Midlands Home Care Limited

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Inspection report

278-290 Huntingdon Street
36 Huntingdon House
Nottingham
Nottinghamshire
NG1 3LY

Tel: 01158800300

Date of inspection visit:
08 May 2018
09 May 2018

Date of publication:
29 June 2018

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced inspection of Midlands Home Care limited on 8, 9 and 11 May 2018. The service was a domiciliary care agency. It provided personal care to people living in their own homes. Not everyone using Midlands Home Care Limited received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. At the time of the inspection, Midlands Home Care Limited supported 61 people with their personal care.

This was the second time the service has been rated as inadequate. Midlands Home Care Limited was also rated as inadequate at our last inspection which was in January 2018. During the course of this inspection, the provider made a decision to close the service. Consequently, we cancelled the registration of the provider, which means the service is no longer registered to provide any regulated activities.

There was a registered manager in post at the time of our inspection visit; however, they were not present during our 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.

During this inspection we found the service was not safe and people were placed at risk of serious harm. People were not protected from risks associated with their care and support. Risks such as falls, pressure ulcers and moving and handling had not been adequately identified, assessed or planned for. This meant people were exposed to the risk of harm. Accidents and incidents were not investigated, consequently action was not taken to reduce the risk of reoccurrence. Medicines were not managed safely and people did not always receive their medicines as prescribed. Effective infection control and prevention measures were not in place, which exposed people to the risk of infection spreading.

People were not protected from abuse and improper treatment. There had been a failure to conduct thorough and robust investigations of allegations of abuse and people were not safeguarded from harm when allegations had been made against staff. Safe recruitment practices were not followed. Risks associated with previous criminal convictions had not been identified or assessed and pre-employment background checks were not completed for all staff. This meant people were supported by unsuitable staff. Staff were not deployed effectively which meant staff were frequently late for care calls. We were also notified of missed care calls. This had a negative impact upon people who relied upon care staff for support with their personal care.

Staff did not receive regular supervision or appropriate training to enable them to carry out their jobs safely and effectively. A suitably qualified person did not provide training and training was not of sufficient quality or quantity. People were not supported to have maximum choice and control of their lives and were not supported in the least restrictive way possible; the policies and systems in the service did not support this

practice. There was a risk people may not receive the support they required with their health as care plans did not contain sufficient information for staff and referrals were not always made to specialist health professionals. Support provided was not in line with current legislation and best practice guidelines. Information was not shared when people moved between services. People were supported with their dietary needs, when required.

People and their relatives told us care staff were friendly and kind, but commented office based staff were not caring in their approach. People were not always introduced to new members of staff before they provided them with care and changes in the staff team had a negative impact upon people. Staff did not always have information about how people communicated. People told us care staff involved them in day to day decisions, but feedback was mixed about involvement in planning care and support. People were not provided with information if they needed the support of an independent advocate to help them express their views.

People were at risk of receiving inconsistent support that did not meet their needs. Care plans were not personalised and did not contain enough information to inform staff how to meet people's needs. Care plans were not always reviewed or kept up to date and some people did not have care plans. There was a risk people's diverse needs may not be identified or accommodated. The provider did not have a robust process in place to investigate and respond to people's concerns and complaints. Consequently, action was not taken to address people's concerns. We were aware of a complaint regarding the quality and safety of care which had been upheld by the Local Government Ombudsman. The provider had not taken action on the recommendations made as a result of this.

The service was not well led. There were a lack of effective systems to monitor and improve the safety and quality of the service. Where there were systems in place these were not robust and did not ensure areas for improvement were addressed. Policies and procedures were not adequate and the provider did not comply with their own policies. People and staff were not involved in the running of the service. People's feedback was not used to develop and improve the quality of the service. Sensitive personal information was not stored securely. The provider did not willingly share information in an open and honest way.

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 protected from risks associated with their care and support. Accidents and incidents were not investigated.

Effective processes were not in place to protect people from abuse and improper treatment.
Safe recruitment practices were not followed.

Medicines were not managed safely and people did not always receive their medicines as needed.

Staff were not deployed effectively and staff were frequently late for care calls.

Infection control and prevention measures were not in place.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive regular supervision or appropriate training to enable them to carry out their jobs safely and effectively.

People's rights under the Mental Capacity Act were not upheld.

There was a risk people may not receive the support they required with their health needs.

Support provided was not in line with current legislation and best practice guidelines. Information was not shared when people moved between services.

People were supported with their dietary needs, where this was part of their care plan.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives told us care staff were friendly and

kind but also commented office based staff were not caring in their approach.

People were not always introduced to new members of staff before they provided them with personal care and changes in the staff team had a negative impact upon people.

People were not provided with information if they wished to speak with an independent advocate.

People told us care staff involved them in day to day decisions about their care but said they were not consistently involved in the development and review of their care plans.

People told us care staff treated them with dignity and respect and ensured their right to privacy was upheld.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not personalised and did not contain enough information to inform staff how to meet people's needs.

There was a risk people's diverse needs may not be identified or accommodated.

The provider did not have a robust process in place to investigate and respond to people's concerns and complaints. Consequently, action was not taken to address people's concerns.

Is the service well-led?

Inadequate

The service was not well-led.

There were a lack of effective systems to monitor and improve the safety and quality of the service.

Policies and procedures were not adequate and the provider was not complying with their own policies.

People and staff were not involved in the running of the service. People's feedback was not used to develop and improve the quality of the service.

Sensitive personal information was not stored securely.

Midlands Home Care Limited

Detailed findings

Background to this inspection

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

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events that the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

We did not request a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what they do well and improvements they plan to make. However, we gave the provider the opportunity to share this information during the inspection.

This comprehensive inspection took place on 8, 9 and 11 May 2018 and was unannounced. The inspection was prompted due to information of concern we received in relation to safeguarding, risk management, staff recruitment and the quality of care.

The inspection was undertaken by two inspectors, a specialist advisor 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 care service. The office inspection took place on 8, 9 and 11 May 2018. On 9 May 2018 the Expert by Experience carried out telephone interviews to gain people's views in relation to the quality of the service and an inspector made calls to staff employed by the provider.

During our inspection we spoke with seven people who used the service and six people's relatives on the telephone. We spoke with nine members of care staff on the telephone and the director who was also the nominated individual. The nominated individual is a person who is nominated by the provider to represent the organisation.

To help us assess how people's care needs were being met we reviewed all, or part of, 12 people's care plans and other information, for example their risk assessments. We also looked at the medicines records of four people, ten staff recruitment files, training records and a range of records relating to the running of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2018, we found people were not protected from risks associated with their care and support. This was a breach of the legal regulation. At this inspection, we found the safety of the service had deteriorated further. There continued to be insufficient risk management processes. This had resulted in a failure to both identify and address risks and placed people at risk of unsafe support.

People were not protected from the risk of falls. The risk of falls was not assessed and consequently action was not taken to reduce future risk. Records for one person documented they had recently experienced several falls. Despite this, there was no falls risk assessment, no information about the risk of them falling in their care plan and no action taken to reduce future risk. The provider advised us that falls risk assessments had only been completed for people who had a new electronic care plan. However, we reviewed the electronic care plan for another person and found this was not the case. They had a history of falls and a number of conditions, which placed them at increased falls and increased risk of injury. Despite this, there was no falls risk assessment and no reference to falls risk in their care plan. This failure to manage risks associated with falls placed people at risk of serious harm.

People were not protected from the risk pressure ulcers. Records showed there were no tissue viability risk assessments and little or no information in care plans about pressure area care. The provider told us one person had a grade four pressure ulcer, they were unclear how or when this developed, but told us it may have deteriorated while the person was in their care as they had chosen not to follow medical advice. There was no pressure ulcer risk assessment or prevention care plan in place and the care plan did not include information about the person's decision to go against medical advice or their capacity to make decisions in this area. This meant we were we not assured the provider had considered the risk of further deterioration of the ulcer, or provided staff with the information required to safely support the person. Another person was cared for in bed. They had very limited mobility and required support to move and transfer. Despite this, there was no assessment of the person's risk of developing pressure ulcers or any reference to pressure ulcer prevention techniques in their care plan. Recent records showed they had developed 'sore' areas of skin, but there was no evidence of any action as a result of this. This placed the person at risk of developing a pressure ulcer.

People were not protected from risks associated with moving and handling. Moving and handling risk assessments had been completed for some people but these were related to risks to staff rather than risks to the person. Consequently, care plans did not contain any important considerations, such as equipment checks, how to use the equipment or the impact of any physical limitations. One person required the support of two staff to enable them to mobilise using a hoist. Despite this, there was no moving and handling care plan and the risk assessment was insufficient. There was no information on the type of sling, how to use it or how to support the person. This meant staff did not have sufficient guidance to inform safe care and support and placed people at risk of harm. In addition, people were subject to unsafe moving and handling practices. Another person required two staff to assist them to mobilise using the hoist. Records showed they had recently been supported by a single staff member to transfer using the hoist. This failure to ensure safe moving and handling practices were followed placed people and staff at risk of harm.

We also identified other risks that had not been sufficiently assessed or mitigated. Risks associated with people's behaviour were not assessed and details were not included in care plans. Records showed one person could behave in a way that placed staff at risk of harm. This had not been risk assessed and was not referred to in their care plan. The provider told us they had identified the risk and assessed this care call to be completed by two staff members to ensure staff safety. However, records showed there had been recent occasions where the person had been supported by a single member of staff. This placed staff at risk of potential harm and distress.

Another person had dementia and was known to leave their home without supervision which placed them at risk of harm. The provider told us, despite the risk, the person was free to leave and often went out on their own. They said if the person was not in when staff arrived they must go round to the neighbours, check 'the usual' places and then call the police. None of this information, including what provider understood to be the person's 'usual' places was in the care plan or risk assessment. This posed a risk the person may not get the support they require to stay safe.

There was a risk equipment was not always safe or effective. The provider informed us staff were responsible for checking the safety and suitability of equipment used in people's care and support. However, staff knowledge of how to conduct checks was variable. Some staff were able to describe checking the general state of repair of equipment but other staff did not have the required competency. For example, one member of staff told us they had 'no idea' how to check the settings of a pressure mattress. This posed a risk that equipment may not be used safely.

There was no effective system to record and review incidents such as falls to try to reduce the risk of recurrence. Incidents such as falls were not recorded systematically which meant the identification and analysis of incidents was very difficult. The provider advised us that because many incidents happened when carers are not there, "There are no lessons learnt." The failure to learn from accidents and incidents placed people at risk of harm.

Medicines were not safely managed. Paper medicine records charts were not consistently completed. One person's medicine records were inconsistent and had different medicines listed over a three week period. There was no dose recorded and it was not always clear what time medicines should be given or how often, there was no signature from the person who had written the meds on the medicines administration record (MAR) chart or an indication they were checked by two staff for accuracy. This increased the risk of error.

People were at risk of not receiving their medicines as required. There were multiple gaps on medicines records. For example, for one person there were 15 instances of medicines not being signed for in a two month period. An electronic medicines record had recently been introduced, which had led to some improvements in recording. However, we continued to find unexplained gaps. For example, for another person there was a gap for all medicines on the morning and tea time calls for 4 May 2018. This meant the provider could not provide assurances medicines were administered as required. Furthermore, staff did not always follow safe practices when administering medicines. Staff told us if a person refused their medicine they would leave it out on the side for them to take later. Although they stated they would record this in care records this did not assure us people received their medicines as required and also posed a risk of people stock piling medicine which could result in intentional or accidental overdose.

Staff competency to administer medicines was not regularly assessed. There were no measures to check staff had the skills and competency required to ensure the safe administration of medicines. The provider told us they used the electronic system to identify any medicines errors. This was a reactive measure which did not take a preventative approach to the safe management of medicines and this increased the risk of

medicines errors and placed people at risk of harm.

People were not protected from the risk of infection as effective infection control and prevention measures were not in place. Although the provider told us staff had access to plentiful supplies of personal protective equipment, we found this was not the case. People who used the service told us staff did not always wear gloves when supporting them. One person said, "The girl turned up and she had no gloves." Staff told us they did not always have access to supplies of gloves. One member of staff told us, "I asked for gloves for two weeks and then bought some of my own." In addition, staff did not use aprons to protect their clothes. One member of staff said, "We don't have aprons, just the blue overalls we wear each day." The lack of access to personal protective equipment did not promote good hygiene practices and increased the risk of infections spreading.

All of the above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were not followed. This meant people were not protected from staff who were unsuitable. This failure placed people at risk of serious harm.

Risks posed by staff who had criminal convictions were not adequately assessed or managed. Before our inspection the local authority informed us a member of staff with a serious conviction had been providing unsupervised support to people. The provider had not conducted a robust assessment of the risks posed by this person. We also found that there were no records of enhanced monitoring of this staff member, such as spot checks or supervisions. This placed people at risk of harm. Although during our inspection, we were informed the staff member was no longer working for the provider, it remains of concern that action had not been taken, prior to our intervention, to protect people from potential risks.

During inspection, we found further evidence that risks posed by staff who had criminal convictions had not been adequately assessed or managed and this placed people at ongoing risk of harm. Another member of staff had declared a recent, very serious conviction on their application form. The provider told us they were unaware of the conviction and we found there was no Disclosure and Barring Service (DBS) check for the person and no risk assessment related to the conviction. The failure to identify and assess a conviction of this nature was a significant risk.

Pre-employment background checks had not been completed for all staff. The service employed a volunteer who they had been recruited from a social media site. The provider said they had not conducted any background checks for them as they were a volunteer so it was not felt necessary to do so. This meant the provider had no assurances about the character of this person. Another member of staff had been employed by Midlands Home Care Limited since March 2018. However, there were no background checks to ensure their suitability for the role. This failure to conduct the required background checks on staff placed people at risk of harm.

Risks associated with employing staff under the age of 18 had not been identified or assessed. Prior to our inspection, we received concerns that the provider employed a member of staff who was under the age of 18. The Management of Health and Safety at Work Regulations 1999, states that an employer has a responsibility to ensure that young people employed by them are not exposed to risk due to a lack of experience, being unaware of existing or potential risks and/or lack of maturity. Guidance also states that the risks of employing a young worker should be assessed giving consideration to additional support to allow them to carry out their work without putting themselves and others at risk. The staff member had commenced employment with Midlands Home Care Limited when they were 16 years of age. Despite this,

there was no assessment of risks associated with their age, no consideration had been given to enhanced training or supervision and there were no records of any supervisions or spot checks. This failure to assess the potential impact of lack of experience and maturity placed people at risk.

All of the above information was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from abuse and improper treatment. There had been a failure to conduct thorough and robust investigations of allegations of abuse. People had recently raised concerns that money had gone missing from their homes. There was no evidence of any written investigation of the allegations of theft and although action had been taken there was no clear rationale for the course of action taken. This meant were not assured that all reasonable steps had been taken to investigate the incident and protect people from abuse.

Action was not taken to safeguard people when allegations were made against staff. Allegations of rough handling had been made against one staff member. This had been referred to the local authority safeguarding adults team for investigation. We asked what measures had been put in place while the investigation took place to safeguard people from harm. The provider told us people were called weekly to check if they had any concerns. There were no other preventative measures in place to safeguard people from harm, such as increased supervision or spot checks of the staff member. This meant all reasonable steps had not been taken to safeguard people from harm.

During the course of our inspection, we received feedback from a social care professional responsible for investigating allegations of abuse. They told us the provider had not shared important information with them to enable the full investigation of the safeguarding concerns. This had resulted in them not being able to conduct a comprehensive investigation of the concerns raised.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care calls were not provided at the planned times. People, their families and staff commented that calls were frequently late and some told us this had a negative impact upon them. One relative told us, "They have to rush sometimes, and if they're late my [relative] misses medical appointments." Records showed, in the 30 days prior to our inspection, 95 calls had been identified as being over 30 mins late. We reviewed a selection of individual call records and found some calls were recorded as being up to three hours late. For example, a care call scheduled for 16:00pm on 29 April 2018 was delivered at 20:07pm, 247 minutes late. Punctuality rates for calls were very poor, for the sample of records reviewed approximately 50% were not on time. The provider told us they monitored late calls via email alerts from the electronic system; however, improvements from this monitoring were not evident as a high percentage of care calls continued to be significantly later than planned.

We reviewed staff rotas and found some calls were scheduled in such a way that no time was allowed for travel between locations. People who used the service said staff told them that care calls could be double or triple booked which meant they could not to get to the calls at the scheduled time. While some staff told us they had ample time to travel between calls, other staff told us they did not have adequate travel time and this resulted in them being late to calls. One member of staff told us calls which were 20 minutes apart from each other were scheduled with no time between them meaning it was not possible to get to the second call on time.

There were no records kept of missed calls. However, we received feedback from people and their relatives that calls had been missed. One relative told us their relations care call had recently been missed and this had resulted in their relative becoming confused and distressed.

All of the above information was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Training was not provided by a suitably qualified person. The registered manager provided all training; however, they did not have the necessary qualifications to do so. For example, the registered manager delivered all safeguarding training. There was no record of the registered manager having attended any safeguarding adults training. The registered manager delivered moving and handling training. However, their moving and handling trainer qualification expired July 2017. In addition, the registered manager had signed off staff care certificates but they were not a qualified care certificate assessor. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe and compassionate care and support. This meant the provider could not provide assurances that training provided to staff was sufficient or effective.

Training provided to staff was not sufficient in quality or quantity. People and their relatives commented on staff competency and told us new staff appeared to be poorly prepared to do their job. One person told us, "Some staff don't know what they're doing and rely on the second carer to tell them everything." A relative told us, "One carer had to phone their colleagues to ask them how to use the equipment." Although the provider told us some courses, such as moving and handling, were one full day long, we found staff had attended multiple training courses in one day. For example, one member of staff attended all of the following courses in one day; food safety, convene and catheter, healthy eating and wellbeing, emergency aid awareness, infection control, health and safety and moving and handling training. This meant the provider could not provide assurances about that staff were provided with sufficient training to ensure they had the skills to provide safe and effective care and support.

Some staff did not have records of any training attendance. For example, two members of staff had no training courses recorded. This was also reflected in feedback from recently recruited staff. One member of staff told us about their induction and said, "(There was) no course attendance, no booklets, no videos, just shadowing." Other members of staff told us they had had little induction to the role. Another member of staff said, "Induction was just a day shadowing someone and left to get on with it." This meant staff were not provided with adequate induction or training to ensure their competency.

Staff did not have supervision. The majority of staff told us they did not get supervision and some commented their work performance was not monitored. During our inspection we only found one record of recent supervision. Records of these supervisions were minimal and did not assure us staff had been given sufficient time and support to reflect upon their practice and voice any concerns they may have. One member of staff told us they got supervision, "Sometimes," but said they are not enough supervisions to, "Go round," as there are a lot of staff. This failure to provide staff with regular training and supervision meant opportunities to monitor staff performance and identify and address any issues or concerns may be missed.

All of the above information was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not protected as the principles of the Act were not correctly applied. Mental capacity assessments and best interest decisions were not always in place when people's decision making capacity was in doubt. For example, records showed, and people's relatives confirmed, that some people were unable to consent to their care and treatment and unable to safely manage their own medicines. However, there were no mental capacity assessments in place for these people. We also found that where people were unable to consent their friends or family had signed consent forms on their 'behalf'. There was no indication that these people had any legal powers, such as a Health and Welfare Power of Attorney, to provide consent 'on behalf of' the person. This meant there was a risk people's rights under the MCA may not be respected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The treatment and care people received by Midlands Home Care Limited was not delivered in line with current legislation, standards and evidence based guidance. For example, nationally recognised good practice risk assessments, such as pressure ulcer risk assessments, were not used by the service. This meant care and support was not provided in line with good practice guidelines and placed people at risk of harm.

Care and support was not properly planned and coordinated when people moved between different services. The provider told us that before people received support from Midlands Home Care Limited, they visited people to conduct assessments to ensure the staff team could meet their needs, this was then used to develop care plans. However, during our inspection, we requested information about a person who had just started using the service. Despite the person having complex support needs, there was no assessment and no care plan in place for them. The provider told us they had shared information verbally with staff. This did not assure us that staff had adequate information about the person to provide safe, person centred care. Furthermore, the provider told us they did not share any information with new providers when a person left their service. This failure to ensure coordinated transitions between services placed people at risk of receiving unsafe support that did not meet their needs.

People could not be assured that they would receive effective support in relation to their health. Risks associated with people health conditions were not assessed or detailed in care plans. For example, the medical history section of one person's care plan stated they had diabetes. However, this was not referred to in any of the other part of their care plan. There was no information for staff about the condition, the impact it had on the person or how to recognise if the condition worsened. This lack of information for staff meant there was a risk staff may fail to recognise a deterioration in their health condition.

We also found limited evidence that referrals were made to specialist health professionals when people's needs changed. For example, one person had recently sustained a number of falls; however, no specialist advice had been sought to reducing the risk of falls. Although staff told us they communicated with health professionals when people's needs changed, this was dependent upon the skill and competency of individual staff members and was not due to the leadership or culture of the service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the type of service provided some people did not require the support of staff with meal preparation or eating their meals. Some were able to do this for themselves or had relatives who would support them. Where people did receive support from staff, they told us they were happy with the way supported them. Care records contained basic guidance for staff on how to support people with making food and drink. People's food likes and dislikes were also recorded in some care plans but that was variable. Where staff prepared food and drink for people this was recorded.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us the care staff were kind and caring. A person who used the service told us, "They talk to me all the time and are very friendly, it helps me relax." Another person said, "They're polite and supportive, I'm very pleased with their work." A relative told us, "They are very kind and friendly, [relation] has a good laugh with them." Care staff we spoke with were enthusiastic about their jobs. Several members of staff told us they enjoyed their jobs. Staff spoke with fondness about the people they supported and knew them well. One member of staff told us, "I like to make people laugh, make their day. Often I'm the only person they see, so I always help out wherever I can. I always do my job to the best of my ability."

In contrast, people and their relatives were less positive about the approach of office based staff. One person told us, "The office staff don't seem to care." A relative told us, "They have an attitude like they're in charge, they don't want to listen." The feedback we received from some people and relatives about the communication they had received from the office based staff showed that people or their representatives were not consistently treated with a caring approach.

People told us there was a high turnover of staff and said they were not always introduced to new care staff. One person told us, "Carers are always changing, they don't seem to last long." A relative commented, "They are polite but all the staff changes make my [relative] anxious." Another relative said, "We had no introduction to the service, they just turned up." Rotas were not organised so people did not always know in advance which members of staff were visiting and at what time. This meant the needs of people were not always considered when planning the delivery of their care and support. In addition, the failure to ensure people were aware of which staff would be supporting them placed them at risk of anxiety and distress.

Care records contained limited information for staff to communicate effectively with people and to enable them to engage with some people in meaningful conversation. One person's care plan stated they had a condition which resulted in them having difficulties in understanding and expressing themselves. Despite this, there was no further information in their plan about how staff should communicate with them. In contrast, people who could communicate their views told us staff communicated with them and involved them in decisions.

Information was not provided for people if they required an advocate to support them to express their views. Advocates are trained professionals who support, enable and empower people to speak up. The provider told us they would search the internet if they thought anyone needed an advocate. This meant the provider could not assure us that people would be enabled to access an advocate if needed.

People were not always involved in planning their care. Prior to our inspection the local authority informed us of concerns that people were not offered opportunity to be involved in the development of their care plans and after investigation they found that some people's signatures had been falsified on care plans. Although no one raised this as a concern during our inspection, feedback about involvement in care planning was mixed. Two people told us they had been involved in the development of their care plans and reviews, but seven people said they had not been involved in any reviews of their care and support.

In contrast with the above, people told us staff consulted them about day to day decisions about their care and support. One person told us, "They talk to me and ask my permission to do things." Another person said, "Staff ask me what I want before they give me personal care." People told us staff respected their choices and this was also reflected in conversations with staff. One member of staff told us, "I ask the person, give them choices and options so they can make their choice."

People told us staff respected their right to privacy and treated them with dignity. Staff were able to describe the steps they took to ensure they treated people with respect. One member of staff told us, "It's really important to remember that you are invading someone's own space every time you set foot in their house. There is no room for judgements on how people want to live, as long as they are safe. We have a natter when I arrive, I don't just get down to it, that would not be respectful."

Inadequate

Is the service responsive?

Our findings

People did not receive a personalised service that met their needs. Calls were frequently late which meant people did not always receive support at the agreed time. One person told us "Staff are often late and in a rush when they get here." Before and during our inspection, people told us they were not informed if their care worker had been delayed and they had to ring the office to find out what was happening. Furthermore, records showed care calls were routinely cut short and did not last the specified duration. This was reflected in people's feedback. One person told us, "I only get 15 minutes out of the half an hour I pay for." Records for another person showed that in a six day period only 241minutes of care were delivered from a scheduled 420 minutes. For the same period 1170 minutes of care were planned for another person; however, only 801 minutes were provided. Further analysis of the records showed patterns of some staff routinely cutting calls short. Late calls and calls being cut short meant there was a risk people may not get the support required to meet their needs.

People were at risk of receiving inconsistent support that did not meet their needs. Care plans were task focused and did not contain sufficient information to inform staff how to meet people's needs in a way that reflected their preferences. Some people did not have a care plan in place at all and other care plans lacked detail and had not been updated to accurately reflect people's needs. For example, the provider informed us one person needed support with all aspects of their care including, personal care, mobility, continence and their health care needs. Despite this, they did not have a care plan to inform any aspect of their care and support. The provider told us they had shared information with care staff; however, when we spoke with staff none of them had any knowledge of the person or their needs. This did not assure us that all staff had access to clear guidance to inform the support provided. This placed people at risk of inconsistent support.

Since our last inspection in January 2018, the provider had started to implement a new electronic care planning system. Staff spoke positively about the impact of this and told us it was much easier to access information about people they were supporting. Despite this, we found some of the new electronic care plans still lacked personalised information and important details about how best to support people. For example, one person's electronic care plan did not contain any information about their sensory impairment or how staff should support them in this area.

There was a risk people's diverse needs may not be met. We asked the provider about how they identified and met people's diverse needs. They told us that they discussed things such as religion when people were assessed, and would accommodate this in people's care plans as needed. They told us at the time of our inspection they did not support anyone with any diverse needs. However, during our inspection we found a number of people had support needs associated with disability, such as sensory impairment, which may have led to inequality or discrimination. This meant people's needs associated with their disability had not been assessed and therefore no actions had been identified on how to meet their needs.

The provider was not aware of their duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. They told us they had not needed to make any adjustments to

meet people's needs in this area and added they would do so if needed in the future. This did not assure us that proper consideration had been given to meeting people's information access needs and posed a risk they may not have equal access to information.

The above information was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have adequate systems in place to address complaints. Before our inspection we received concerns from people who used the service who told us the provider had not responded to their complaints. During our inspection, we found there was no effective system for identifying, handling and responding to complaints. The provider told us they had not had any recent complaints. However, we found evidence of three separate complaints in care records and people's families told us about other occasions where they had raised complaints and concerns. Despite this, there were no formal written records of recent complaints and no evidence of action being taken to address concerns and complaints. In addition, people and their families had given poor feedback about the management of complaints in a recent customer satisfaction survey. This was also reflected in feedback form people during our inspection. One person told us "I've had to complain about staff lateness but I've not seen any improvement." Another commented, "I complained previously but nothing seems to have changed." A third person told us the provider only took action to address their complaint after them getting the local authority involved.

During the course of our inspection we were notified of a complaint regarding the quality and safety of care which had been upheld by the Local Government and Social Care Ombudsman (LGO). The LGO are the final stage for complaints about adult social care providers (including care homes and home care agencies). They investigate complaints in a fair and independent way. The LGO had ruled that a person's nutritional and hygiene needs were often not met due to late calls. They recommended Midlands Home Care Limited should apologise and provide financial remedy. However, at the time of writing this report the provider had not responded to these recommendations.

The above information was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in January 2018, we identified concerns about the leadership and governance of the service. This was a breach of the legal regulation. At this inspection, we found the required improvements had not been made and the quality and safety of the service had deteriorated further.

We had serious concerns about the continued safe and effective running of Midlands Home Care Limited given reductions in both managerial and operational staff. During our inspection, five staff were identified as unsuitable to provide support due to an absence of adequate recruitment checks. In addition to this, the registered manager was absent from work. This has resulted in a sudden reduction in carers, drivers, administrative staff and management. This left only the provider, to manage the day to day running of the service, ensure care calls were covered and make the required improvements to ensure the safety of people using the service. We discussed the continued safe running and management of the service with the provider who advised they planned to ask a senior carer to support the management of the service. The provider had not considered that this could have a further negative impact on safety of the service due to an additional reduction in the number of staff available to cover care calls.

There were a lack of effective systems to monitor and improve the safety and quality of the service. The provider told us the electronic system was used to monitor areas such as late and missed calls and medicines errors. However, this system had not been effective in addressing late calls or in identifying medicines errors. The provider told us they monitored quality by making regular calls to people who used the service to identify and address any concerns. We reviewed records of these calls and found although issues were identified, effective action was not always taken to address concerns raised. For example, in calls conducted in week commencing 16 and 23 April 2018, 10 people raised issues about late calls. This continued to be an issue during our inspection. The provider told us the registered manager conducted medicines audits; however, there were no records of these audits since January 2018.

In addition, there were no checks on other aspects of the service. For example, no checks had been completed on the quality of training provided to staff or on recruitment processes. Consequently, we found serious concerns in these areas during our inspection. This lack of effective systems and failure to identify issues related to the quality and safety of the service placed people at risk of serious harm.

Policies and procedures to ensure the safe and effective running of the service were not adequate. For example, the recruitment policy did not cover employment of staff under the age of 18 and we found this to be an area of concern during our inspection. The provider's Disclosure and Barring policy stated that there was an additional policy that related to employment of ex-offenders. However, this policy did not exist, and again we found issues related to this during our inspection. Other procedures to ensure the safe running of the service were not adequate. The business continuity plan was not relevant to the service as it referred to organisational departments and branches that did not exist. Furthermore, the plan was not comprehensive and did not cover contingency plans for situations such as adverse weather conditions or systems failure.

The provider was not compliant with their own policies and this had a negative impact on the quality and

safety of the service. For example, the safeguarding policy stated an investigation of all safeguarding concerns would be conducted. However, the provider was unable to evidence that this had taken place. The complaints policy stated that record of complaints would be held on specific complaints forms in a complaints file. Despite this, we found there was no coordinated system for identifying, recording, handling and responding to complaints.

People's feedback was not used to improve the quality of the service. In a March 2018 survey, people shared concerns about communication from the office, failure to address complaints, late calls, concerns about specific staff members and staff training. There was no action plan created to address this feedback and during our inspection the provider told us they used the electronic system to monitor and try to address late calls. This had not been effective in reducing late calls and did not address other concerns, such as, staff training and communication with the office. Consequently, these areas remained of concern during our inspection.

Feedback about the support that staff received from the provider was mixed. While some staff were positive and said they felt supported, others told us they did not feel the management team were approachable and did not feel supported. Two members of staff told us about times when they had been unwell and had been pressurised to come into work. This was also reflected in comments from people who used the service. One person told us, "You can tell the staff aren't happy with their managers." Another person said, "I don't think they ever give them any praise, they're just expected to get on with it," and a third person commented, "Staff seemed to get messed about by the office."

Sensitive personal information was not stored securely. Staff had access to electronic care records on their personal phones. There were no restrictions upon staff accessing the care plans other than when they left the employment of Midlands Home Care Limited. This posed a risk staff may access sensitive personal data for unauthorised purposes. The provider told us they could check on the system if staff had logged in outside of working hours if there were any concerns. This was a reactive measure which did not ensure people's rights under the Data Protection Act (1998) were respected.

The provider did not conduct themselves in an open and transparent way. During our inspection the provider did not readily disclose information required by us for the purposes of inspection. For example, at the start of our inspection we asked the provider to disclose any staff who were directly or indirectly related to the management team. During the course of our inspection we identified that two further members of staff, that we had not been made aware of, were closely related to the registered manager or provider. This failure to disclose the required information when asked led us to believe this information was intentionally withheld from us.

The above information was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured that we were notified of incidents at the service, which they are required to by law. There had been a failure to notify us of safeguarding incidents which had occurred at the service. A failure to notify us of incidents has an impact on our ability to monitor the safety and quality of the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.