Heath Lodge Care Services 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?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Heath Lodge Care Services Limited is a domiciliary care agency which provides care and support to people in their own homes. It provides a service to older adults and younger disabled adults. The agency had a total of 91 clients, 80 of whom received the regulated activity of personal care.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager registered with CQC on 8 February 2018.

We last carried out a comprehensive inspection of this service in December 2016 when we rated the service as Requires Improvement overall. We found breaches of regulation in relation to a lack of risk assessments, recruitment processes, person-centred care and quality assurance. Following that inspection the registered provider submitted an action plan to us telling us how they planned to address our concerns. We carried out this inspection to see if the registered provider had taken action in line with their action plan. We found that despite being told all concerns would have been addressed by May 2017, this was not the case.

Risks to people's safety were not always identified or staff were not provided with sufficient information in order to help keep people safe. Where incidents that had occurred which were potential safeguarding concerns, these had not been acted upon. Staff did not take appropriate action or learn from accidents and incidents. Staff did not always use the appropriate personal protective equipment when carrying out personal care to people and there was a lack of staff to meet people's needs. Staff did not always stay the time they were allocated to do so.

Where people lacked capacity to make decisions we found that staff had not followed the legal requirements in relation to consent. There was a lack of person-centred information in people's care plans to help ensure people received responsive care. Care plans were not always reviewed as often as they should be and staff did not always know about people's individual needs.

People had been given information on how to make a complaint, however not all complaints had been logged as such and it was unclear from the records whether or not complaints had always been resolved.

Although the registered manager had a clear vision for the service we found there was still a lack of robust quality assurance monitoring processes in place. This meant the registered provider could not guarantee people were receiving a good standard of care. Staff did not always feel supported or valued by the registered provider.

People were cared for by staff who showed kindness, care and attention. People told us they communicated well with staff and they encouraged them to make their own decisions and remain independent.

People received the medicines they required as well as sufficient food and drink. People were cared for by staff who had appropriate training and had been recruited through robust recruitment processes. Staff had access to the training they required to undertake their role. In addition, they had the opportunity to meet with their line manager on a regular basis.

People were supported to access healthcare professionals when they needed them. Before the agency started to provide care an assessment was carried out to ensure they could meet a person's needs. People were asked for their feedback about the agency and they told us that on the whole they felt the agency was well-managed.

As a result of our findings we have made one recommendation to the registered provider and found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service has therefore been placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not always identified or guidance in place for staff to keep people safe from risk.

Potential safeguarding concerns were not escalated and as such people may be unsafe.

There was a lack of sufficient numbers of staff to ensure people received their full allocated time.

Staff did not always use the appropriate personal protective equipment when carrying out care.

Staff did not learn from accidents and incidents to help ensure they did not reoccur.

People received the medicines they had been prescribed.

Staff recruitment processes helped to ensure only suitable staff worked at the agency.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mental Capacity Act assessments and best interests decisions had not been made for people in line with the legal requirements.

Staff had access to appropriate training for their role.

People were provided with the food and drink of their choice.

People's needs were assessed before the agency started to provide care.

People were supported to access the healthcare services they required.

Is the service caring?

Good

The service was caring.

People had good relationships with the staff who supported them.

Staff treated people with dignity and respect and we received positive feedback from people and relatives about staff.

People were encouraged to be independent and involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not always person-centred or contained sufficient information to help ensure people received responsive care.

Complaints information was made available to people, however records in relation to complaints was not always up to date.

Is the service well-led?

Inadequate

The service was not well-led.

Internal auditing and monitoring was still not robust enough to ensure people received a good level of service.

Staff were involved in the agency, but did not always feel supported or valued by the registered provider.

The registered manager had a clear vision for the service.

On the whole people felt the office was well-managed. However, some people told us communication needed to improve.

People were invited to give their views and feedback about the service.

Heath Lodge Care Services 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 was a re-inspection of this service to check whether the provider was 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 an updated rating for the service under the Care Act 2014.

This inspection took place on 13 & 14 February 2018. The inspection was carried out by five inspectors. Two inspectors carried out telephone interviews with people on 13 February 2018, one inspector carried out home visits and spoke with people and staff on 14 February 2018 and two inspectors visited the office on 14 February 2018. We gave the provider six days' notice of this inspection in order that they could arrange home visits and telephone interviews for us. It also meant they could be sure that someone would be available in the office to assist us with the inspection.

We carried out this inspection because we had some concerns about the number of missed calls that were being reported to us by the service. We had received notifications that nine missed calls had occurred since July 2017. However, it was unclear whether or not there had been more as the previous registered manager had not realised that they needed to notify us of missed calls if there were potential safeguarding concerns as a result of them.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We also spoke with the local authority in relation to the agency.

We had previously requested a Provider Information Return (PIR) however the registered provider had experienced problems with completing the form. This was reported to us at the time. This is a form that asks the provider to give some key information about the service, what the service does well and improvements

they plan to make. This meant we were unable to review the PIR as part of this inspection.

On the day before we visited the offices we carried out telephone interviews and spoke with four people and two relatives. During our inspection we spoke with five people, three relatives, eight staff, the registered manager and the provider's senior management team. We also reviewed a variety of documents which included the care records for 11 people, five staff files, medicines records and other documentation relevant to the management of the agency. This included quality assurance processes, staff timesheets, safeguarding notifications and the accident and incident log.

The last inspection to this service took place in December 2016. At that inspection we found four breaches of Regulation and we gave the location an overall rating of Requires Improvement.

Inadequate

Is the service safe?

Our findings

At our inspection in December 2016 we issued a breach of regulation to the registered provider in relation to a lack of risk assessments for people. We also made a recommendation in relation to deployment of staff. Despite the registered provider telling us they would take action to address these shortfalls by May 2017, we found this had not happened.

Some people were able to give us examples of where staff had demonstrated risk management. For example, one person had an extreme asthma condition and they praised the staff highly on their response to this risk. Another person who was at risk of falls told us, "They (staff) keep everything free from clutter and they walk close to me to keep me standing." A third person who had a risk of pressure sores said, "They check my skin and put ointment on if required." A further person told us, "They put a non-slip mat and a special seat in the shower for me which makes me feel safe." However, we did not find that people would always be protected against risks to their safety. This was because there was a lack of information to guide staff on how to keep people safe from avoidable harm.

Risk assessments were generic and covered a number of standard personal and environmental risks. Some people suffered from epilepsy and yet there were no risk assessments in place relating to this to tell staff what may trigger a seizure and as such what action to take. One person smoked and although their care plan stated, 'aware of risks' a detailed assessment was lacking in relation to ensuring fire safety equipment was available when this person smoked. A second person who smoked had no assessment in relation to whether they had any topical medicines (medicines in cream format) which may contain petroleum and as such be flammable. A third person was recorded as being, 'over familiar with strangers – tends to hug everyone' and yet there was no further information on how to avoid this. A staff member told us in relation to this same person, "She is at risk of choking. If she is not in a good position she may choke" and yet there was nothing about this in the person's care plan. A further person was registered blind but there was no risk assessment in relation to this. A relative told us the key to their family member's medicine cabinet was on a combination lock and they had noticed that staff had not always been careful enough to twist the lock round so that their family member could not open it. This meant the person may be put in a position of risk in relation to medicines.

Staff did not learn when things went wrong. Staff were not routinely using accident and incident forms to record incidents. We spoke to one staff member who informed us of two recent incidents which related to people being found unwell and an ambulance called, however neither had forms completed in relation to these incidents. The staff member told us, "I don't have anything to fill in. I just inform the office and complete the daily records." We looked at a folder that contained information about medicines errors and noted on one occasion in January 2018 a staff member gave a person the incorrect medicine. As a result it was noted, 'unpaid medication training and to have medication competency'. This training had yet to take place, however this staff member was still being allowed to administer medicines to people.

People told us their care workers helped them keep their homes clean and hygienic and that staff washed their hands. Staff had received training in infection control and the agency had an appropriate infection

prevention and control policy. Staff told us they always had access to personal protective equipment, such as gloves and aprons, when providing people's care. However, some people told us staff did not always wear aprons. One person said, "Some wear gloves but not aprons." Another person said, "They wear gloves but not aprons." However another person told us, "Yes, the carers are always very good in this regard – they are meticulous." The staff we observed during our home visits were seen using gloves to support one person with personal care and washing their hands before and after preparing someone's lunch. However, we noted in the minutes of the most recent staff meeting that the registered manager had discussed the lack of aprons being used by staff which they had noted when carrying out visits to people's homes. They reminded staff of the importance of wearing them in order to help reduce the risk of transferring infections.

The lack of keeping people safe from risk was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe using Heath Lodge Care Services. One person told us, "I feel completely safe with them." Another said, "It is safe, they make sure I have a jumper on if I need one." A third person said, "I always know who's coming. Familiarity makes me feel safe." A relative told us, "It is safe, I can't find any fault with them whatsoever." However, despite this feedback we identified some concerns.

People may not have always been protected from potential abuse. Although staff received safeguarding training and we saw that the agency held a safeguarding policy we found that potential safeguarding concerns had not always been escalated. This was despite staff telling us during our inspection that if they had any concerns they would, "Tell the office straight away obviously." We became aware in July 2017 that the agency had experienced missed calls and yet the registered manager at that time had failed to notify us or their local safeguarding authority even though they were potential safeguarding incidents. Following that a further four missed calls had occurred which prompted this inspection. Although the new registered manager had put processes in place in December 2017 to try to ensure these would not happen again, since that time a further four missed calls had been reported. The registered manager told us that they had introduced a system whereby office staff would telephone the care staff member prior to a call to double check they were going to attend. However, there was not one individual member of office staff who took overall responsibility for this and as such there was no monitoring to ensure this always happened. A staff member told us, "The office would not always know (we had turned up). Sometimes the office ring but not all the time." In addition, we read in the minutes of a recent staff meeting that on-call staff stated they were not happy doing this as it took a vast amount of their time when they were on duty. This system was therefore unsustainable and as such the risk was that people would continue to experience missed calls which could put them at risk of neglect, ill health or injury if they did not receive the required support.

During our inspection we identified there had been a recent incident in relation to one person. A staff member told us they had visited this person to review their care package. Due to the pain this person was in this person's GP prescribed this person an (end of life) medicine to be administered by staff. On 11 January 2018 care staff found this person wedged between their bed and the wall. They phoned the on call team and as a result called for an ambulance. However, a family member cancelled the ambulance and transferred their family member from the position they were in themselves. Later, at this person's evening call staff found them, 'dopey and hallucinating' and the following day this person was found unresponsive. A staff member told us, "I literally had to wake her up to feed her which is so unusual for her." A member of care staff said they had marked a line on the medicine bottle and had noted that the liquid had gone down when staff had not been administering the medicine. Rather than reporting this to safeguarding or police or completing an incident form, the staff member was asked to mark the bottle again and, 'see what happens'.

People's information was not always kept confidentially. We read in some people's care plans a note of their

key code pin number used to enter the person's house. One person's care plan also contained details of the code for their medicines cabinet. This information should only be available to staff who are attending the call and as such this was not safe practice and could leave people exposed to harm if other people visiting their home had access to this information. In addition, we noted two incidents of staff falsifying records by recording they had stayed longer than they actually had. This meant people may be at risk of potential financial abuse by the registered provider as they may be charged for time that they did not receive.

The lack of safeguarding people from potential abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in December 2016 we made a recommendation to the registered provider in relation to deployment of staff. This was because people and staff told us they felt there were insufficient staff and that staff were not allocated travelling time between calls. We identified similar concerns at this inspection.

We asked people about call times and punctuality of staff. One person told us, "They are on time, but sometimes there is traffic. If they have been late they have always called me." Another said, "They usually turn up on time." A relative told us staff usually turned up on time and if there was an emergency or delay they got a call. None of the people we spoke with had experienced any missed calls. However, we had identified concerns in relation to staff deployment.

People were cared for by an insufficient number of suitably deployed staff. We asked staff whether they felt there were enough staff. One staff member told us, "In general they need more staff." Another said, "Honestly? No." Staff said travel time was not always allocated between calls. A staff member told us, "Sometimes travel time is included and sometimes no gaps – I just have to be late for people. It's upsetting to keep telling them (people) that I am going to be late. People tell me, 'They haven't got enough staff'. Every week this happens and sometimes I have to spend less time with people. The client is unhappy and thinks it's unfair that I'm not focusing on them." One person told us, "Carers always do their best but they don't get allocated travel time, and there are not enough of them." We reviewed timesheets for a period of six days and noted that on each day there were times when travel time was not included. Another staff member said, "We are turning down packages as we don't have enough staff. It impacts on my role. We do try and have travel time but if we know the clients we know how we can get the call done in 45 minutes (instead of an hour)." In the December 2017 client survey we noted of the 42 responses received, 12 people had said that staff, 'sometimes' did not stay the full allocated time. One person had written, 'sometimes they've been in a rush and had to leave after 10 mins'. We read that this person required 30 – 45 minute calls.

We asked people if staff stayed their full time. One person told us, "Not always." Another person told us, "Sometimes they have no-one to send in the evening." There was a lack of auditing of staff timesheets to check staff were staying the full allocated time. We noted some staff did not complete their arrival and departure time, or ask the person to sign to confirm how long staff had been with them.

The lack of a sufficient number of deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us their care workers helped them keep their homes clean and hygienic and that staff washed their hands. Staff had received training in infection control and the agency had an appropriate infection prevention and control policy. Staff told us they always had access to personal protective equipment, such as gloves and aprons, when providing people's care. However, some people told us staff did not always wear aprons. One person said, "Some wear gloves but not aprons." Another person said, "They wear gloves but not aprons." However another person told us, "Yes, the carers are always very good in this regard – they are

meticulous." The staff we observed during our home visits were seen using gloves to support one person with personal care and washing their hands before and after preparing someone's lunch. However, we noted in the minutes of the most recent staff meeting that the registered manager had discussed the lack of aprons being used by staff which they had noted when carrying out visits to people's homes. They reminded staff of the importance of wearing them in order to help reduce the risk of transferring infections.

We recommend the registered provider ensures staff follow good practice in relation to infection control.

At our inspection in December 2016 we found there was a lack of robust recruitment processes in place to help ensure only suitable staff were employed. At this inspection we found the registered provider had addressed this.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who used care and support services. There were also copies of other relevant documentation, including employment history and professional and character references in staff files to show that staff were suitable to work in the service.

People received the medicines they needed in line with the prescription instructions. One person told us, "They give me one tablet at night and put my cream on." Another person said, "They give me my medication because I can't see." We reviewed people's medicine records and saw that staff had administered medicines and topical creams (medicines in cream format) to people in line with the written instructions. Each person had a medicine administration record (MAR) which included details of their GP and whether or not they had any allergies. MAR charts were returned to the office for auditing once they were completed and we noted that any shortfalls identified were addressed with staff. Where staff took responsibility for disposing of unwanted medicines for people we saw agreements in place authorised by the person. A staff member told us, "We have medicine charts. We sometimes prompt people and only fill in the chart once you know people have taken it. If they refuse then you record it."

Requires Improvement

Is the service effective?

Our findings

At our inspection in December 2016 we made a recommendation to the registered provider in relation to the Mental Capacity Act 2005 (MCA) and legal requirements in relation to consent. We found at this inspection no action had been taken and staff had continued not to follow the principals of the Act.

The 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 when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people lacked capacity to make decisions for themselves, mental capacity assessments had not been carried out. We noted in several care plans the statement, '[Name] has been assessed to not have capacity. Their family do not have power of attorney over their health and wellbeing but will act in their best interests'. There was no evidence of mental capacity assessments or best interests decisions. In addition, we read in the case of one person who had capacity that staff were being instructed to override any decisions they made. This person's care plan stated, 'She will often refuse care - even if she is dressed she must have a bath and if she smokes while you are there ask her not to and if she persists report it to her daughter'. Therefore we could not be assured that people's rights were protected under the Act.

The lack of compliance with the legal legislation in relation to the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the principals of the Act and we did hear staff asking people for their informed consent. A staff member told us, "You measure whether people are making the right decision for them. Dementia could affect that." We heard staff asking one person if it was okay to provide personal care. They also asked this person if they would like their lunch. One person told us, "I have my daily care routine. If there was a change, I'm sure they would ask."

Staff received an induction when they started work and this included a period of shadowing more experienced staff. One person told us, "Sometimes if they send a new one I tell them what's needed and they look in the folder." Another person said, "They always send trainees with another staff member. They ask for my permission first but it's important, everyone must start somewhere." One staff member told us their induction included observing practice and meeting people. Another staff member said, "I had a whole week at the office and three full days of shadowing. It wasn't enough shadowing. You find out about people when you first meet them. With no travel time we need more time to get to know people's needs."

Staff were provided with the skills to support people effectively and people told us they felt staff seemed competent and completed tasks as expected. We observed one staff member prompting a person to use their nebuliser when they became breathless. This person told us new staff were always shown how it worked before they supported them. They told us, "They (staff) know what to do and I feel confident in them." Another person said, "The most important thing is feeling confident and I do with them (staff)." A

relative said, "They are trained. I'm very impressed. They use the equipment safely whenever I have observed." We also saw staff supporting people to transfer in bed, providing verbal reassurance throughout. Staff told us they felt the training was good.

Staff undertook mandatory training when commencing employment with the agency. This included first aid, moving and handling, medicines, basic first aid and food hygiene. We were told that if staff did not have a national qualification in care they would be expected to complete the Care Certificate (a nationally recognised set of standards in relation to care). A staff member told us, "I think the training is fine."

Staff were given the opportunity to meet with their line manager to discuss aspects of their role. This included any good practice, training requirements or professional development.

Before people received care from the agency an assessment was carried out to help ensure that the service could meet their needs. One person told us, "The care lady came round first to ask what we needed. That took a load off our minds." Local authorities commissioning care provided the agency with their own initial assessment of a person's needs. A care co-ordinator from the agency then visited the person to carry out the agency's own assessment. We noted people's assessments held information about their medical needs, mobility, nutrition and personal care.

People's needs were met in relation to their nutrition and hydration. People confirmed that staff always left them with enough food and drink. One person told us, "I do my own food, but they make a good cup of tea." We observed staff encouraging one person to eat a rice dish that they had prepared. The person was given time to eat and staff patiently encouraged them to eat when they became distracted.

People were supported to remain in good health. One person suffered from leg ulcers and had to have their legs elevated. They told us that staff always remembered to ensure their legs were up. Another person had redness on their heels and a staff member had contacted the district nurse to visit. One person told us that staff had spoken to the GP for them about their repeat prescription as they struggled to use the telephone. A relative told us that staff provided good support for their family member's rehabilitation from a stroke. They told us, "Her speech has got better because they actually take time to sit and talk to her." Another relative said staff would ring them unless it was an emergency, in which case they would call the doctor or an ambulance.

Good

Is the service caring?

Our findings

People told us staff had a caring nature. One person told us, "[Staff member] always comes in cheery and goes the extra mile." They told us the staff member spent time chatting with them and would do anything extra they asked, such as shopping. Another person said, "They always send carers that actually care." A third person said, "They (staff) are all very polite and helpful." A relative told us, "They're (staff) always very kind."

People told us they were treated with respect. One person told us, "I am looked after and treated with absolute respect and dignity." Another person said that they had some personal problems that affected their toileting. They said staff were very discreet and they liked the way they handled it as it was something they got quite embarrassed about. A third person said, "Polite, courteous, treat people with dignity and respect and they respect my wishes." We saw staff were respectful when coming into one person's home. This person said, "They are very respectful, we have some close chats. They always ask if I would like a cup of tea and a chat first." Another person received personal care during our visit. The staff member was mindful that we went to another room whilst this took place.

People were encouraged to be independent and make their own decisions. One person said, "I am able to do things myself and they just prompt or encourage me." A second person said, "The regular carers know what I like to do for myself." Another person told us, "I can choose what I want to wear." A staff member told us about one person, "She can eat on her own but hasn't been well this week. We still give her the spoon though and talk her through it." We observed the staff member doing precisely this whilst giving this person their lunch. A relative told us, "We wouldn't ever have wanted care but they (staff) fit with our routine so well."

People were shown attention by staff. One person told us staff had recently spent time helping them tidy and organising their medicines, even though they administered them themselves. They also said staff had gone to pick up medicines when running low and the delivery did not take place. This person told us staff showed attention to detail when taking them out, such as making sure they had a blanket on them to stay warm. Another person said, "Real treasures – very caring and kind." We observed one person making lots of jokes with a staff member throughout their visit. They had a good rapport together. A relative said, "The girls are brilliant, they have a lot of patience."

People felt staff communicated with them well. One person told us they got on well with the staff who supported them and there had been no issues with communication. Another told us they communicated well with staff. They said smiling (about one staff member), "She's very chatty, I can't get a word in edgeways." A third person said, "They speak English and can communicate with me well enough."

People's cultural needs were recognised. One person told us that some staff spoke German and Dutch, which benefitted them as German was their first language. They said they enjoyed talking to staff about their backgrounds. Their relative said, "The visits really cheer her up and I hear them in the bathroom having long conversations." Another person said some of their care workers were Estonian and they spoke Finnish. We

observed a staff member communicating with this person in their native language throughout the visit whilst supporting them to have lunch and personal care.

People said that they received care from consistent staff that they knew. One person said, "I have a regular carer and she is wonderful." Another person told us, "It's always the same one in the morning and the same one at night. There is some change at weekends, but familiar faces." A third person told us they had the same staff for their visits. They said staff knew them well and talked to them about their interests. It was evident that poetry was a very important part of this person's life and they confirmed staff chatted to them about poems and knew about their passion for poetry. A relative told us, "They (staff) look after him and they all know him now." Another relative said, "They try to give us the same staff; there is consistency." They said they sometimes saw new faces as they were double up calls but always with staff that knew their family member already. Staff were able to tell us personal information about people and we saw in the case of one person nearly all their daily notes were written by the same two staff members.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in December 2016 we found that people's care plans were not always personalised and they lacked detailed guidance for staff. Although the registered provider told us in their action plan that all care plans would be reviewed and updated by May 2017 we found this not to be the case. However, people told us they felt their care was personalised.

One person said, "I am agoraphobic so this (their bedroom) is my world. They (staff) always sit and spend time with me and know how to make me feel better if I am (feeling) down. [Name] brushes my hair and it relaxes me." Another person told us, "They (staff) are very observant and changes clothes if they see they are not clean." Their relative told us, "They always give her a good clean, we couldn't ask for better care." A third person said staff provided the right amount of support to enable them to shower as independently as possible. They said, "The only thing I can't do is lift and they (staff) are aware of that."

People's care plans were not always person-centred or contained sufficient information to help ensure staff would provide responsive care. One person's care plan stated, 'assist with arm exercises' but there was no further information about this. It also stated this person was on a pureed diet, however the person was being PEG fed (fed via a tube directly into their stomach). We asked staff about the arm exercises and were told, "I think the live-in carer does the arm exercises" but they did not know for sure. The staff member told us that this person became fixated on particular things such as why a staff member may be late and as such this made them anxious. However, none of this was in this person's care plan. Another person had a muscle wasting illness, there was no information in their care plan about what this was, how it may progress or how long they had had it. Staff were unable to tell us what the illness was.

One person was described as having, 'erratic behaviour' but there was no guidance for staff on how best to manage this. It also stated they were, 'bi-polar and had depression' but nothing further about either of these conditions was in their records. A further person was listed as having a, 'fractured neck of femur'. Staff had told us this person was in considerable pain, particularly when being moved and yet their care plan did not contain guidance to staff on the best way to move this person to cause them the least pain. One person was noted as suffering from a brain malformation however their care plan did not describe to staff what this was or how it presented itself in this person. A further person was noted as requiring to be 'weighed every Friday' however it was not clear why this was necessary. We looked at the daily records for this person and found that this did not always happen. We saw that on four occasions during a period of four months staff had not weighed the person. However, in another person's care plan staff had recorded they were at risk of weight loss, but staff had not been asked to monitor this persons' weight. A staff member told us, "I will look at the name and what needs doing. I don't get a chance to read them (care plans) all. If they (the office) allowed us more time..."

People told us their care plan was reviewed. One person said, "I have regular reviews. We talk about what I want and if I'm happy. I've had no issues though." A relative told us, "Someone from the agency reviews her care plan regularly as well." However, we did not always find care plans were reviewed when they should be which meant the registered provider could not satisfy themselves that staff would always be providing the

most appropriate care to people. For example, one person's care plan had not been reviewed in February 2017 when it was stated it should have been and another person's review was due in June 2017 and that had not happened. We read in another person's care plan, 'temporary arrangement [name] is having bandaging on leg'. This was recorded over a period of three years, so it was unclear whether or not this arrangement was in fact temporary or something that had ceased. We asked staff about reviews of people's care records. A staff member told us, "For the whole of August no reviews were done. We don't know if things are changing. We don't know if clients are happy. They are old and vulnerable and may not want to ring if they are not happy with something. We are trying to get care plans done. At the moment they are really hard to read."

The lack of person-centred care planning for people was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with information on how to make a complaint should they wish to. One person said, "If I ask for something there is no song and dance about it, they just get on and do it." Another person told us they could raise anything they wished with a field co-ordinator who regularly visited them. A third person said they had not raised a formal complaint but they had an issue with an unkind staff member which was addressed quickly. A relative told us, "I've had nothing to complain about." We read that 13 complaints had been received by the agency within the last 12 months. We read that some had been recorded as being resolved however it was not clear whether or not all of them had as the records were not up to date. In addition, we read a complaint in one person's care plan that a member of staff had not arrived for their call. This complaint was not included in the complaints folder, so it was difficult to see how it had been resolved or responded to. We spoke with the registered manager about this at the end of the inspection who informed us they held an internal electronic system for logging complaints and most of the information would be held there. We also noted information on the registered provider's complaints policy was incorrect in that it signposted individuals to CQC if they were unsatisfied with the response from the agency in relation to their complaint. CQC does not have the regulatory remit to respond to individual complaints and as such people should be given information on how to contact the Health Ombudsman in such events.

We recommend the registered provider ensures they record all complaints as such and hold records in relation to complaints in one place.

We did read some compliments received by the agency during spot checks and telephone reviews with people. These included, 'very happy and cheerful (staff)', 'I'm very happy with all the girls' and 'can't fault Heath Lodge – [staff name] is wonderful'.

Inadequate

Is the service well-led?

Our findings

At our inspection in December 2016 we identified a lack of sufficient robust quality assurance processes. Despite being told in the registered provider's action plan that this would be addressed by May 2017, we found it had not.

There was a lack of effective governance and management oversight of the agency to help ensure that people received the high quality, safe and responsive service that they should expect. Although we noted that people's MAR charts and daily notes were reviewed by office staff, the registered manager did not carry out an overarching audit on any actions that were identified during this process. This meant they could not satisfy themselves that shortfalls were addressed robustly or identify whether or not individual staff needed additional training or support. In addition, despite the number of missed calls experienced by the agency there was a lack of rigorous systems in place to help prevent these happening again and as such further missed calls had occurred. Staff were meant to complete and sign timesheets to confirm their arrival and departure time from people's homes and yet the data we reviewed showed that this did not always happen and office staff had not taken action to address this. We reviewed timesheets for a period of six days and found nine staff were not recording anything on the forms. Some staff told us that due to the shortage of staff at times paperwork and audits were behind. Spot checks should have been carried out by both telephone and face to face for people and staff. We noted in the records that so far this year only three face to face spot checks had taken place and four telephone audits. A staff member told us, "I can't meet the clients as much. Spot checks aren't being done as much." People's care plans were not being reviewed as often as they should be which meant staff may not have the most up to date information about a person. There was also a lack of planning in relation to staff induction which meant that although they had completed an induction and shadowed a more experienced staff member they may go to someone they had not been to before. Staff told us they were not introduced to people who were new to them. We also found records in relation to complaints were disorganised in that some records were held in a folder, others were on the agency's computer system and some were logged in people's care plans.

The registered provider's senior manager informed us that they had investigated an electronic system for the agency which would give them the tools to help ensure missed calls did not occur and that they could track and audit staff whereabouts and timekeeping. A proposal had gone to the board of directors. They told us, "We have shortlisted some providers, but we have not got the licences yet. It is boiling down to expense." In the meantime however the agency had not ensured systems and processes in place were robust.

Staff meetings took place in order that staff had the opportunity to contribute their thoughts, concerns and give feedback. We read that a series of meetings had been held so the newly registered manager could meet as many staff as possible. In addition, senior staff meetings were held that involved the field co-ordinators, registered manager and regional manager. Upon reading the minutes of the meeting we noted all aspects of the service were discussed, however much of the content hinged around missed calls, out of hours duties and staff culture.

We read from the staff meeting minutes from October 2017, 'Issues with coordinators at times, feel rushed

and not listened to, calls not being returned, messages not being passed on, turning up to calls that have been cancelled and not informed'. We were told following our inspection that a staff meeting held in January 2018 had started to address these concerns. A staff member told us what they felt could improve with the agency was, "Improved communication between the office and staff."

Staff gave us mixed responses as to whether or not they felt supported and valued. One staff member told us they had been promoted from a care worker to a senior co-ordinator. They said they had been supported to do this. However, another staff member told us, "I don't feel valued. We never have feedback about what we do. I could feel more motivated." They added, "Leadership is upside down. [Registered manager] is trying. She met with us to introduce herself and she has introduced better MAR sheets."

The lack of effective quality assurance systems was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had a clear vision for the service. It was clear from the minutes that the registered manager had picked up on some attitudes and behaviours of staff which they were trying to change. We read and were told that experienced staff were reluctant to take new staff out shadowing and this had caused some discord. In addition, the registered manager had found staff were not always wearing the correct uniform, were not completing MAR charts properly, were using blue ink when writing daily notes and that people's calls needed to be 'person-centred, rather than routines'. The registered manager had explained to staff that, 'A lot of improvements were needed in all areas and it is her aim to achieve this with everyone's assistance'.

Staff told us, "I think I feel supported by [registered manager] and colleagues. When I have a problem someone always gives me a cuddle. [Nominated individual] is fantastic." They continued, "I think though we need more carers and longer calls (to people)." A further staff member said, "As a company I love working here. I get on really well with [registered manager] who is trying to improve things."

We had mixed responses from people and relatives in relation to the office. One person said, "The staff in the office are wonderful, so polite and friendly." They told us when they called to cancel calls staff had been understanding. Another person told us they felt the agency was well run, although they did not have much contact with the office. They told us a care co-ordinator did their calls and as such provided them with information and took their feedback to the office. A third person said, "I have nothing but compliments for the service." A fourth told us, "Yes, it is well-led. When I had a query on my invoice they came out to see me to go through it." A further person told us, "I met the new manager today … it is improving in last few weeks." A relative said, "I can speak regularly with [staff member] who works in the office." Another relative told us, "I don't think I've ever met the manager but they're (staff) all really helpful. Mum wouldn't be able to stay in her own home without them." However one person told us, "I've tried to phone them a few times and hung on for ages, but no-one picks up. There's no answering service either. I tried the out of hour's number as well but I didn't get a response from them either." Another person told us they needed to restart their care package after a spell in hospital and they said, "The duty phone was being held by a person who wasn't at work."

People were given the opportunity to give their feedback about the agency. We read that 42 people had responded to the most recent satisfaction survey. However noted that there were mixed views on whether or not staff were punctual, stayed the full length of time or wore an appropriate uniform. The registered manager had collated the responses and the plan was to meet with people and their families to address the issues one by one.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider could not ensure people were receiving person-centred care.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to ensure the legal requirements for consent were being followed.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to ensure people were always being kept safe.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure people were being cared for by a sufficient number of staff.

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 robust risk assessments were in place for people.

The enforcement action we took:

We have issued a warning notice to the registered provider in respect of Regulation 12 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set timescales in which the registered provider must become compliant with this Regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have robust governance and quality assurance processes in place.

The enforcement action we took:

We have issued a warning notice to the registered provider in respect of Regulation 17 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set timescales in which the registered provider must become compliant with this Regulation.