Kumari Care Limited

Kumari Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 4, 5 and 6 of April 2017. The provider was given 24 hours notice of our inspection. This is because the service provides care to people in their own homes and we needed to make sure the registered manager or their representative would be available to support the inspection.

The service provides domiciliary care to approximately 200 people in the Bath, Bristol and South Gloucestershire areas.

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.

There was a registered manager 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 2008 and associated Regulations about how the service is run.

We found shortfalls in relation to the safety of the service. Information about medicines was unclear in people's support plans. We also found some poor practice in the recording of medicine administration. This meant there was a risk that people would not receive their medicines in line with their prescribed needs. We also found that risk assessments were not sufficient to ensure that staff had clear guidance about how to manage risks associated with people's care.

Recruitment procedures were not sufficiently robust to ensure that new staff were safe and suitable for their roles. Disclosure and Barring Service checks were not always completed for office based staff; references and gaps in employment history were not always investigated fully.

People were supported by staff who did not receive adequate supervision and training. This was found to be a breach of regulation at our last inspection and the concerns had not been addressed since that time. People were at risk because staff did not have the specialist training required to ensure they were confident and able to meet people's complex needs. Staff performance and development needs were not regularly assessed through supervision. Staff confirmed with us that there were gaps in their training and support.

People's support plans were not sufficient to guide staff in meeting people's needs. Where people had complex health needs, there was no clear information in care plans to guide staff in meeting those needs.

There was an inconsistent approach to managing and addressing people's complaints and concerns. We saw examples of complaints that had been investigated and responded to appropriately; however we found others that had not been addressed.

Quality monitoring systems were insufficient to ensure that concerns and issues with the service would be identified and acted upon before they presented a risk to people. There was a breach of regulation at our last inspection in relation to the systems for monitoring the service; the service continued to be in breach of this regulation. The provider was reactive to shortfalls identified by external inspections, rather than proactive in identifying concerns within their own service.

Feedback from people who used the service was varied. Some people made positive comments about the care staff that supported them but others raised concerns about the approach of care staff and their ability to build a positive relationship with them. Missed and late visits were a concern identified by people in their discussions with us.

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

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.

Information was not clear in relation to people's medicines and poor practice was found in recording of administration.

Risk assessments were insufficient to ensure risks were safely managed.

Recruitment practices were insufficient to ensue staff were safe and suitable for their role.

Staff received some training in safeguarding vulnerable adults and were aware of the procedures to follow if they had concerns.

Is the service effective?

Inadequate

The service was not effective.

There were shortfalls in staff training and supervision which had not been addressed since our last inspection.

People's nutritional and health needs were not always accurately described in their support plans.

It was not always clear whether appropriate authorisation was in place when people were being deprived of their liberty.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We received mixed feedback from people about how well they were able to build relationships with their care staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The service was inconsistent in how it responded to complaints.

Care plans didn't contain sufficient information to guide staff in meeting people's needs.

Is the service well-led?

Inadequate

The service was not well led.

Systems for addressing shortfalls were reactive rather than proactive.

All staff did not feel well supported in their roles.

Kumari Care

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 checked 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 an updated rating for the service under the Care Act 2014.

This inspection took place on 4, 5 and 6 April 2017 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service.

The inspection was carried out by three inspectors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Prior to the inspection we reviewed all information available to us, including notifications and information of concern. Notifications are information about specific events the provider is required to tell us by law.

As part of our inspection we spoke with 33 people using the service or their representatives. We spoke with 15 staff and the Registered Manager.

We reviewed the care records of five people who used the service and 12 staff files. We looked at other documents related to the running of the service such as audits and quality monitoring documents.

Inadequate

Is the service safe?

Our findings

The service was not safe. We found shortfalls in a number of areas that meant people were at risk from poor practice.

In relation to recruitment of new staff, there were shortfalls in the processes in place to assess people's suitability for their role. For three members of staff based in the office, we found that no Disclosure and Barring Service check (DBS) had been carried out. A DBS check identifies people who are barred from working with vulnerable adults and whether a person has any convictions. These office staff had access to people's personal information and confidential details. Without a DBS check in place it would not be possible to fully assess whether there were any risks to people using the service in relation to the role these office staff carried out.

The recruitment files for five care staff that we checked, did contain a DBS check. However there were further shortfalls that meant overall recruitment procedures were not robust. In one file we found that the member of staff had not provided any reason for leaving previous employment on their application form and there was a gap of four months in their employment history that was not accounted for. It is a requirement of regulation to ensure that gaps in employment are accounted for.

The registered manager told us that it was company policy to request two references from previous employers. Personal references would be acceptable if it was not possible to collect two work related references. This policy had not been followed consistently. For one member of staff a reference had not been sought from their previous employer in a care home. For another member of staff a verbal reference had been sought from an employer, the verbal reference raised issues about the staff's reliability and punctuality but there was no evidence that these concerns had been explored further. In another file, there was a personal reference from a family friend but there was no name on it and it hadn't been signed so it was unclear who had provided the information.

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

People were at risk from poor practice in relation to medicines administration. Care plans contained limited information about the support people required with their medicines. In one case, the care plan contained no detail at all about the support the person required, although did identify that a cream should be applied if required. There was no further detail about this, for example what it was for or in what circumstances it should be applied. This person had a Medicines Administration Record (MAR) in place which detailed that medicines had been prompted. On one date, it was detailed that two other medicines had been taken; there was no information about these medicines in the person's care file. For this person, we also found poor practice in relation to recording on the MAR chart. On several occasions ditto marks had been used to indicate that the same medicines had been taken as on the previous line in the chart. This practice had taken place over several days so it was difficult to identify what had been given.

In another person's file it stated in the care plan that 'the carer is required to assist (name) to take tablets from the blister pack. The carer is required to place medication into a pot for (name) to take'. It was not clear from the information provided whether care staff were meant to observe the person take the medicines. There was no detailed information in the person's assessment about the medicines they took, only that they were contained in a blister pack. On this person's MAR chart it was evident that staff were supporting the person with a cream for the person's feet, and warfarin. Warfarin is a medicine that requires careful management and guidance but there was no reference or information about this in the person's care plan.

In the care plan for a third person, it stated that staff were to prompt the person to take their medicines from a blister pack. There was no detailed information about the medicines contained within the blister pack. The MAR chart for this person detailed that staff were supporting the person with eye drops, a cream for the skin and warfarin. No reference was made to these medicines in the person's care plan.

The lack of guidance and detailed information about the medicines people were taking and the support they required with them put people at risk of receiving unsafe support with their medicines and errors occurring.

Feedback from people who used the service suggested that in some cases, where staff supported people with their medicines, the timing of their visits were such that medicines were either not given at the right time or with the wrong amount of time between them. One person told us "the visits should be 9am, 12 to 1pm and 6pm; sometimes the lunchtime call is at 11am. And the evening call is at 4pm; not only does this mean that from 4pm to 9am there is nothing, but as the carers give medication, this is not spread out". Another person told us "I need help with taking medicine on time so if staff don't turn up I can be in trouble".

The registered manager told us that at the time of our inspection, MAR charts were not being brought back to the office on a regular basis. This meant they would not be routinely checked for errors and accuracy. In two of the examples we viewed, all of the MAR charts for the year 2017 were still in people's homes, meaning they hadn't been checked for at least three months consecutively.

The process for assessing risks associated with people's care was not robust and this placed people at risk of unsafe care. Where a risk had been identified, the measures to minimise the risk were not clearly identified. In one person's care plan there was information that they were at risk of falls. There were no clear measures in place to guide staff in how the person should be supported to reduce the risk of falls. Two people's files contained information about them being at risk of pressure damage to the skin; there was some information about the signs for carers to look for that might indicate a concern but no further information about what measures might be required to reduce the risk of pressure damage developing.

This was a breach of regulation 12 2 (a) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff told us they had received safeguarding vulnerable adults training during their induction and they were aware of the reporting procedures to follow if they had concerns. There were records to show that the registered manager had engaged in the safeguarding process for some people when concerns had been raised. However within the provider's own quality monitoring systems we saw that a person had made a serious allegation concerning the conduct of staff. There was information in the person's care file that highlighted how the person could make allegations about staff due to their mental health needs; however there was no robust plan in place to manage this and ensure that concerns were investigated and the person protected. There was no record that the concern highlighted in the quality monitoring process had

been referred to the relevant safeguarding authority or investigated by the registered manager.

The registered manager told us that they had current vacancies for field supervisors and were also recruiting for a quality assurance manager and a trainer/supervisor. Interviews were taking place for these posts during the week of our inspection. Views from staff varied about whether there were sufficient care staff to meet people's needs. One staff member said "I have regular people I support. I have my rota every week. Sometimes they change it but they let me know. Sometimes I do extra on weekends". Another staff member told us "At the moment yes we have enough staff to support people but it is always better to have more staff". Other comments included "I have regular runs and cover weekends if necessary but rarely, I have a choice to say no so there is no pressure" and "I don't feel they have enough staff. Sometimes I don't have anyone to relieve me so I can go for training".

It was evident through people's feedback that timing of calls and missed calls were a concern. As part of the service's own monitoring, they spoke with people over the phone and recorded their responses. We saw a number of comments about missed visits and timing of calls. This was reflected in comments from people we spoke to. One relative said "three months ago, they missed coming several times but this has since improved" and "I wouldn't mind but there was no phone call". Another relative said "they didn't turn up and there was no phone call to explain" and "I had to chase them". They also said "this happens probably about once every six weeks on average".

We spoke with the registered manager about the number of missed visits and they shared information with us from their own management systems. The registered manager told us that in January 2017 there had been six missed visits, four in February and 11 in March. In April to date at the time of the inspection there had been five missed calls. This meant that the service was inconsistent in ensuring there were sufficient staff to ensure calls were made on time.

Comments from people who used the service included "I feel very safe, my staff are very good". Another said "I feel very safe, yes". Three people said "I have no problems", and one person said "my staff look after me well since I got out of hospital". A relative said "they are very conscientious and called me immediately when my mother was absent as she had gone out with a friend". Another relative said "I have no concerns about safety".

Inadequate

Is the service effective?

Our findings

The service was not effective. At our last inspection we found that staff did not receive adequate training and supervision. At this inspection we found that there were continued shortfalls in training and supervision.

People were supported by staff who had not undergone a thorough induction programme which gave them the basic skills to care for people safely. We found most staff had not received an in depth induction to prepare them for the role. The Care Certificate standards are recognised nationally to ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. It is the new minimum standards that should be covered as part of induction training of new care workers, and takes around three months to complete all 15 standards. The CQC's Fundamental Standards state, "It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles." The Fundamental Standards are the standards below which, care should never fall. The training records showed only one member of staff had completed the Care Certificate and 23 additional staff should be enrolled on courses to complete the Care Certificate.

Where staff completed workbooks after training, these were not always marked. One staff file contained three workbooks which had not been marked and another staff file had one workbook unmarked. This meant there had not been any checks to ensure the member of staff was competent.

People were being supported by staff who did not have the opportunity to develop and maintain their skills and knowledge. Training records showed staff had not completed training the provider considered mandatory. The provider's own analysis of their training identified 47 staff needed to complete safeguarding training. During our inspection we found concerns that represented a risk to service users that had not been addressed or investigated. The training records showed staff had not been provided with specialist training to be able to provide care and support for people with a range of healthcare needs, such as diabetes, challenging behaviours, depression and people who used catheters and other clinical devices. This meant staff did not always have the training they needed to meet people's needs and ensure their safety.

People were supported by staff who did not always have regular supervisions (one to one meeting) with their line manager. Staff told us, "Supervisions are only done as and when" and "I've not had a supervision; they're only there to make you feel bad about yourself anyway". One member of staff's file showed they had received two observations in May 2016 and the previous observations had been August 2014. Another member of staff's file showed they had not had supervision since October 2013 while other staff files showed their last supervisons were August 2011and October 2012. Only one staff file contained records of appraisals, the last appraisal was carried out in August 2012. Annual appraisals give both managers and staff the opportunity to reflect on what has gone well during the year and areas for improvement or further training required.

The shortfalls in training and supervision were reflected in the feedback we received from staff. Staff told us they have not received training in specialist areas in relation to the service users they are supporting. For

example, some staff told they were supporting people with diabetes, Parkinson's disease, multiple sclerosis (MS) and palliative care. One staff member told us" I was told to go and relieve a carer when I finished my induction. I did not have training on how to care for the person. The carer told me what to do and went". Another staff member said I would have liked to do training on palliative care. Sometimes you are thrown into a deep end". It would be good to have training on MS and it will give you a better understanding on the condition and how to care for the person". Some staff told us they have not had training updates in subjects such as medication, manual handling, safeguarding, health and safety and other relevant subjects. One staff said "We know that our trainings are out of date".

Staff were unaware of the Mental Capacity Act 2005 (MCA) and had not received training in this legislation. The MCA is legislation that protect the rights of people who are unable to make decisions independently about their own care and treatment. Without knowledge and training in this legislation, there is a risk that staff will not uphold people's rights in line with this legislation. One staff member said "I don't know what that means. I know we talk a lot about people with dementia". Another staff member said "I have never heard of it".

All staff who were employed less than six months ago that we spoke with said they had received one or two spot checks. Staff who had worked longer at the agency longer told us they had not received supervision, spot checks, observations or appraisals. One staff member said "We don't have supervisions any more. We use to have a few years back but not anymore. We don't have appraisals either. I think it is because of the high turnover of staff in the office". Another staff member said "We used to have spot checks and observations but it stopped. I have not had appraisals for a few years". I only had one or two supervisions several years ago." However, one staff member I have had appraisals I have had supervisions. I have had spot checks. They come around to see what I am doing" Comments from people included "They have not all had good training, I have to tell the young ones what to do." "Carers have not had enough training to know what they should be doing." And "Not all the carers know how to use the hoist, but I am able to tell them."

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

Some people in the service had care in place 24 hours a day. It was not always clear whether applications had been made to the court of protection to ensure that if people were being deprived of their liberty then appropriate authorisation had been sought. In one example we found, it was clear that an application had been made. However, in another case it was not identified in the care plan that an application to the court of protection had been made and the registered manager was unsure whether one had been made. Whilst it is the responsibility of the local authority to make the application, the registered manager does have a duty to raise any concern about a person who may be deprived of their liberty to ensure that their rights are being met.

Information in care plans did not give staff clear guidance about the nutritional support people needed. For example, one person's care plan noted the person required a softer diet, but did not specify whether this should be pureed or mashed with a fork. Information in this person's care plan instructed staff to prepare breakfast for the person, and listed toast and cereal as appropriate foods. We saw this person's food and fluid intake records. These showed the person had been given biscuits, toast, cake, chocolate and pizza. This meant there was inconsistent information in the person's care file and a risk that their nutritional needs were not being met. Another person's care plan stated they had sandwiches for lunch, and another care plan for the same person instructed staff to heat the person's prepared meal. A support plan written by the local authority, which assessed the person's need for support, said carers, should re-heat a ready meal in time for their tea-time visit.

Feedback from people who used the service raised concern that staff weren't consistently able to meet people's health needs. One person who had a medical condition affecting their physical abilities told us staff did not understand this condition and as a result they could no longer have their personal care managed in the way that they preferred.

Requires Improvement

Is the service caring?

Our findings

Feedback from people who used the service was varied. We received a number of positive comments from people, but also feedback that suggested people weren't able to build strong caring relationships with staff. Positive comments included; "they are splendid, really lovely people", "she is very good and caring", "My carer is thoughtful, efficient and is respectful and friendly in the right balance".

Other comments included; "Carers are not chatty, there is no relationship, but they are respectful and polite.", "I do not feel comfortable with my carers, they do not understand my situation and what I am unable to do", "Some are just doing their job, they are all different, some good, some struggle" and" My carers are hopeless".

We also received varied responses in relation to whether people were treated with dignity and respect by care staff. One person commented that their carer would have a "distasteful" look on their face when carrying out personal care and had asked not to have the person again. Another person said "My carer is respectful, polite and kind, she is like the daughter I never had".

Preferences for gender of carer were identified in people's support plans and generally these wishes were respected. People commented; "I asked for a male carer and they gave me one", and another said "I prefer females, and that's what I have". One person said "at first I wanted a female, but the man who filled in was so good that I asked if he could stay on". Another person said "I have a female and a male and it works well".

Some people felt that communication difficulties affected their relationship with staff. We saw records in recruitment files to show that staff communication abilities had been assessed; however in practice feedback suggested that a number of people found communication problematic. People told us "the language barrier can be exhausting, especially when you're trying to explain something, like items on a shopping list". Another person said "new staff don't speak very good English" and "it can be difficult to tell them something". Another person said "they are trying to improve their English, and this needs to be encouraged by Kumari". Another said "their English isn't good but they do their best".

Support plans described where people were able to be independent and the aspects of their daily care they were able to complete for themselves.

From the comments we received, it wasn't always clear that people had been involved in or asked their opinions about what they wanted to be in their care plans. One person told us that care staff had used the care plan from another agency for 19 months before completing their own. Other people weren't aware of their care plan or what was included in their care package. However, within a certain geographical patch covered by the agency, people were generally positive about their care plans and the frequency of them being reviewed. Comments included; said "I have a review more than once a year", and another said "I have reviews with Kumari occasionally". One person said "I had a review about six months ago" and a relative said "she has had a review since Christmas".

Requires Improvement

Is the service responsive?

Our findings

People's care records did not contain sufficient or accurate information to ensure they received personalised care. For example, where people had conditions such agoraphobia, panic attacks, kidney stones, pressure areas and high blood pressure, there was no information in people's care plans giving staff guidance about how to meet the person's need. Other people had conditions such as insulin controlled diabetes, heart disease and irritable bowel syndrome but there was no guidance for staff how to support the person with these conditions. One person had dementia and could be anxious. Staff had recorded an incident when the person became anxious when they may have been unwell. There were no further records to show this person's care had been reviewed to ensure staff had the guidance they needed to provide the care and support necessary. There was no guidance for staff if there were any triggers for behaviours that challenged and no guidance for staff how to support the person when they were anxious. Three people's care records had duplicated care plans.

Some information in care records gave conflicting information. For example, one person had two care plans in their file, one of which said they had a pressure sore, and another care plan which did not have this information. As there were no dates on the care plans, it was not possible to see which one was the current version. Another person's assessment noted they needed cream to be applied to vulnerable areas; however this information had not been included in the persons care plan.

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

The recording of complaints and the provider's response to them was inconsistent. There was a log in place of complaints received. In some cases it was clear what action had been taken in response to them but in other cases, the original concern had been recorded but not what had happened subsequently. In three out of the four cases, where it was unclear from the log what had been done in response to concerns, the registered manager was able to show us further evidence that the concerns had been addressed. In a fourth case however, there was no evidence that the concern had been followed up although the registered manager reported verbally that the person concerned was now happy with their care.

Through our discussions with people who used the service, we heard about concerns that people told us had been reported to the office but there was no evidence that these had been recorded or action taken in response to them. In one example, a person raised potential concerns about the safety of people using the service. The registered manager did take steps to address the concern when we discussed it with them.

Overall comments were mixed about people's confidence in making complaints. Comments included "I am fairly confident that if a complaint was made it would be taken seriously and they would try to put it right". Another person said "if I ring to moan, they usually try to put it right". Two people said "they do take me seriously". A relative said "I rang the office to complain about a member of staff but nothing changed".

A number of people we spoke to raised concerns about the timing of their calls and visits being missed. One

person told us "I have no idea who is coming, they are meant to arrive between 9.30 and 10am, but more often than not it is 10.30 to 11am, they have even been as late as 12.30, or just not turned up with no warning or explanation." Another person said "They are supposed to come every night between 1.30 and 2am to help me to bed but more often it is 2.45am and has been as late as 4am. This is disturbing for X who is disabled as they cannot settle until carers have been." One relative told us "X has 2 night calls, sometimes these are too close together, so on one of the visits they do nothing, by the time the next call is made, maybe by the daytime carer, X is uncomfortable". Other people hadn't experienced any issues and felt the timing of calls was working well for them. Comments included "I get a different carer each time but they are usually on time as this fits in with a daily visit from a nurse." And "I get the same carer every morning, she lives locally and I am her first call so she is on time."

Inadequate

Is the service well-led?

Our findings

The service was not well-led. At our last inspection in August 2016, we rated the service as requires improvement. At this inspection we found the service to be inadequate; previous breaches of regulation had not been addressed and further breaches of regulation were found. Following our last inspection in August 2016, the provider submitted an action plan to tell us how they would address the breaches of regulation we found. These action plans had not been met and we therefore did not have confidence that the provider would address shortfalls promptly. For example, the action plan from our last inspection stated that the provider would enrol staff on Mental Capacity Act training and other specialist areas such as end of life care. It was evident at this inspection that this action had not been completed.

The systems in place to monitor the quality and safety of the service were insufficient to ensure that shortfalls would be identified and rectified within a timescale that protected people from the risks of receiving unsafe care.

The service received visits from the local authority and these visits had identified areas requiring improvement. An action plan was in place to address these issues and in an early stage of implementation. We weren't therefore able to judge how well the action plan was driving improvement. Overall the provider's arrangements to address shortfalls were reactive to issues identified through external monitoring processes, rather than proactive in identifying issues before they presented a risk to people using the service. For example, there was an electronic monitoring system (EMS) in place for staff to log in and out of their calls. It had been identified through the local authority inspection that this wasn't being monitored well enough and as a result this was put into the action plan for the service. Prior to this, there was a risk that missed calls would not be identified promptly and addressed. When we asked the registered manager for information about their missed calls, this information was not readily available and information from the EMS required further analysis before this information could be given to us. Without this information, the registered manager could not investigate why calls were missed and whether people had been placed at risk because of it.

As part of their quality monitoring, a satisfaction survey was carried out and the results analysed. The registered manager also shared their care plan audit with us. This identified whose care plans had been reviewed and whether any changes had been made. However it hadn't been used to identify any overall issues or concerns with care plans and hadn't been used to identify the breach of regulation found at this inspection in relation to lack of clear information in support plans.

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

The registered manager told us that there were vacancies for senior staff in the office. At the time of our inspection they were in the process of recruiting for two field supervisors and a quality and training manager. This meant there had been gaps in the management structure of the service and so the registered manager had lacked support in running the service.

The provider was being supported by a consultancy company since November 2016 to support them in making the necessary improvements to the service.

Feedback from staff was mixed about how well-led the service was and how supported they felt. Staff said, "The support just isn't there", "It's terrible really", "The thing that gets me is how the staff are treated" and "It's not a very nice place to be in". One staff member told us. "We don't have staff meetings. We get updated through text messages and email". Another staff member said "I don't feel valued and listened to. Management don't listen to us". However, other staff were more positive and commented "Kumari is a good care agency. They help you when you need help" and "If you have any problem you ring her and she will do what she can to help you".

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 This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Care plans did not contain sufficient detail to ensure people's individual needs were met. Regulation 9 3 (b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Risk assessments were not sufficient to protect people from the risks associated with their care. Regulation 12 2 (a) Guidance in care plans and practice in relation to medicines was not sufficient to ensure people's safety. Regulation 12 2 (g)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed This was a breach of regulation 19 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014

Recruitment procedures were insufficient to ensure the safety and suitability of staff

Regulation 19 (2) (3)

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 17 HSCA RA Regulations 2014 Good governance This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Systems for monitoring the service were inadequate and failed to identify shortfalls in the service. Regulation 17 2 (a) and (b)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 People were at risk because they were supported by staff who had not received sufficient training and supervision. Regulation 18 2 (a)

The enforcement action we took:

warning notice