Proline Care Limited

# Proline Care Limited - 4th Floor

## Inspection report

4th Floor, 21 Bennetts Hill
Birmingham
West Midlands
B2 5QP

Tel: 01216878871
Website: www.proline.org.uk

Date of inspection visit:
04 October 2016
18 October 2016

Date of publication:
06 December 2016

## 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

Proline Care Limited are registered to provide personal care. They provide care to people who live in their own homes within the community. There were 210 people using this service at the time of our inspection.

At the last inspection of this service on 2 February 2016 we identified that improvements were needed to address breaches of legal requirements. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. At that time systems and processes were not in place to effectively assess, monitor and mitigate risks relating to the health, safety and welfare of people who used the services. The provider had not ensured the proper and safe management of medicines and there were ineffective quality assurance systems in place for the effective running of the service.

We undertook this announced inspection on 4 and 18 October 2016 to check that the provider had followed their own plans to meet the breaches of regulations and legal requirements.

There was a registered manager in post who was present throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People were not kept safe from the risk of actual and potential harm. Known risks to people were not properly assessed, reviewed or managed. There was insufficient numbers of staff available to meet the needs of people and people often experienced late or missed calls. The management of medicines was not safe which meant there was a risk that people did not get their medicines as prescribed.

People could not be certain their rights would be upheld as staff lacked knowledge. Not all staff demonstrated an understanding of the mental capacity act and what it meant for the people who used the service.

People told us that they were supported to access healthcare professionals. However recommendations made by professionals about support needed were not always followed or were not always included in the care plans to guide staff on how people were to be supported.

People's dignity and privacy was not always respected. People told us that they made decisions about how they wanted their care provided but this was not always provided as requested. Most people told us that generally they received care and support by kind and caring staff.

People told us that they had been involved in the formulating of their care plans. However, records did not always contain accurate and up-to-date information. People and their relatives told us they felt confident to raise concerns but most people told us that their concerns were not responded to and changes were not

made. There were no effective systems in place to ensure complaints were responded to in an appropriate and timely manner.

Some people were not happy with the way the service was managed. Feedback that had been sought from people had not been utilised to drive continual improvement. Staff told us that they did not receive on-going supervision in their role. We found that whilst there were some systems in place to monitor and improve the quality of the service provided, these were not always effective in ensuring the service was consistently well led and compliant with the regulations.

You can see what action we told the provider to take at the back of the full version of this report.

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

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People were at risk of neglect when support was not provided as planned or their known needs were omitted.

The provider had not made sure that people were supported by sufficient numbers of staff.

People were at risk of not receiving their medications as prescribed.

### Is the service effective?

**Requires Improvement**

The service was not effective.

People could not be certain their rights would be upheld as staff lacked knowledge and understanding of the Mental Capacity Act (2005).

People's dietary needs were not always reflected in their care plans.

People were supported to access healthcare professionals to meet their individual needs.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People told us that on occasions their privacy and dignity had been compromised, and people could not be sure that confidential information about them would be shared inappropriately.

Some people told us that they were involved in making decisions on a day to day basis about their care.

Most people told us that the staff who provided them with care and support were kind and compassionate.

## Is the service responsive?

**Requires Improvement**

The service was not responsive.

Some people told us that they had been involved with the planning of their care. However, information about the changing needs of people was not always used to update how care was to be provided.

People told us that they knew how to complain. However there was no effective system in place to ensure that complaints were addressed and responded to in a timely manner.

## Is the service well-led?

**Inadequate**

The service was not well-led.

People did not benefit from a service that was well-led. The lack of effective management placed people at risk of harm and failed to ensure regulations were being met.

Some staff told us that they did not feel supported.

The provider did not have robust processes for monitoring the quality and safety of the service that people received.

# Proline Care Limited - 4th Floor

**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.

Previously we had undertaken an announced comprehensive inspection of Proline Care Limited on 2 February 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our February 2016 inspection had been made.

An inspection took place on 4 October 2016 and 18 October 2016 and was announced. Prior to the first day the provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to ensure the provider could make arrangements for us to be able to speak with people who use the service, care staff and to make available some care records for review if we required them. Shortly after the first day we received information of concern in relation to the safety of the service. We used the additional information received to help inform our inspection activity, and we returned to Proline on 18 October 2016. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

As part of our visit we reviewed information the provider had sent us in response to our last inspection which outlined the action they planned to comply with regulations. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We refer to these as notifications. We reviewed the notifications the provider had sent us and any other information we had about the service.

During the inspection we met and spoke with the registered manager, the providers' representative, 2 care co-ordinators, 1 field supervisor, 3 senior care staff and 10 members of care staff. We spoke with 22 people

who used the service and eight relatives of people. We sampled some records, including nine people's care plans, five staff files and training records. We sampled the providers systems for monitoring and improving the quality of the service.

Inadequate

# Is the service safe?

## Our findings

At our last inspection on 2 February 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not ensuring the safe care and treatment of people through appropriate management of medicines. Staff's competence had not been checked to see if they were safe to administer medicines. The provider's representative had produced an action plan of how they would respond to concerns raised.

At this inspection in October 2016 we found that people were placed at risk by the lack of clear systems and records to ensure that people who needed support received their prescribed medication as had been directed.

Although people we spoke with told us that they were happy with the support from staff in respect of their medicines and they made positive comments about how staff supported or prompted them we identified concerns about the safety of how medication was managed for people. The Medicine Administration Records (MAR) that we looked at did not record which medicines staff had administered to people or prompted people to take. Medication records were frequently inaccurate and incomplete. We found medicine records were not detailed and failed to confirm that people had been supported to take their medicines. There were missing signatures on records and it was unclear if medicines had been given or omitted at those times. People were not being supported by consistent staff which increased the risk presented by the unsafe medication management processes. On one person's care records it indicated that staff were to administer the persons medicines, however in the daily notes we saw staff had recorded that the person self-administered their medicines. This meant there was a risk that the person would be supported by staff to take medication that they had already self-administered placing them at risk of a received double dose of medication or receiving no medication at all. The registered provider advised us that they would take immediate action to address these issues so we could be assured that people were being provided with safe care and treatment.

We saw four examples where medicines including creams, antibiotics and eye drops had not been listed along with instructions for staff to know how they were to be used. Records for the application of and use of topical creams were incomplete. We found there to be no consistent approach to providing staff guidance in respect of the administration of PRN (as required medicines). A PRN protocol provides guidance for staff when people lack capacity to ensure these medicines are administered in a safe and consistent manner.

During discussions with the registered manager we identified that staff had not had their competence checked to see if they were safe to administer medicines. The management of medicines had not been audited effectively and had failed to identify the shortfalls we had found.

The provider was not ensuring the safe care and treatment of people through appropriate management of medicines and this was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 12.

At our last inspection in February 2016 we found that reviews of risk assessments had not been undertaken when people's needs had changed putting people at risk of not receiving required support.

At this inspection we found that that whilst some risks were being better managed than they had been previously, people were still at risk of not receiving support needed to keep them safe and maintain their health. Reassessment information and up to date records had not consistently been made available for staff and a lack of detailed guidance about known risks placed some people at increased risk. For example one person's care records indicated that they were at high risk of falls and seizures. Whilst most staff knew about the individual risk to this person there was no risk assessment and management plan in place to protect the person when they were supported by a member of staff who did not know them or know how they were to be supported to keep safe. Another person's records identified that they were at 'high risk of injury' in respect of the use of bedrails. We found there was no risk assessment in place to guide staff in how to use this equipment and keep the person safe. The registered manager advised us this would be rectified immediately.

The care records for another person identified that the person required support from staff with the use of a wheelchair when out in the community. The risk assessment did not reflect what amount of support was required and did not contain guidance for staff to follow to ensure the wheelchair was used safely. The registered manager had not assessed the risks to the health and safety of people who used the service and had not taken action to manage known or related risks.

The failure to ensure that care and support was provided in a safe way was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 12.

The registered manager and provider had failed to ensure that enough suitably skilled and competent staff were deployed to meet peoples care needs safely and appropriately as had been identified as necessary. Numerous people, their relatives and staff expressed their concerns in respect of staffing levels in particular at weekends. One person told us, "If I have missed calls they are on weekends. I have to ring my daughter to come and help me." One relative we spoke with told us, "Every weekend I have to call the office due to staff being late or not turning up." Another person told us, "Monday to Friday carers do stay for the correct length of time. Not at weekends though ... We had two new girls [staff] ... they stay for less than the half hour ... but they put in the book that they had."

People also shared concerns about the number of late calls that they experienced and we found that late and missed calls had been experienced by a number of people. One relative we spoke with told us that on one occasion two staff arrived instead of one and said, "They [the staff] thought they could do everything quicker together so they rushed and gave my relative a doughnut for their tea instead of a proper hot meal as directed." One relative we spoke with told us, "When mum phoned the agency out of hours to explain the staff had not arrived, she was advised to go out of her property and knock on neighbours doors to ask them to heat her food. Mum was left without a carer to provide a hot meal for her. She's in her 80s, vulnerable and rarely leaves the house. It was dark and cold outside." A number of people we spoke with told us that sometimes their morning care staff arrived so late it coincided with the visit from their lunch time carer staff.

Some staff we spoke with told us they were concerned about staffing levels and told us that they were consistently contacted by the office requesting them to cover additional calls. The registered provider confirmed that a number of care staff had left which had resulted in staff shortages and advised us that they were continually recruiting staff. Some staff told us they had 'shortened calls' in an attempt to not be late and told us as a result they had to rush people. We reviewed staff rotas and found that staff were not allocated travelling times between calls this meant that staff were late for their following calls that were

scheduled immediately afterwards. The registered provider advised us of their intention to allocate travelling time following the inspection visit.

Staff actions did not always keep people safe. One relative told us of an issue with their relatives front door not being shut securely and said, " 'There's only one [member of staff] who locks the door [the others do not] so if I arrive in the morning I can walk straight in which means my parents' home has been unlocked all night." Two staff we spoke with told us that they had not been issued with identity badges which they should show people they are visiting before entering their homes. This meant people were unable to check if the member of staff visiting them was genuine and this put people at risk of harm. We shared our findings with the registered provider who advised us they would rectify this immediately. The registered provider failed to ensure that there were enough suitable staff working in the right place and for the right duration.

Failing to provide staff in suitable numbers to meet the needs of people using the service is a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 18.

We looked at the process used to ensure that robust checks were made of potential new members of staff. All the staff we spoke with confirmed that they had completed application forms prior to their interviews and had to provide references and a Disclosure and Barring check (DBS) before they could start work. We reviewed five staff files. We saw in two staff records that whilst checks had been undertaken, safe recruitment practices had not always been followed in relation to obtaining references. The registered manager advised us that this would be rectified immediately.

We were advised that a number of staff had transferred to the registered providers in March 2016 when the provider had taken on work from another agency that had ceased providing care at short notice. Whilst these staff had been transferred under a formal recruitment process the registered provider had no systems in place to check the employment history for this particular group of staff.

One recruitment file for a newly appointed member of staff could not be found on the day of our inspection. There were no systems in place to check that recruitment processes had been followed correctly. This meant people could be placed at risk from staff unsuitable to work in adult social care.

Staff we spoke with demonstrated a good understanding of how to report any suspicions of abuse. Staff consistently told us they would report these to the manager or to external agencies which included the Local Authority or The Care Quality Commission. We saw in another person's care records that a safeguarding Incident had been reported to the Local Authority. The registered manager had not notified the Care Quality Commission about this incident as required. We received the safeguarding notification following this inspection.

Requires Improvement

# Is the service effective?

## Our findings

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.

Staff we spoke with did not all have an understanding of the MCA and were not able to confidentially describe to us what this meant for people who used the service. Some staff told us that they had received training in MCA but could not recall the content and how to apply their learning into practice. Although some people told us that staff sought their consent and agreement before providing care and staff were clear about how they did this, consent was not consistently sought by all staff. Some staff told us they did not know what the principles of MCA were and had not received any training. This meant that people could not be certain their rights would be upheld as staff lacked knowledge. Discussions with the registered manager identified they also had a lack of understanding in the principles of the MCA.

When people lacked capacity to agree to the care and support being provided this was not always reflected in their care plans to indicate what this meant for the person. For example, in one person's care records it indicated that the person lacked capacity, but there was no mental capacity assessment in place to support this and no details about what aspect of their lives that they lacked the capacity to make decisions about. Some care documents we viewed had 'consent forms to agree to care and treatment' that had been signed for by a relative of the person receiving the service. There was no evidence to support that the relative had the appropriate authority to sign for the person and there was no evidence to say people lacked capacity to give their own consent. Staff we spoke with assumed that families would make decisions on behalf of people and did not understand best interest decision making processes in line with legislation.

Discussions with a member of staff in the office identified that one person did not have capacity but when we reviewed their care records it identified that the person did have capacity, the rights of this person to make their own decisions were not being supported by the service.

The provider was not ensuring the care and treatment provided was with the consent of the relevant person and this was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 11.

We looked at whether staff received training and the necessary support from the registered provider. This included regular supervision and access to personal development to enable them to carry out their duties. Most people told us that they felt the staff who provided them with care and support had the right knowledge and skills to meet their needs. Staff told us that they had received training that was relevant to their roles and responsibilities. One staff member told us, "We do get training and it is refreshed. I've got a level 2 in health and social care." Discussions with the registered manager identified that the electronic system that the provider has in place to record staff learning and development was not up to date and that

there was no automatic or manual system in place to monitor staff training needs or updates required. This meant that people may have received support from staff that had not got the appropriate up to date knowledge and skills.

Not all staff felt supported in their roles and some staff advised that they had not received appropriate supervision at a level that would give them suitable support. One member of staff told us, "I don't feel supported. The office staff just do not get back to us." Another member of staff told us, "I'm new and [I've] not had the appropriate support." Records confirmed that supervision had not met the provider's expected levels in respect of frequency. The registered manager advised us that they were behind with one to one supervisions due to staff shortages.

Some staff we spoke with told us that their knowledge, competency and learning was monitored through unannounced 'observation spot checks' on their practice. However, on the day of the inspection we looked at three staff files and no record of any competency checks could be found until the second day of the inspection. The registered manager advised that some observation spot checks to check competency had been done but they had not been continued due to staff shortages.

All the staff we spoke with told us that they had received an induction when they first commenced working at the service. One member of staff said, "I shadowed and worked alongside other staff before going out on my own." The registered manager indicated that following the appointment of new staff they received a one week programme of training, which included training on, first aid, moving and handling, food hygiene and safeguarding. We saw that the registered provider's induction programme included the Care Certificate standards [a nationally recognised set of standards used for induction training of new staff]. This would ensure that new staff had the skills and confidence to carry out their roles and responsibilities.

People who used the service and needed support with their meals and drinks told us that they were happy with how staff helped them. One person said, "Staff always ask me what I want and then cook it well and it's nicely presented." Staff we spoke with described people's individual dietary needs. One member of staff told us about a person's culture and that different foods were delivered to the person's home. A number of people who used the service were living with diabetes and whilst staff we spoke with could describe how they supported people with certain health conditions, this was not always underpinned by records available to staff. People were not consistently supported by people who knew them. There were no risk assessments, management plans or specific guidance for staff about how to support a person effectively to minimise any risk related to the dietary needs.

People told us that when necessary staff would support them to access other health professional services. One person told us, "I was poorly and the care staff called the Doctor for me." Staff we spoke with told us and described that when people may be in need of treatment from other health care professionals they would take the necessary action. We saw records that demonstrated referrals had been made to the relevant health services such as the district nurse or doctors when people's needs had changed and in support of their healthcare needs. This meant that where it was needed staff had taken the appropriate action to ensure that people's healthcare needs were met.

Requires Improvement

# Is the service caring?

## Our findings

Whilst some people told us that most staff treated them with dignity and respect and made positive comments about their care and support, this was not a consistent experience for all people using the service. Some people and staff we spoke with described some examples of when people had not been treated respectfully. One person told us, "We had a member of staff come in who was like a 'sergeant major' and told us what to do." Another person said, "Once a carer came two hours early in the morning and told me to get up. My husband told them to leave."

A member of staff told us about a person they provided care and support to and said, "[name of person] lives with dementia and needs routine in their lives." They then went to advise that on one occasion the staff covering the call had arrived at the wrong time. As this was not in keeping with the person's routine it had led to a great deal of distress for the person when they had no support to use the toilet. The staff member advised that the person was very distressed when they had arrived and needed additional support. The staff member told us that they had not reported this to the office and said, "Nothing will get done about it." A relative we spoke with told us that on many occasions their parent's front door had not been locked and on one occasion a district nurse had walked in when a member of staff was providing intimate personal care. Staff had failed to protect the privacy of the person being supported and had failed to respect the need to keep their home secure.

People, their relatives and staff told us that staff changes were often made at short notice and that they did not receive support from consistent staff as regularly as they would wish. One person told us, "All the girls [the staff] that come to help me are great. The one thing that frustrates me is I get someone different every day. There is no continuity of care, they don't get to know me and I don't get to know them." Another person told us, "Not always the same staff ... some days I have a different one every day in the mornings but I have the same one at night. They have to keep asking what they have to do ... it's annoying. If my main carer is away, they send whoever is available but they don't let me know." A relative said, "My relative has dementia and needs a routine, some faces he recognises. However, all the carers are different at weekends when things go [wrong]. I've seen nine or ten different carers."

Whilst all the staff were able to describe examples of what they did to protect peoples dignity and privacy, a number of people expressed their concerns about the lack of confidentiality. One person told us, "Staff are not confidential. They talk about previous calls to each other [in front of me]. If they did it about me I would be furious. They should respect people's privacy." Another person who used the service said, "Some staff do talk about other people but tend to mention just their first name." This meant people were not certain their confidentiality would be protected or that they would be treated with dignity and respect.

People using the service were not treated with dignity and respect at all times and this was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 10.

Most of the people we spoke with described most of the staff who provided them with care and support as kind and compassionate. One person who used the service told us, "They're [the staff] lovely. I couldn't be

without them." Relatives we spoke with told us that most of the staff showed concern for their relative's well-being in a caring way. One relative said, "The frontline care is excellent." However, some people described some staff as not being so compassionate and that they had voiced their concerns to the registered manager. One person told us, "One carer turned up and I didn't like her attitude and was really not caring enough, She just did the job and moaned that she didn't want to be with here. She even left her coat on. "

One person we spoke with told us, "They [the staff] do everything for me. They wash me ... feed me ... and give me my meds [medication]. They do everything I ask them to do ... even put my washing in the machine every Wednesday." Numerous people told us that they were not introduced to staff when they first started to use the service. Staff confirmed that they were not given the opportunity to meet new people before they provided them with care and support. One staff member told us on two occasions they had been sent into someone's home to offer care and support without being aware of people's health conditions and needs. For example, the staff member had arrived at a person's home to find that they were unable to communicate as English was not their first language and told us, "I was embarrassed and felt sorry for the person who used the service and their family. They were really distressed and angry. I had to leave them without helping them." On another occasion the staff member arrived at a person's home to find the person was living with a mental health condition that the staff member was unaware of. The person was unwell at the time of the visit. This meant people could not be certain that staff would have the knowledge and information needed to meet their individual needs with a caring and meaningful approach.

A record of one complaint we saw indicated that a person who used the service was unhappy with a member of staff's attitude. We discussed our findings with the registered manager who advised us that when concerns had been raised by people who used the service in respect of staff, the staff member had been 'barred' from providing the person with care and support. However, we were unable to establish what long term actions had been identified. The registered manager was unable to confirm if any actions were taken to support the staff to improve through the use of additional training or supervision of their practice.

Most people told us that they were involved in making decisions about their care and support. One person told us, "Staff are caring. I am able to say what I want and staff listen to that. I make my own decisions and plan my own care." Staff that we spoke with described examples about how they support people to make decisions. One staff member told us, "People all like things done differently. I just make sure calls are person-centred to the individual." Another member of staff told us, "People have got the right to choose their food and clothes to wear and the right to refuse us entry."

Requires Improvement

# Is the service responsive?

## Our findings

People and their relatives told us mixed views about the quality of the service delivered. Whilst some people told us they were happy with the service and support from staff, other people told us that they were not being supported to live their life in the way they chose or experiencing the quality of life that they wanted. One person said, "I don't like the times of my morning call, it's too early." A relative we spoke with told us, "Dad gets a bit stressed out sometimes ... because they [the registered provider] are so short-staffed ... so Dad doesn't always get what he needs. As a result Dad can't rely on having a certain carer." Some people we spoke with told us that the registered provider had not been responsive to their request to change aspects of their care, for example the frequency or timing of their calls. One person we spoke with described how unhappy they were with the times of their call and said, "I'm not a child, I don't want to go to bed at the time the staff come. This is affecting the quality of time I spend with my family." Another person told us, "The one thing I would change about this company is that they are not very responsive, I want a later call and they can't accommodate me."

People and their relatives told us that they had been involved in formulating the person's care plan. One person told us, "I was involved in my care plan. The staff asked me what I wanted." We looked at care records for people who used the service to ensure staff had the guidance they needed to support people in a personalised and appropriate manner. We found most care plans were personalised to the individual. Although we saw that records held in the office for one person contained information and recommendations from healthcare professionals about people's care and treatment that had not consistently been used to inform the care plans. In one person's assessment details from the Local Authority the assessment stated that the person had diabetes and had a specific nutritional need. However on the persons current active care plan it indicated that the person had no special dietary or nutritional requirements. The lack of action to use assessment information supplied to inform the care and support to be provided had failed to ensure that people consistently received personalised care.

We saw care plans were not updated to reflect the current or changing needs of people. For example, one person's had received increased support due to a fall that they had experienced. However, these changes in the person's needs had not been reflected in their care plan. Some care plans we reviewed did not always provide staff with the relevant information for them to support people's individual needs. One person's care record that had been compiled by their former agency seven months prior to the inspection indicated that the person was living with dementia, but on their current care records there was no indication of this. There was no indication that the records supplied by the former agency had been assessed or judged to be inaccurate. This lack of information meant that the person was at risk of receiving inappropriate support and treatment. Whilst most staff that we spoke with were able to describe individual people's likes, dislikes and life histories some staff told us that they did not consistently provide care and support to the same people which meant it was difficult to get to know people well.

We saw that some people had been involved in the reviewing of their care plan. One person told us, "I'm very involved in my care plan. It has recently been updated because I've had a new hoist." However, some care plans did not reflect that the care and support people had received had been reviewed and failed to indicate

for staff if there were any changes in how the person was to be supported. We found that some reviews had not been undertaken. One person told us that had been receiving a service for 12 months and had not had a review during that time. Another person told us that they would have liked to have had the opportunity to take part in a review of their care and support needs so that they could ensure that staff knew if things had changed.

The service asked people about their cultural and spiritual needs as part of their pre-assessment process. A staff member told us, "I support [name of person] whose first language is not English. We find different ways to communicate." The staff member then went on to describe how they met the persons religious and cultural needs in a specific manner as had been agreed. Discussions with the registered manager identified that staff employed by the service reflected the diversity and culture of the people they supported. The registered manager told us that they matched people, where possible, with staff who understood their faith and were able to communicate in the person's preferred community language.

The provider had ensured that information about how to make a complaint was provided to people when they started using the service. Whilst people told us that they would feel comfortable to raise a complaint most people told us that they did not feel they were responded to properly or listened to and on occasions their concerns had not been rectified. One person said, "If I leave a message at the weekend ... I end up having to ring back again ... things don't get resolved." Another person said, "I believe that sometimes they listen to you but sometimes they're not really interested."

The lack of action to identify issues and the lack of an effective process to review all complaints and identify any trends or how to prevent negative experiences reoccurring again for people meant that opportunities to make changes as a result of any complaints received was missed. Although the registered provider had conducted some investigation and taken action in respect of some complaints received there was no effective system in place to ensure all complaints were responded to in a timely manner and recorded appropriately.

The provider was not ensuring that all complaints were investigated and responded to and this was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 16.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection on 2 February 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have effective systems in place to monitor the quality and safety of the service provided. We found the provider had not made the improvements required for good governance.

Previously we had identified that the systems in place failed to assess, monitor and drive up improvements in the safety and quality of the service being provided. Systems in place to assess and manage risks were not effective and failed to reduce the impact on people from not addressing and managing known risks. The systems in place had not identified that records relating to care were not being consistently maintained and that people had not been engaged and involved in giving feedback to evaluate the support service being provided.

Following the inspection in February 2016 the registered provider had produced an action plan of how they would respond to concerns raised at our last inspection. Although the provider had started work to address the areas of development as identified in their plan, some actions were still outstanding or had not been completed as had been planned.

Systems in place had failed to identify and address issues we identified in respect of medicine management, management of known risks, and impact from insufficient staff being available to meet known support needs of people using the service. People's human rights were at risk of being compromised and care was not delivered in accordance with consent or the principles of the Mental Capacity Act (2005).

The registered provider and the registered manager acknowledged and agreed with the concerns noted during this inspection. Their audits and systems had not been effective in identifying the action that was needed to improve the quality of the service provided. Audits of care and medicine reports had failed to identify that they were not completed accurately or were missing information. Systems in place to monitor and record incidents, safeguarding concerns and complaints were inadequate and failed to mitigate risks to people. The provider had received 25 complaints from people about various aspects of the service they had received which had failed to meet their needs. The registered provider had failed to identify and analyse trends from the complaints which could prevent the likelihood of negative experiences for people recurring. There were no effective processes in place to record staff training to ensure that people were supported by staff with the appropriate knowledge and skills. The registered provider was not aware of these failings and inadequate records and did not have an oversight of these situations to enable suitable action to be taken. The provider remains in breach of this regulation as they had not taken the action required to ensure that effective systems would be in place to assess and monitor that the service would consistently deliver high quality, safe care. The management, leadership and governance of the service had not been effective.

These issues regarding good governance of the service were a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 17.

People and their relatives expressed mixed views about the service. Whilst some people made positive comments about the care staff who directly supported people, a number of negative comments were also made. People expressed concerns about the management of the delivery of care, the response from office staff and the lack of effective or timely response to concerns. A relative we spoke with told us, "We are pleased with the service but only because of the frontline staff, not so pleased with the management and office side." Numerous people told us that they felt communication was not effective. One person told us, "Office communication is terrible. I have to keep ringing them to make sure someone is going to turn up." One relative we spoke with said, "They [the provider] promise call backs but rarely do. They're now phoning me to say a carer will be late ... this is an improvement, but the real problems lie in their systems and management." A number of people told us that they required the support of two staff and on many occasions the two staff arrived at different times which consequently meant people had to wait for their care and support to be provided. One relative told us, "Communication from Proline is appalling especially when we've had carers not turn up. On occasions my mum has two carers arrive instead of one and then we have days when no-one arrives."

The views of people who used the service were not sought consistently by the provider. The registered manager advised us that questionnaires had been sent out to people using the service to find out their experiences of using the service. One person who used the service told us, "A fellow phoned me the other week ... to ask how the care was going. I said it was excellent. I have been sent a questionnaire in the past as well… about every two months." Another person explained that they had been asked for feedback and said, "The manager does this about once a month. She asks am I satisfied with the carers that come in." However, some people described that they had never been asked to give their feedback. A relative said, "No one's ever asked me for my feedback ... no-one has contacted Mum or Dad. I think we should be given the opportunity to say how we feel." The registered provider was unable to locate the overall analysis of the surveys during the inspection. Although the provider did not confirm that analysis from the previous survey had been used to inform practice or drive up improvements the provider had arranged for a further survey to be undertaken.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. The registered manager had ensured that notification systems were in place and that staff had the knowledge and resources to do this. We found one example of a safeguarding incident. Whilst we saw that the concerns had been responded to and reported to the Local Authority, the registered manager had not notified the Care Quality Commission about this incident as required. The monitoring systems in place had failed to identify that the notifications had not been submitted as required.

Discussions with the registered manager identified that they had kept up to date with developments, requirements and regulations in the care sector. For example, where a service has been awarded a rating, the provider is required under the regulations to display the rating to ensure transparency so that people and their relatives are aware. We saw there was a rating poster clearly on display in the office.

We found that support systems were not in place for staff. Some staff told us that they did not feel supported by the management team and the main issues communicated to us were around staffing levels and communication. Discussions with the registered manager confirmed that staff meetings were planned but were poorly attended. One member of staff we spoke with told us, "I don't go to staff meetings because they are held in the office and it's too far to travel." The registered provider advised of their intentions to hold more regular meetings in different locations.

Staff told us that they did not receive their schedule of work until the night before they were due to visit people. Discussions with the registered provider identified that a number of office staff had left which had

resulted in staffing shortages. This meant there was a potential risk that staff may not know who their scheduled visits were to and people may not receive their call as needed.

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 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider did not ensure that all people who used the service were treated with dignity and respect. Regulation 10 (1) (2)(a) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider was not ensuring the care and treatment provided was with the consent of the relevant person. Regulation 11 (1) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider was not ensuring the safe care and treatment of people through appropriate management of medicines. Regulation 12 (2) (g)<br><br>The provider had not assessed the risks to the health and safety of people who used the service and had not taken action to manage known or related risks. Regulation 12 (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider was not ensuring that all complaints were investigated and responded to. Regulation 16 (1) (2) |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have robust systems in place to monitor the quality of the service.<br><br>The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service.<br>Regulation 17 (1) (2)(a)(b) |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure that there was enough staff working in the right place and for the right duration. regulation 18 (1)(2)(a) |