Libra Domiciliary Care Ltd

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

Summary of findings

Overall summary

The inspection took place on 1 and 8 August 2017 and was announced.

The service provides personal care to people living either in their own home or the home of a family member. At the time of the inspection, approximately 20 people used the service and a registered manager was in post. 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 and associated Regulations about how the service is run. The registered manager was also the registered provider for this service.

People did not receive care in a safe way. People and their families experienced missed care calls and calls that were shorter than they expected. Systems in place did not effectively monitor and identify when people had a missed calls so that action could be taken promptly to prevent the incident happening again.

The registered manager also did not have systems in place to monitor how staff supported people with their medicines to ensure they received them in a safe way. People's Medical Administration Records were not completed fully and no time was listed to indicate when the person received their medicines, despite this being highlighted at the previous inspection.

The registered manager did not assure herself of staff competency in supporting people with their medicines. Staff had received training at their induction but the registered manager told us this had not been reviewed since.

Staff did understand how to support people from abuse and who they needed to report their concerns to. Staff had received training and could explain their understanding of abuse. People were supported by staff that had had checks of their background to assure the registered provider of their suitability to work at the service.

People could not be assured that checks were in place to refer the person to a medical professional if needed. Guidance was not available to staff to direct them on what to do if they were concerned a person was not taking their medicines. Staff understood the importance of obtaining a person's consent and explaining their care. People received choices in the food and drinks prepared for them.

People liked and valued the care staff but care staff did not always have time to spend with them because they needed to attend the next call. Staff knew about people's care needs and could explain how people preferred to receive their care.

People did not have confidence their complaints would be listened or responded to. People had tried contacting the administration office did not always receive an explanation to their complaint by telephone or letter.

People were not always involved in reviewing their care to ensure the care met their needs and preferences. Risk assessments did not always show how people were involved in discussing their care needs as well as risks identified.

People's care was not routinely reviewed and monitored. Systems were not in place to identify how people's care had been checked to ensure that it had been provided in accordance with their needs. The registered manager could not confidently confirm how many people received care. The registered manager did not have a system for checking that people received care calls and that they received a call for the duration they expected. The registered manager did not also have a system for ensuring people received the help they needed with their medicines at the time they expected. People's care was not updated regularly and we could not be assured that people received the care they needed.

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 not assured that care staff would turn up for calls. Staff training on supporting people with their medicines was not always reviewed. Staff recruitment included background checks on the suitability of staff to work at the service.

Is the service effective?

Requires Improvement

The service was not always effective.
People could not be assured that a referral to another medical service would be made. The registered manager did not always check the effectiveness of the information or training staff received. People were offered choices in the food they were offered.

Is the service caring?

Requires Improvement

The service was not always caring.
People did not always receive the full call they expected in order they receive the care they needed. People liked the care staff supporting them who treated them with dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive
People did not feel assured their complaints would be acknowledged and dealt with. People were not involved In feeding back what they thought of the care they received.

Is the service well-led?

Inadequate

The service was not well-led
The registered manager did not have a system in place that effectively monitored and updated people's care. People were not always confident that they would receive a response from the administration office if they called with a query. The registered manager did not have a thorough understanding of people's care needs.

Libra Domiciliary Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 8 August 2017 and was announced. The registered provider was given notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to see us. The inspection was carried out by two inspectors.

The inspection was brought forward due to concerns raised about the quality of care from the service. We contacted the local authority prior to the inspection to seek feedback about the service and was received after our visits to the administration offices.

We reviewed the information we held about the home and looked at the notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

As part of the inspection we spoke to three people receiving care from the service together with three relatives, five care staff, the administration assistant, operations manager and the registered manager.

We reviewed six care records, the complaints folder, compliments, daily records, Medical Administration records, policies and procedures for the service and recruitment processes.

Inadequate

Is the service safe?

Our findings

Some people were supported with their medicines. One family member told us, "Sometimes they give the medicines, and sometimes we do." It was not clear from people's records if people had received support with their medicines from family members or from care staff. We asked the registered manager about checks she undertook to ensure people received their medicines including people's Medicines Administration Records (MAR). The registered manager told us this was reviewed on a quarterly basis. We asked about how the registered manager knew if people had missed or declined medicines, they told us they relied on staff alerting them if this happened.

We reviewed people's administration records and saw there were numerous gaps where we could not be assured that people were receiving their medicines safely. In one MAR we saw there were four consecutive days when this had not been completed. We asked to review the person's daily records to understand if staff had administered the medicines the person wanted, or if there had been an issue with recording it. The daily records did not tell us if the person had received their medicines. We also saw that some daily records were missing.

We reviewed other MARs to see whether people who required time critical medicines were receiving these as they should. We saw the MARs did not stipulate the time people received their medicines. We asked the Registered Manager about how they could be assured people received the correct support to have their medicines at the right time, with sufficient gaps between medicines. The registered manager confirmed their current checks did not provide this assurance.

We asked how the Registered Manager about monitoring staff competency in administering medicines and how they could be assured that staff understood the support people needed. They told us medicines were covered in staff induction. We clarified whether this was monitored again. The Registered Manager told us this wasn't and would consider evaluating this going forward.

Staff could explain to us the risks people lived with. Staff told us they had learnt about people's risks from having cared for them and developed an understanding of their needs. We saw that care plans did not always explain the risk staff needed to be aware of. We reviewed two care plans together with the registered manager and saw that risk assessments had not been reviewed or updated, despite the registered manager telling us that these should have been reviewed at least quarterly. We were not assured that the registered manager understood people's up to date care and support needs so that the correct staffing levels were known to the registered provider.

Prior to the inspection, we received information of concern relating to missed calls. A family member told us, "There's been lots of instances of missed calls." We asked the registered manager whether there had been any missed calls. The registered manager told us there had not and said a new system of monitoring calls had been established since April 2017. When we reviewed the calls records for people using the service we saw the records showed people had not consistently received their planned care. The registered manager told us some staff had not been logging in and out of their system effectively. In addition, the registered

manager told us on some occasions people elected not to accept their care calls. We asked the registered manager about the suggestion of missed calls but they told us this was a response to "Personalised care" and some people declined calls. We asked if there were any records to confirm staff had attended and people had declined calls, but no records of this were available.

The registered manager did not operate an adequate system for ensuring staff supporting people with their medicines were competent to do so. This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

At the previous inspection, improvements were identified in how the provider safely recruited staff. At this inspection we saw the improvements. We reviewed three staff files and saw that the provider had a system in place for ensuring all Disclosure and Barring Service (DBS) checks were made. This check is carried out as part of a legal requirement to ensure care staff were able to work with people and any potential risk of harm can be reduced. We also saw references had been sought for staff

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 27 November 2016, we rated this section as Good. At this inspection, we identified a lack of systems in place to highlight people's care needs.

We could not be assured people were consistently supported to see healthcare professionals when appropriate. For example, we asked the registered manager whether there was a protocol in place if people declined aspects of their planned care. They advised us a protocol was not in place to manage this, but the registered manager gave us an example in relation to people's health and medicines. The registered manager explained staff would alert people's GPs, if people declined medication for four consecutive days. Records we checked showed us one person had not received their medicines for four days. However, there was no record of a referral to the person's GP.

We also found inconsistencies in the way people's care was reviewed, and actions required as a result of reviews were not always recorded. We reviewed how the registered manager was assuring themselves staff had the knowledge to understood people's care needs. When we asked for evidence this was checked this could not be provided. We reviewed one person's care plan and saw that they lived with Parkinson's disease. We asked what information or guidance staff had been provided with, so they would know how to care for the person. We reviewed the care plan together and the registered manager agreed that this information was not in people's care plans for staff to refer to. There was a potential risk that care staff would not be able to recognise symptoms that the person needed further medical advice. For example, the consequences of the person not receiving their medicines on time were not recorded for staff to refer to.

We checked people's care needs to understand the needs of people supported by the service, and what actions staff took if people's needs changed. We asked the registered manager about the frequency of reviews of people's care to check people were happy with their care. The registered manager told us each person had a "28 day review followed by a quarterly review" and that these reviews could either be via telephone or face to face. We reviewed two care plans together with the registered manager and asked for evidence of the reviews. The registered manager agreed that the care plans contained no evidence of either the 28 day or quarterly reviews despite the people concerned having received care for more than five months.

The registered manager did not operate an adequate system for ensuring people received care that met their needs. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

Staff told us they had access to training and that they seek further training if this was needed. The operations manager showed us systems they used for monitoring staff training. We reviewed three staff files and saw that staff had access to supervision meetings. Staff told us that they felt confident speaking to the management team if they had any concerns outside of a supervision meeting if needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People told us care staff ensured they were happy to have help with their care, before care staff began supporting them. Care staff explained to us the importance of obtaining someone's consent when caring for them. Care staff described how they would offer to support people but if someone refused they would respect this. Care staff told us they had received training on the Mental Capacity Act and felt they understood the importance of the legislation.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive someone of their liberty must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA. The registered manager told us they did not support anyone that did not have capacity, or that had been referred to the Court of Protection.

Not all people received help with their meals but people who did told us they were offered choices in the meals staff prepared for them. They told us staff asked them about the meals to prepare for them. Staff we spoke with knew people's meal preferences and explained how they ensured people received choices. They could describe what people liked to eat and the drinks they preferred.

Requires Improvement

Is the service caring?

Our findings

People told us that it was sometimes difficult to maintain a relationship with care staff because care staff were often in a rush and needing to reach their next appointment. We reviewed call logs that detailed the duration of calls. One family member told us their relative did not always get the care they needed because care staff were rushed or failed to attend. We reviewed call attendance for the person's relative and saw that during one week within the month of May they received six calls shorter than their expected duration, with one call lasting three minutes and another seven minutes. The call should have lasted 30 minutes. We reviewed daily sheets for this person and saw that on a separate occasion a lunch time call had been missed and the person received their lunch time meal at their tea time call at 4:10pm. People described staff warmly but did not feel they were able to enjoy their time with staff.

People told us they liked and knew the care staff supporting them. People told us they had regular care staff who were familiar with and who they had established a relationship with. One person told us, "Its mostly one girl" that supported them. Another family member told us, "It's usually the same girls."

People were not always involved in the day to day decisions about their care. One person told us, "They come at various times." The person suggested that call staff arrived at times they had not stipulated. We asked people about when call staff failed to turn up, whether it was always their decision to cancel the call. People told us they did not always have notice a call would not be completed. One relative told us they felt anxious because they did not always know if staff would attend.
Staff we spoke with could explain to us how they supported people this so people could make their own day to day. They could describe to us people's routines and preferences and how they cared for people. For example, one staff member told us about how they one person became anxious and how they supported their person to reduce their anxiety.

People told us they were supported by staff who understood how to support them to maintain their dignity and independence. One person told us they had specific needs in relation to skin care and that this was important to their sense of identity. They told us the staff that supported them understood this, and knew how to help to maintain their skin care in the way they preferred.

Staff told us they understood how to support people with the dignity and independence, they told us they had received training and this had helped them. Staff gave us practical examples of maintaining a person's dignity such as closing curtains when they received personal care and ensuring people had access to a towel to enhance their dignity when personal care was provided.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 27 November 2016, we rated this section as Good. At this inspection, we identified a lack of systems in place to understand and respond to people's complaints.

People and their families told us they did complain, but said staff from the administration office did not always get back to them. One relative told us, "They always say 'We'll look into and get back to you tomorrow.' But they never do." Prior to the inspection, we had also received complaints from family members about how their concerns were not listened and responded to. As a consequence, the family members felt no alternative but to contact the Care Quality Commission. During the inspection, we did not see details of those complaints recorded but saw the actions requested as a result of two different Safeguarding investigations. We asked the registered manager to show us details of correspondence or meetings they had had with family members to confirm complaint investigations had been initiated and completed when concerns were raised, and to advise the person of the outcome of any complaints. This could not be provided. We referred to the registered provider's complaints policy which advised people their complaints would be responded to with a written explanation within 15 days. We could not therefore be assured that people had received effective resolution to their concerns or complaints.

We asked the registered manager about how they understood how people felt about their care. They told us they frequently shared some of the care calls and this allowed them to understand people's experiences of the care provided. We asked about any analysis they did of the feedback they received, but this could not be evidenced.

The registered provider did not operate an effective system for handing and responding to complaints. This was a breach of Regulation 16(2) HSCA 2008 (Regulated Activities) Regulations 2014.

At the last inspection, 27 November 2016, we identified that people were not involved in discussing risk assessments and the risks to their health. At this inspection we founds things had not improved. We reviewed two care plans together with the registered manager who agreed that the person or their families involvement in the risk assessment could not be demonstrated. The registered manager also told that they would normally review and update risk assessments quarterly. The registered manager agreed risk assessments for both people contained no evidence that risk assessments had been reviewed.

We asked people and their families if there were other ways in which they could share their thoughts about the care they received in order to check they were getting the care they needed and preferred. We spoke with one relative that told us, "No-one has ever called. Anytime there's been any communication, it's me calling them because no-one has turned up." We asked whether they had received any questionnaires or telephone calls from the office. People told us they had not been given the opportunity to complete questionnaires and they had not received calls from the office.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 27 November 2016, we rated this section as Requires Improvement because systems for ensuring people's records were consistently completed were not in place. At this inspection, we identified a lack of systems in place to ensure people's care was being reviewed, updated and monitored.

There was a registered manager at the service. 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.

The registered manager failed to display their ratings from the previous inspection on either their website or within their administration office. When this was brought to their attention, the website was immediately updated and their ratings were displayed in the office.

The registered provider did not meet their requirement to display their ratings. This was a breach of Regulation 20(a) HSCA 2008 (Regulated Activities) Regulations 2014.

We found the registered manager did not consistently understand their legal responsibilities and obligations to meet the needs of the people being supported. We also found the registered manger did not know what care the service had provided to people. The registered manager was unable to answer basic questions about the service. We asked how many people were supported by the service and she advised us "10 or 11". We asked for a list of people using the service, and a list was given to us approximately two hours after our request. We were given a list with 12 names. When we asked for clarification, the registered manager advised that the number given was the number of people supported by the local authority. The local authority confirmed to us that they commissioned 16 packages of care. We were also aware that the service also supported some people who paid for their own care. We were not able to ascertain exactly how many people received support from the service.

We saw people's records were not organised in a way which promoted easy access to records required. Throughout the inspection, we asked to a see a number of records that could explain how people received care. At each request, there were long delays as staff told us they were looking for records. When we visited the Registered Manager in her office we saw piles of files and papers stacked in unorganised piles.

Systems for reviewing and monitoring people's care and the quality of the service provided were inadequate. We asked the registered manager to describe the system they used. The registered manager told us "I just know." The registered manager then explained all care records were reviewed on a quarterly basis. The registered manager told us they had transferred their care records from paper based files to an electronic system, but people's risks assessments, care reviews and staff training details were yet to be added to the system.

We reviewed people's care records to understand the system of review. We found some care records had not

been reviewed since April 2017, up to five months after they had been completed. We could not be assured that that risks to people's wellbeing were being effectively monitored and any necessary action taken promptly. We noted from people's care records that some people lived with complex health needs. The registered manager could not demonstrate to us how they kept up to date with people's needs.

We asked how accidents and incidents were being monitored by the Registered Manager. Initially, we were advised that there had been no accidents or incidents. Later as the inspection progressed, we found the results of a disciplinary incident accidently misfiled in an unconnected person's care plan rather than in the staff member's personnel file. This included details of an incident that could have resulted in a person receiving serious harm.

Systems were not established and operating effectively to ensure people's care needs were assessed and monitored and improvements in the quality and safety of the service provided made. For example, there were gaps in key areas of people's records, including medication and daily logs. The systems in use at the time of the inspection had not highlighted these concerns to the registered manager in a timely way and effective action had not been taken to address this. We could not be assured people were receiving the care they needed or improvements in the care provided to people were driven through.

We spoke to people about spot checks and the frequency of the reviews of their care. People we spoke with told us no senior staff members had checked on staff's competency through spot checks or reviewed they were happy with their care. When we asked the registered manager about spot checks they could not explain why people said they had not had any spot checks. They gave us sheets they completed regarding spot checks but could not explain why they did not involve people in providing feedback when they completed spot checks. We could not be assured of the effectiveness of the spot checks given that people could not be certain if spot checks were taking place.

The registered manager and provider did not make regular checks of the service and had not ensured high quality care had been delivered. This was a breach of Regulation 17(1) HSCA 2008 (Regulated Activities) Regulations 2014.

The registered manager was supported by an Operations Manager and Administration assistant. We could not always be certain of the registered manager's understanding of her responsibilities and obligations. When we asked the registered manager a question, the registered manager frequently advised us that she did not know and needed to check with the operations manager. For example, when we asked about people's reviews of their care, she told us, "I think he has a spreadsheet" The registered manager told us they relied on the Operations Manager for support and guidance on policies and procedures. However, the Operations Manager was not always confident in their understanding of their policies. The Operations Manager explained they had updated the policy relating to Deprivations of Liberty. However, when asked how the policy had changed, they advised. "I'm not sure to be honest." We could not be assured that information needed by the Registered Manager was accurate and could be relied upon.

Staff liked the registered manager and able to approach her and discuss any concerns they had with people's care. One staff member told us, "We are a team." Staff felt able to contact either the Operation's Manager or the registered manager for advice. Staff described a warm environment to work within. We asked staff how they kept up to date with their knowledge about people and their needs. Staff we spoke with told us they relied on the Registered Manager to updates people's care plans via the electronic system so that they could refer to the information.

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 People did not receive care that met their needs.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered provider failed to display their ratings following their recent inspection.

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 People did not have access to safe care and treatment

The enforcement action we took:

We imposed a condition to preventing the registered provider from taking on any new packages of care.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People and their families could not be assured that their complaints would be responded and investigated and an outcome to their complaint offered.

The enforcement action we took:

We imposed a condition to preventing the registered provider from taking on any new packages of care.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care was not reviewed and updated regularly. People could not be assured they could receive high quality care in line with their care needs.

The enforcement action we took:

We imposed a condition to preventing the registered provider from taking on any new packages of care.