Care Avenues Limited

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Inspection report

Venture Presswork
Berry Street
Wolverhampton
West Midlands
WV1 1HA

Tel: 01902423666

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

This comprehensive inspection took place on 8,14 and 20 March 2018. The first inspection visit was unannounced but we informed the provider when we would return for the second and third visits. The service had been registered with us previously and was rated as requires improvement. There has been a change to the provider's legal entity and this was the first inspection since this service was re-registered in November 2017. Prior to re-registering, we last inspected the service in May 2017 and rated the service as 'requires improvement' overall. This inspection was prompted in part by information of concern we received about the service. This included people experiencing missed and late calls, a lack of risk assessments and guidance, poor record keeping, weak leadership and a lack of staff with the suitable skills required to meet people's care needs. At this inspection we found evidence to substantiate these concerns and identified breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are deciding our regulatory response to this and will issue a supplementary report once this decision is made.

We shared the concerns we identified during our inspection with two local authorities who commissioned care packages from the service. They told us they were suspending the commissioning of further care packages until they completed their own assessment of the care people received. We also notified local safeguarding authorities of two people who were at risk of harm.

Care Avenues Limited provides personal care to 47 people. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults.

Not everyone using Care Avenues Limited receives the regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection the service had a registered manager who was present during our inspection visits. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. We were also accompanied at each inspection visit by the regional registered care manager who was responsible for managing the registered manager and for overseeing the quality of the service on behalf of the provider.

Adequate assessments of people's care needs had not taken place which put people at risk of receiving inappropriate or unsafe care. Staff did not consistently demonstrate the safe management of medicines.

There were insufficient numbers of knowledgeable and experienced staff deployed to ensure people were supported on time by staff they knew. People told us they had often been supported by staff who did not know about their care needs and preferences. People experienced late and missed calls, which had resulted

in some people missing meals and medicines.

People were not consistently supported by staff who wore protective equipment to prevent and control the spread of infection. The registered manager was unable to provide records that staff had received updates and refresher training so they knew good infection control practices

The registered manager had not followed local authority procedures to protect people from abuse by notifying the local safeguarding authority when people had experienced or had been placed at risk of neglect. Although people told us they had raised concerns there were no records or analysis completed to prevent untoward incidences from happing again.

People were not consistently supported to receive suitable food and drink to stay well. The provider did not regularly review or seek people's views about the care they received.

People who were sometimes supported by unfamiliar staff who did not know their preferences or took time to interact and express compassion. People could not always speak to the registered manager or office staff to raise concerns. People told us that staff supported them to be as independent as much as possible. People said that staff who regularly supported them were kind, polite and respected their privacy.

People told us they were often supported by staff who did not know their specific care needs and the appropriate action to take. Care records did not consistently contain detailed information so staff would be able to identify and respond appropriately if people were at risk of or experiencing harm. Although no one who used the service at the time of our inspection visit was receiving end of life support, there were processes in place should they require it.
People we spoke with said staff who regularly supported them were responsive to their needs and most people said they were pleased with the support they received to take their medicines. People told us staff asked them for consent before providing care.

The overall rating for this service is 'Inadequate' and the service is therefore in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question of overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found that the provider was not meeting all of the requirements of the law. We found multiple breaches

in regulations. You can see what action we told the provider to take at the back of the full version of the report. 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were placed at risk of receiving unsafe care and treatment because adequate assessments of their care needs had not been undertaken.

People were at risk of not receiving their medicine as prescribed because staff did not consistently demonstrate the safe management of medicines.

There were insufficient numbers of suitably qualified staff to ensure people were supported by consistent staff who knew how to protect them from harm.

People could not be assured that robust systems were in place so the service would learn from adverse events and prevent them from reoccurring.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not undergo effective training based on best practice guidelines so they had the skills, knowledge and experience to promote the wellbeing of the people they supported.

People were not consistently supported to receive suitable food and drink to stay well.

When necessary the registered manager had involved other health professionals to ensure people received effective care.

Staff sought consent and supported people in line with the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not consistently supported by staff who knew their preferences and took time to interact and express compassion.

People could not be assured that their views would be heard and responded to effectively.

People who were regularly supported by the same staff said they were polite and respected their privacy. Staff spoke fondly about the people they supported.

People told us that staff supported them to be as independent as much as possible.

Is the service responsive?

Requires Improvement

The service was not responsive.

People could not be assured they would be supported by regular staff who knew how to respond to their specific care needs and preferences.

People were at risk of experiencing repeated poor care because their concerns were not always recorded, analysed or responded to.

There were processes in place should people who used the service require end of life support.

Is the service well-led?

Inadequate

The service was not well-led.

Records that provided an oversight of the care people received could not be accessed.

Systems in place had failed to ensure care records provided up-to-date and consistent information for staff.

Systems in place had not ensured people would be supported on time by consistent staff.

There were no effective systems in place to engage with people who used the service and respond appropriately to feedback about the quality and safety of the service.

A lack of effective processes for meaningful and effective engagement limited how staff could influence and develop the quality of the service.

Care Avenues 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 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 visit took place over three days on 8, 14 and 20 March 2018. On the 8 March the inspection was unannounced and the inspection team consisted of one inspector who visited the service's office and two experts by experience who spoke to people who used the service on the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. We told the registered manager we would return on the 14 March 2018. On this day the inspection team consisted of one inspector. We told the registered manager that we would return on 20 March 2018 to complete our inspection. On this day the inspection team consisted of two inspectors. The inspection was prompted in part by information of concern we received about the service.

When planning our inspection, we looked at the information we already held about the provider. This included any notifications they had sent us. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We reviewed information about the service from the local authorities who commission services and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We considered the information of concerns we had received about the service. We used this information to plan our inspection visit.

During our inspection we spoke with seven people who used the service and nine people's relatives. We spoke with the registered manager and their manager, the regional registered care manager and nine care staff. We spoke with one health professional who supported a person who used the service.

We sampled records for 16 people including care plans, risk assessments and medication records. We reviewed records the provider used to identify staff were suitable to support people and other records used by the provider to manage the quality of the service. We reviewed information we received after our inspection from the provider and local authorities.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received information that people who used the service were at risk of harm. This information suggested people were supported by staff who did not know their specific care needs and some people experienced late and missed calls. During our inspection we found evidence to support these concerns and we concluded that care was not provided in a safe way.

People were placed at risk of receiving unsafe care and treatment because the service had failed to ensure adequate assessments of their care needs had been undertaken and plans were in place to ensure staff provided safe care. The registered manager and the regional registered care manager told us they had not conducted assessments of the care needs or had devised any care plans in place for two people who used the service. A member of staff who supported one of these people told us, "I haven't see any care plan [for the person]," and "We follow [the person's] lead." The registered manager told us both service users required support with their mobility in order to reduce the risk of falling however a lack of a falls risk assessment and guidance for staff about how to reduce the risk of falls meant these people were at risk of avoidable harm.

The care records for one service user identified they were incontinent, lived in their bed and could not move without assistance. People who suffer incontinence and are unable to reposition independently have a higher risk of developing pressure sores and skin lesions. Although an 'Incontinent Risk Assessment' in the service user's care records had been partly completed it did not identify any level of risk or any mitigating action staff should take to prevent the person from developing pressure sores. The registered manager said they felt the service user was at high risk of developing skin lesions but could not confirm if staff took any action to protect the service user. We sampled a selection of daily records for this person which had been completed by the staff who had supported them. We saw they had not recorded any action, such as repositioning, had been taken to prevent the person developing pressure sores.

A member of staff told us they had not received any guidance or instruction about how to support a person who used a PEG tube. A PEG tube is a way of introducing food, fluids and medicines directly into the body by passing a thin tube through the skin and into the stomach. It is usually used when people are unable to swallow safely. The member of staff told us they relied on a relative of the person being available to offer verbal advice and guidance about how to manage this condition and any risks. The person's care records did not contain detailed information for staff about the person's PEG tube and associated risks such as infections and bleeding. A lack of detailed guidance about the associated risks meant that staff may not recognize when the person was at risk of harm or what action to take.

The registered manager told us a person who used the service used a catheter and had a history of developing urinary tract infections (UTI). One member of staff who supported the person said they were aware that a risk of catheterisation is UTI's, however there was no guidance for staff about how to identify if the service user was suffering from a UTI and any appropriate action to take. The lack of detailed information about the risks associated with the servicer user's specific condition meant that some staff may not recognize when the person was experiencing a UTI.

Staff did not consistently demonstrate the safe management of medicines. The registered manager confirmed two people who used the service required warfarin medication. Failure to take this medication as prescribed could be catastrophic. Warfarin, especially if taken incorrectly, increases the risk of dangerous bleeding. Side effects can also include interactions with some foods, prescription medicines and over-the-counter supplements. The registered manager could not confirm and the people's and medication administration records (MAR) did not identify what dosage of warfarin these people required. They told us this information was kept in the people's homes. Although staff who supported the service user said visiting nurses told them what dosage the people required, the registered manager did not conduct any checks to identify if they had received the correct dosage. There was no guidance for staff about this medication, associated risks and the importance of ensuring it was administered as prescribed. This put people at risk of not receiving the appropriate support if they did not receive their medicine as prescribed.

People did not always receive their medication when required. One person told us staff were required to wear gloves when they applied their cream. However, they told us they had not always received their cream because, "[Staff] don't have gloves which [they] must have for them to administer my creams. So I send them away." The relative of one person told us, "They help [person who uses the service] with their tablets. They missed them completely last Wednesday because they did not turn up."

Records did not contain clear instructions about how staff were required to support people with their medicines. The care plan for one person instructed staff to, 'Apply cream to red areas in (sic) needed'. The registered manager told us these instructions were incorrect because the person did not use any creams. The MAR for another person recorded they had taken their, 'Dosset Box,' medication but did not contain details for staff about the person's individual medication, dosage, time, appearance and how it should be administered. A dosette box is an individualised box containing medications organised into compartments by day and time, so as to simplify the taking of medications, Staff had also failed to fully complete the MAR and had not included the service user's name, date of birth and details of allergies as directed. This meant that it was not possible to check if the person had received their medicines as prescribed.

The registered provider had failed to ensure that risk assessments relating to the health, safety and welfare of people were completed and mitigated the risks presented by people's specific conditions and medicines. This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

People, staff and professionals told us that people regularly experienced missed and late calls which had resulted in people experiencing anxiety, missing meals and medicines. The registered manager had not however followed local authority procedures to protect people from abuse by notifying the local safeguarding authority when people had experienced or had been placed at risk of neglect. Failure to notify other agencies of untoward incidences did not safeguard people from harm or reduce the risk of them experiencing similar incidences again.

There were insufficient numbers of staff deployed to ensure people were supported by consistent staff who attended calls on time to meet their care needs. People told us that they often supported by staff they did not know and had frequently experienced missed and late calls. One person told us, "When my regular [staff] is off, I dread it. I don't know who is coming or when." Another person told us, "I have had late and missed calls. I phoned the office but got no reply so I just gave up. Now I get either friends or my [relative] to come in." A person's relative said, "When [regular carer] is off, it's hit or miss. Last weekend nobody called at all." Another person's relative told us, "They are hit and miss with their times. Their timekeeping is terrible. They have missed calls. It has been as late as 11:45 pm for the evening call." We saw a recent email from a social worker asking the registered manager to investigate why a person had recently experienced a late morning

call and a missed evening call. The registered manager told us they had worked additional hours in February 2018 to cover care calls due to a lack of available staff.

Although staff we spoke with said they were usually able to get to their planned calls on time we saw that calls were not planned to ensure all the people who used the service would receive their calls at their required time. The master rota for 10 February 2018 recorded one person received a planned 10 am call later at 11:15 am and staff were regularly double booked to provide calls to different service users at the same time. Some carers were not allocated time to travel between calls. Failure to have sufficient numbers of staff suitably deployed meant that service users were at risk of experiencing missed or late calls and not receiving the support they required to meet their care needs. One member of staff told us that one of their regular clients had experienced missed calls when they were away. Two members of staff said they did not always receive a weekly rota to inform them who they were supporting and relied on past rotas for guidance. One member of staff told us, "I don't always get a rota but I would like to get a hard copy." Another member of staff said, "I have three clients and I know the times, so I don't look at the rotas." This did not assure us that people would receive calls in accordance with their latest care needs.

People could not be assured they would be supported by staff who had the necessary knowledge and skills they required to safely meet their needs. People often told us they were sometimes supported by staff who had not been introduced to them or had an understanding of their specific needs and the risks associated with their conditions. One person told us, "The [carers] that cover are not good. I would question their skills and knowledge." A person's relative said, "Cares that have come in the past to cover told me they had no training at all." However, people told us that staff who regularly supported them had gotten to know their conditions and how they wanted to be supported. One person told us, "[My carer] was nervous at first. She wasn't too sure what to do but I wouldn't be without her now." Two members of staff told us they had requested training in the specific care needs of people they supported but this had not been provided. One member of staff who supported a person who was diabetic told us, "I wouldn't know how to spot if they were [becoming unwell]." Records of two people with specific conditions showed they were being supported by staff who had not received training about these conditions and any associated risks. This meant staff might not recognise if people was becoming unwell or know the appropriate action to take.

The registered provider had failed to ensure people were supported by enough suitable staff who knew how to protect them from the risks associated with their conditions and medicines. This constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

People we spoke with said they were not consistently supported by staff who wore protective equipment to prevent and control the spread of infection. One person said they had to buy gloves for staff to use. They told us, "My regular carer has been asking for gloves from the company for ages, they say they will get some but still haven't." One person's relative told us, "The regular carer wears gloves and an apron when required but the others don't including the [registered] manager when she comes to cover." Another person's relative told us, "[Staff] don't wear aprons but they do put gloves on."

Staff told us they had received infection control training as part of their general induction but the registered manager was unable to provide records that staff had received updates and refresher training so they remained aware of latest infection control guidance and good practice. Care plans did not contain guidance about the risk of infection associated with people's specific conditions. This put people at risk of being supported by staff who did not know how to prevent or recognise if a person was suffering from an infection. Staff told us and we saw there were supplies of gloves and aprons available in the office for their use. Staff told us the registered manage would delivery these items to them if they were unable to attend the office.

Supervision records for one member of staff recorded they had not used an apron to reduce the risk of spreading infection when supporting a person with personal care. There was no evidence that this issue was followed up with the member of staff to prevent them from them repeating this unsafe practice in the future.

People could not be assured that robust systems were in place so the service would learn from adverse events and prevent them from reoccurring. The registered manager told us they were unaware of any untoward incidences and could not produce any evidence that any information of concern had been recorded or analysed. This did not enable the registered manager to identify action required to prevent people from experiencing missed or late calls in the future and reduce the risk of receiving unsafe or inappropriate care.

People told us they felt staff who regularly supported them kept them safe. One person told us, "I feel safe with them, yes." Another person said, "They use my key safe to come in and get me up every morning so quite safe." Several people said they were not confident that staff who did not visit them regularly would know how to keep them safe. One person told us, "With [regular carer] yes [I would feel safe] but not so much with the others." A person's relative said, "I do not have confidence in his safety leaving him with [staff who did not visit regularly]." Another person's relative said, "They don't know how to [move a person], I have to show them and so my confidence goes." Staff we spoke to were aware of the signs which may indicate that someone was being abused and the action to take. A member of staff confirmed they had training in safeguarding people from abuse during their induction training.

Prior to our inspection we received information that adequate recruitment checks were not undertaken before staff started to support people with personal care. We spoke to three members of staff who told us that the provider had obtained suitable references and conducted checks to identify if they had any criminal convictions. They told us they were not able to support people until these checks had been completed. We reviewed the personnel file of four members of staff and saw that suitable checks had been conducted. Rotas showed these staff had not supported people before their checks had been completed. The registered manager showed us evidence of action taken to mitigate any risks when it was identified staff had criminal convictions. This ensured people were supported by suitable staff.

Requires Improvement

Is the service effective?

Our findings

Assessments of people's care needs and the support they needed to achieve a good quality of life and positive outcomes were not robust. Care plans were not always completed or lacked information. There were no care plans for two people who used the service and no information for staff about other people's specific conditions such as diabetes and its associated risks. This meant staff did not have access to sound guidance about how to best support people in order to improve their general wellbeing. Care was not consistently based on good practice and evidence based guidance. We saw that the provider based their induction training on the 'care certificate' which is a national recognised training programme to equip staff with the care skills they would require when first providing basic care. Details of a member of staff's induction programme, the regional registered care manager sent us after our inspection visits, did not include equality and diversity training so they would know to respect and support people to pursue their individual lifestyle choices. The registered manager and regional registered care manager told us there was no other evidence based training for staff such as NICE guidelines and Accessible Information Standards (AIS) at the service. AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for adult social care services to comply with AIS. People could not be assured they would receive care in line with current legislation and evidence based practice.

The service did not ensure all staff had the skills, knowledge and experience to meet the needs and promote the wellbeing of the people they supported. Staff we spoke with told us that they received an induction when they first joined the service but did not receive regular updates about how best to meet people's care needs. One member of staff told us, "I have not had any training for about two years." Although the provider's policy required staff to undertake three days shadowing experienced staff, records showed staff usually spent just two days shadowing. One member of staff told us however, they did not shadow any experienced staff and only attend one day's induction before they supported people who used the service. Two members of staff confirmed they relied on the people they supported, family members or their own experiences to identify how best to meet people's care needs. One member of staff told us, "We were just told to go and administer 'personal care'". Two members of staff confirmed that they had been sent to support people without first having a briefing or handover from experienced staff about people's care needs. One member of staff said, "I didn't have a briefing before I supported [person's name]. He was good enough to talk to me." Another member of staff told us, "I hurt myself recently because I had not been shown how to use a [specific piece of equipment]." This meant people were at risk of being supported by staff who had not received sufficient information about how to meet their specific needs.

Staff did not receive regular training opportunities to maintain and update their knowledge. Two members of staff told us they were required to complete on-line training however they did not have access to computers. One person told us that they had been offered the use of computers in the office for the completion of their on-line training but it was too far away and they would be unable to complete their training while also attending their planned calls. The registered manager and regional registered care manager were unable to provide us with evidence that staff had attended regular training. They told us attendance sheets of training course undertaken by staff were stored at another of the provider's locations

and promised to supply them to us on our second and third inspection visits. They were unable to access and share this information as promised. This did not enable the managers to check if staff had received the training they required to meet the needs of the people they were assigned to support.

The registered provider had failed to ensure people were supported by staff who had the skills and knowledge to meet their specific care needs. This constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

People told us that staff who provided regular support had, over time, learned the skills and knowledge they required to meet their specific care needs and preferences through guidance from themselves. One person told us, "My two main [carers] are brilliant. They know me very well."

People we spoke with told us they were happy with the support they received to eat and drink. One person told us, "They get my lunch ready for me. I choose what I want on the day." The relative of one person said, "I leave a sandwich ready [for the person who uses the service] and then staff will make him a drink and a biscuit if he wants one." Staff we spoke with said that the people they supported could express what they wanted to eat and drink and they were able to meet their wishes. We saw that the service also supported some people with shopping trips so they could purchase foods and drinks they enjoyed.

We found however that people were not consistently supported to receive suitable food and drink to stay well. An email sent to the registered manager on 20 March 2018 from a social worker had raised concerns that a person who used the service and was known to be at risk of losing weight had not been supported to receive suitable nutrition. They identified that staff had failed to provide the person with breakfast on three occasions since January 2018. The registered manager told us they were currently investigating these concerns. Records showed that some people had experienced late calls which meant they did not always have their meals at the times recognised as necessary in their care plans. This put them at risk of not receiving the nutrition they required to stay well. Menu charts for one person had not been fully completed so it was not possible to check if the person had received a meal at each call in line with their care plan. Staff had recorded in two people's daily logs that they had prepared the people's meals but did not identify what the person had eaten or if they enjoyed it. Therefore it was not possible to identify if the person had received enough to eat or help other staff to support the person to eat meals they enjoyed.

Staff did not work constantly well together to deliver effective support. Two members of staff told us they did not always receive their weekly rotas and would assume there were no changes to people's call times. This put people at risk of experiencing missed or late calls. Two members of staff also told us they did not have handovers with experienced staff before providing care to people they hadn't supported before. One member of staff told us they had recently missed a training session because they had not received a text from the office informing them of the event. This put people at risk of not receiving support in line with their care needs and wishes. We spoke with a nurse from an NHS anti-coagulation service who visited two people who the service supported to take anti-coagulation medicine (Warfarin). They told us they had not met the care staff who supported these people however, the people had not exhibited any signs that they were being supported inappropriately. A member of staff who supported these people said the nursing staff left clear guidance about how the people required supporting in their homes. Records did not consistently contain details about people's specific conditions and information so staff could identify if a person was deteriorating or at risk of harm. This did not support staff to identify when other agencies might need to be involved in supporting a person to stay well.

People we spoke with told us they or their relatives usually arranged access to other health professionals when necessary. The registered manager told us and records confirmed that when necessary they had

involved other health professionals to ensure people received effective care. In one instance we saw the registered manager had reviewed a person's care needs with an occupational therapist. This had resulted in redesigning the layout of a person's home so they could remain independent and reduce the risk of them falling.

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 told us that staff respected their choices. One person told us, "They always ask how I am and will ask what I would like to have done first." A person's relative told us, "They are good at [asking permission] and won't commence doing anything on mum unless she's okay with it." Staff we spoke with explained how they sought people's permission and we saw in one person's care plan that staff were to offer a person a choice of clothes to wear. We saw that people were supported to involve family members and other health professionals in agreeing their care plans. This enabled people to express their views and receive support which was in line with their preferences and best interests.

Requires Improvement

Is the service caring?

Our findings

People were not consistently supported by staff who knew their preferences and took time to interact and express compassion. One person told us, "[Regular carer] can't do enough for me. She knows me well and what I like. Unfortunately I can't say the same of the others". Another person said, "Some [carers] are in and out in ten minutes. No time to sit and talk at all." A person's relative told us, "[The] regular carer stays the time but the others don't. When they finish, they just go and the one puts down she has been here for the full time when she hasn't." Another person's relative said, "Our regular [carer] will stop and chat to him, which he likes and means a lot to him." People told us they were not always notified if their care calls were going to be late or if they were going to be visited by staff who were unknown to them. People said this could cause them worry and anxiety. One person told us, "Recently a carer turned up who I had not seen before and she just let herself in. It did un-nerve me a bit." A person's relative told us, "They don't let me know if they are going to be late and [person's name] gets very agitated when they are late." Staff did not regularly take the time to know the people they supported or make them feel they mattered.

People who used the service and staff told us incidences such as missed and late calls were not always responded to. A person's relative told us. I have spoken to them about the late and missed calls and we get nowhere." Several people told us that phone calls to the office and dedicated out of hours phone line were not always answered. One member of staff told us, "There's been times when the on-call number has just ringed out. I've seen a [person who uses the service] on the phone for ten minutes [before it was answered]." We saw evidence that late calls had resulted in people not receiving meals and personal care in line with their needs. This could make people feel their views and experiences were not important to the provider.

Staff spoke fondly about the people they supported. One member of staff told us, "[The] clients are lovely people. They can talk to me about anything." The registered manager told us how they had provided additional calls to one person because they were lonely. They told us, "We will just sit with her. It's lovely to see her improving."

People told us they were approached to express how they wanted to be supported. One person's relative told us, "They listen to both of us, which is important to me as I'm the main carer so I need to be involved." Another relative told us, "The carers listen, but not sure about the manager. Although the manager does come out when they are short staffed." People told us they had been involved in writing their care plans when they first started to use the service however some people told us they had not been involved with reviewing their care plans or approached to comment on how their care was being delivered. We found that there were no care plans in place for two people. These people had not been given the opportunity to express how they wanted their care to be provided and identify any specific requirements they had. This did not enable staff to deliver care based upon the people's likes and wishes.

People were not consistently treated with dignity and respect. People told us that staff who did not support them regularly were sometimes disrespectful. One person told us how a member of staff attended their night time call wearing their pyjamas. They said, "They recently sent a carer who I didn't know. She had her pyjamas on and she said they had got her out of bed to come to me." They added, "It's not very respectful to

come in your pyjamas on a visit." This could have made the person feel they were a nuisance and inconvenience.

People who were regularly supported by the same staff said they were polite and respected their privacy. One person told us, "They are all very respectful. They always knock on the door and shout before they come in." A person's relative said, "[staff] make sure the door is shut, things like that."

People told us that staff supported them to be as independent as much as possible. A person's relative said, "They do let [person's name] do as much as possible." The registered manager told us how they supported a person to rearrange their kitchen so they could begin to bake cakes. They also told us about another person who they described as, "fiercely independent." However there were was no guidance for staff about how to support the person to achieve the level of independence they wanted. This did not help ensure staff would support the person to be independent in line with their wishes.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with said staff who regularly supported them were responsive to their needs. One person told us, "It's the way they always ask what I want and the way they go out of their way to make me comfortable; like even making a cooked breakfast if I want one." The relative of one person said, "They [care staff] all treat [person who uses the service] well and know her preferences that she has with certain carers showering her." Three people we spoke with said staff who did not support them regularly did not always know how to provide care in line with their needs and preferences. The relative of one person told us, "The [non-regular carers] that come to cover for [regular carer] are totally unaware of [person's] condition." Two members of staff we spoke with said they relied on the people they supported and their families to explain people's preferences and how they wanted to be supported.

We saw care records did not consistently describe the specific risks associate with people's conditions and medication so that staff would be able to identify and respond appropriately if people were at risk of or experiencing harm. This meant people might not receive the support they required from staff to be safe and well. Although in one instance we saw a person's care records identify that staff were to support a person to watch television and how they liked to drink tea, other records sampled did not contain detailed information about peoples' preferences. This meant that people were at risk of being supported by staff who did not have information about how to respond to peoples, specific likes and wishes. The regional registered care manager told us that they had recognised the current format of care records did not support staff to deliver a person centred approach and showed us a new care record format they wanted to introduce which they said would support staff to provide individualised care. The registered manager told us that they recognised the need to respect people's culture, religious and lifestyle choices. They said that when possible people were supported by staff who shared the same language and cultural heritage. People we spoke with did not raise any concerns about how the service meet their cultural needs.

People gave us mixed views about how well the provider responded to their concerns and complaints. Comments from people who used the service included, "I would ring the manager [with any concerns], but you can never get through to her;" "I phoned [to make a complaint about missed calls] and never got an answer so gave up. This has happened a few times," and "I have information and numbers to call if I need to." Comments from people's relatives included, "[I called] once about a missed call. The manager answered and said she was not aware of it. She never called back to explain." Although the registered manager said they were not aware of any complaints being made about the service, some people we spoke with and three members of staff said they had raised concerns with the registered manager about the care some people had received. A monthly quality audit completed by the regional registered care manager recorded that two complaints had been made about the service in February 2018, however neither they or the registered manager could identify what these were. People who used the service could not be assured that their concerns would be accurately captured and responded to in line with the provider's policy. The registered manager showed us the provider had a policy for reporting and handling complaints. We noted information about how to raise a complaint was included in a service user guide which people confirmed they received when they started to use the service. This meant people would know how to raise a complaint or concern if needed.

Although no one who used the service at the time of our inspection visit was receiving end of life support, there were processes in place should they require it. The registered manager explained this would include identifying people's preferences and if they wanted to be resuscitated. The relative of one person who had recently been supported by staff to receive end of life care said they were very pleased with the care given. They said, "The staff were very good. They seemed to know what they were doing." We saw people were supported by other health care professionals when necessary which would ensure they would have prompt access to equipment and other health professionals in the last days of their lives.

Inadequate

Is the service well-led?

Our findings

Prior to our inspection we received information that the service was not well led. This information suggested a lack of robust governance and monitoring of the service and care people received. During our inspection we found evidence to support these concerns.

Systems did not ensure records relating to the care and treatment of service users could be easily accessed by senior staff. The registered manager told us they were unable to supply information we requested about a person's medicine because a member of staff who held this information could not be contacted. On each of our inspection visits the registered manager and registered care manager was unable to supply us, despite assurances they would, records that staff had undertaken training in the specific conditions of the people they supported. There were no records of untoward incidents, feedback or complaints despite people who used the service, their relatives, staff and health professionals telling us they had raised concerns with the registered manager. Failure to have easy access to this information prevented the oversight of care delivery.

Systems in place had failed to ensure care records provided up-to-date and consistent information for staff about people's conditions and how to support them safely. For example, the 'Manual Handling Assessment' for one person identified they, 'Need the help of a hoist or other equipment for transfer.' There were no further details about the specific equipment referred to or how it should be used. This did not enable senior staff to monitor if staff were using the correct equipment safely. Audits of care plans, including risk assessments and medicine administration records had failed to identify they lacked specific details about service users' conditions and how staff were to mitigate against associated risks. The medication assessment document for one person stated, "My medication is in a blister pack." However, the person's 'My health action plan' document recorded that, "I'm not on any medication at present." These audits had also failed to identify that staff did not record the specific medicines they had supported people to take. Failure to identify that care records did not have clear information and guidance for staff meant senior staff were unable to check if people were receiving care in a way which met their needs and kept them safe.

Systems to check that service users were being supported by staff who had the suitable skills, knowledge and qualifications to meet their needs were not robust. People frequently told us they were supported by staff who did not know their specific care needs. Governance systems had failed to identify that staff had not received training and information about people's specific support needs and associated risks. The registered manager was unable to show us any records to demonstrate that staff had attended any training apart from their basic induction. We saw there was no process in place to ensure staff supervisions and meetings occurred regularly for all staff so they received regular training and updates in the latest best practice and guidance. A failure to maintain robust training records meant people were at risk of being supported by staff who were unable to meet their specific needs.

Systems to monitor if there were enough suitable staff on duty so people were supported safely and in line with their care plans were ineffective. The regional registered care manager told us the electronic call monitoring system used to plan people's calls was ineffective and had failed for part of a day. This had

meant they were temporarily unable to identify the calls people required. They also told us the system was due to be replaced, however there were no contingency plans in place to ensure an effective temporary call management system was in place until a new system was operational. There was no effective contingency plan to check that service users who did not use the call monitoring system had received their calls as planned and the registered manager told us they were reliant on people who used the service or staff alerting them to late or missed calls. The lack of an effective system had resulted in people experiencing missed and late calls which exposed them to risks to their health, safety and welfare.

There were no effective systems in place to engage with people who used the service and respond appropriately to feedback about the quality and safety of the service. People regularly told us that when they wanted to raise concerns, their calls to the office were not always answered or staff would not always call them back. One person told us, "When I call they say [the registered manager] is not available. She never gets back to me." One person's relative told us, "[The registered manager] is nice and approachable but doesn't come back to you if you have a query." The registered manager told us on several occasions they were not aware of any complaints or concerns being received about the service and that there were no records of untoward incidents, feedback or remedial action for us to review. Records of an audit by the regional registered care manager identified that two complaints had been received but they were unable to tell us what they were and suggested this was a recording error. Systems had not ensured concerns about people's care and exposure to the risk of harm were not shared with the other authorities. Failure to have effective systems to capture and respond to feedback prevented prompt and effective action and improvements being made to how service users' care was provided.

Failure to have effective governance in place resulted in an inability to drive improvements in the quality and safety of the services provided including the quality of the experience for service users. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

People we spoke with gave us mixed views about the quality of the leadership at the service. One person told us, "I have spoken to the manager, she is very obliging." Another person said, "I think the [carer staff] are good, mainly. Not sure about the office [staff] though." One person's relative told us, "Could be better. Lateness of calls needs addressing and training of staff needs to be improved." Another relative said, "[I'm] very happy. In fact I don't know what I would do without them." Staff we spoke with said the registered manager was approachable and was available for advice. One member of staff said, "[Registered manager] definitely approachable." However one member of staff told us, "The management is shambolic. My manager said they would come out and show me how to use [equipment] but haven't." Two other members of staff told us they were frustrated with a lack of response to their requests for training.

People gave us mixed views about how they were supported to engage and comment on the quality of the service they received. One person told us, "I had a full review of my care plan last October with social services, but the [provider] was not there." A person's relative told us the person's care plan had, "Not been reviewed since it was set up some 18 months ago. When I look at the plan here, only one out of five [medicines] has been spelt correctly and this is a concern if she is given the wrong ones." Three other people told us they had an input into their care plans but had not undergone any reviews because they had only started to use the service. The registered manager said that there was no formal plan in place to ensure people's care plans were regularly reviewed or people were approached for their opinions. They told us they were planning to introduce a service user's questionnaire to capture people's views of the service. Failure to have robust systems to seek people's views of the care they received did not enable the provider to develop the service so it met people's specific needs and improved their experiences.

Several staff we spoke with raised concerns with the quality of communication at the service. Two members of staff said they did not regularly receive rotas and another member of staff said they had not been notified of a planned training event held after our inspection visits. A member of staff told us, "[There is] not much communication. I'm left to it." However another member of staff told us they spoke with the registered manager most days. On two occasions during our inspection visits we experienced delays in obtaining information from two members of staff. They both told us that this was because the provider did not reimburse them for mobile phone calls made while working for the service and they had both run out of phone credit. A lack of effective processes for meaningful and effective staff engagement limited how staff could influence and develop the quality of the service or promote the provider's vision and direction of the service.

We saw that there were systems in place so the service would work with other agencies in order to ensure people received prompt and appropriate care. We noted however these systems were not always followed. For example processes had not been followed to alert other agencies when people had been put at risk of or had experienced harm when they had not received their care as planned. This had resulted in people continuing to be at risk of experiencing late and missed calls. The registered manager had not notified the Care Quality Commission of events they were required to do so by law, such as when people had died or been put at risk of harm due to missed medication. We saw however that on one occasion staff had worked with another agency in order to support a person who was at risk of malnutrition. Failure to consistently involve other agencies in order to meet people's care needs and improve their experiences put people at risk of receiving unsafe or inappropriate care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure that risk assessments relating to the health, safety and welfare of people were completed and mitigated the risks presented by people's specific conditions and medicines. Regulation 12 (1)(2)(a)(b)(c)(g)(h)

The enforcement action we took:

NOP

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to operate effective systems and processes to assess, monitor and improve the quality of the service. Regulation 17 (1)(2)(a)(b)(c)(e)

The enforcement action we took:

NOP

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure people were supported by enough suitable staff who knew how to protect them from the risks associated with their conditions and medicines. Regulation 18(1)(2)(a)

The enforcement action we took:

NOP