needs.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People were put at risk of being cared for by staff who had not been checked to ensure they were of good character.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not in receipt of person centred care.

The enforcement action we took:
We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment of service users was not provided in a safe manner

The enforcement action we took:
We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Risks were not assessed, monitored and mitigated in relation to the carrying on of the regulated activity. Accurate records were not maintained in respect of each service user.

The enforcement action we took:
We served a warning notice.