Bradnet

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Inspection report

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Date of inspection visit: 4 - 12 November 2015
Date of publication: 31/12/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

Bradnet provides domiciliary care services to a range of client groups across Bradford. This includes people with learning disabilities, physical disabilities, elderly people and children.

A registered manager was not in place with the previous manager deregistering with the commission in August 2015. 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. A new manager had been recruited who told us they were in the process of applying to become the registered manager for the service.

Most people told us they felt safe in the company of staff who visited their homes.

However most people or their relatives we contacted raised concerns about the overall quality of the service. Prior to the inspection we sent questionnaires to people who used the service and their relatives. Of the eight questionnaires returned, six people voiced concerns about various aspects of the service. When we spoke with

Summary of findings

people during the inspection we found a high level of dissatisfaction with the service. For example, out of the 16 people or relatives we spoke with who received personal care, 15 people raised concerns about some aspects of the service and 12 expressed major dissatisfaction with the service. We spoke with an addition five people who used the service whom after speaking with them we concluded they were not receiving personal care and thus fall outside our regulatory remit. However three of these people raised significant concerns with the service. This evidence is not discussed within this report; however we passed this information to the local authority who commission the service.

A significant portion of people who used the service lived with relatives. Relatives told us that care staff often arrived late or sometimes not at all, which meant they often had to step in to provide the required care. The service did not deliver appropriate care as care workers often turned up late. We found examples of care workers not completing all the required tasks at each visit.

Risks to people's health and safety were not properly assessed and mitigated. We found risk assessment documentation was incomplete or missing from some people's homes. Following incidents, appropriate investigations were not undertaken and risks assessments were not put in place. This meant there was the risk incidents could reoccur.

Staff displayed a good knowledge of the medicines we asked them about and had received recent training in safe management of medicines. However documentation detailing the medicines people were supported with was not consistently in place.

Safe recruitment procedures were not consistently in place because assurance had not been sought that agency staff working on behalf of the provider had their backgrounds and characters checked.

There were insufficient staff to ensure a safe and consistent service was provided. 15 out of 16 people or relatives we spoke with raised timeliness as an issue and a number of people said calls were often missed. Care staff were overly stretched and there was a lack of travel time allocated to carer workers resulting in them not being deployed in the right place at the right time.

The service had taken recent steps to improve training provision with most staff now up-to-date with mandatory training. However 14 out of 16 people or their relatives said there was a lack of continuity of workers which meant care was often delivered by staff who did not know people's individual needs.

Although most people and their relatives praised some individual staff members and their kindness, 11 people or their relatives we spoke with were able to give us examples of how they had not been treated with dignity and respect by care staff or the management team.

12 people and their relatives told us their complaints were not dealt with appropriately by management. They said meetings and /or promises of positive changes failed to materialise. A complaints system was in place but it failed to record or investigate a number of complaints we identified.

A service improvement plan was in place and the manager and service director showed us their plans to drive improvement in the service over the coming months. They told us they were currently two thirds of the way through the planned improvements. However people and their relatives told us there had been no recent improvement in the service and many told us the service had got progressively worse over the last few months. This showed us the improvement plan so far to be ineffective in improving people's experiences.

Systems to monitor and improve the service were not adequate. For example there was a lack of spot checks on staff practice, and lack of review of records of daily care and medication.

We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. You can see what action we asked the provider to take at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

Summary of findings

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risks to people's health and safety were not properly assessed, monitored and mitigated.

There were not enough staff deployed at the right time to ensure a consistent and reliable service.

Medicines were not safely managed as records were not consistently in place and there was no safe system to check and review medication records.

Inadequate

Is the service effective?
The service was not always effective.

Action had been taken to address shortfalls in staff training. However people and relatives we spoke with said that the lack of continuity of carers was a significant barrier to effective care due to staff unfamiliar with people's needs providing care and support.

Most people told us they were supported appropriately at mealtimes by the provider. However we found a lack of detailed information was present to guide staff on the support required and how to manage any risks.

Requires improvement

Is the service caring?
The service was not caring.

Most people and relatives we spoke with gave us examples of how a some staff were kind and caring and treated them well. However most people and their relatives were also able to give us examples of how they had been treated poorly by care staff or the management team.

People said they were not listened to by management, and their views and opinions were not acted on.

Inadequate

Is the service responsive?
The service was not responsive. Care plans did not consistently contain enough information for staff to deliver appropriate care.

People did not receive personalised care that met their needs. Calls were often late or the second care staff did not always arrive.

Complaints were not appropriately managed. Everyone who had complained told us their complaints had not been acted on and resolved

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

People described the management team as ineffective and disorganisation and said meetings planned to address concerns failed to materialise. Despite a service improvement plan being in place people told us the service had not improved.

Systems to assess, monitor and improve the service was not sufficiently robust to identify shortfalls and drive improvement within the service.

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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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place between the 3 and 12 November 2015. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case experiences of services for older people.

The visit was announced. We gave the provider a short amount of notice (48 hours) to ensure the management team was available on the day of the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 21 people who used the service or their relatives, 16 of which received personal care from the provider. This was a mixture of phone calls and face to face conversations during home visits. We spoke with nine care workers, the service director, the nominated individual, manager and three care co-ordinators.

We looked at a number of people's care records and other records which related to the management of the service such as training records and policies and procedures.

Prior to the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information prior to the inspection as part of the planning process. Prior to the inspection, we sent questionnaires to people who used the service and their relatives asking them about the quality of the service. We received eight questionnaires back, six from people who used the service and two from relatives.

Before the inspection we also contacted the local authority to get their views on the service.

Inadequate

Is the service safe?

Our findings

Prior to the inspection we sent questionnaires to people and their relatives to ask them about various aspects of the service. The results showed that 83% of people told us they felt safe from abuse and harm from care workers, with 17% saying they did not. During the inspection we asked people about their safety. Although most people told us they were dissatisfied with or had concerns about with the service, they said generally they felt safe in the company of the care workers who visited them and delivered care.

Staff had received training in safeguarding. Staff we spoke with had a basic knowledge of how to identify and act on allegations of abuse however some staff were unsure of external agencies they could report concerns to. A system was in place to record and investigate safeguarding concerns. In some cases we found evidence appropriate action had been taken to investigate concerns and refer appropriately to the local authority. However we noted that not all concerns were logged. A care co-ordinator we spoke with told us all unexplained bruising should be logged on the safeguarding log and investigated. However we noted in one person's daily records they had been discovered with a swollen eye and on another occasion a bruise. The carer had reported this to the person's relative but not escalated the concern within the organisation. This meant this was not properly investigated to establish the cause. In addition, we found incidents and accidents were also not routinely recorded and properly investigated by the provider.

People consistently told us that when they needed support from two care workers, the second staff member often turned up late. This resulted in a delay in care and support and sometimes meant a relative had to step in to provide the support. Some people told us that on occasions the second care worker didn't arrive at all. For example one person's relative told us a care worker had rushed in, refused to wait for the other care worker and moved the person to their wheelchair. When the relative challenged the worker they told us the worker replied, "There is no law that says I can't do it myself. Even the CQC can't tell me." Following the inspection visit we asked for a list of missed calls during October 2015. The information provided showed there had been 12 missed calls in October 2015, where one or both care workers did not turn up. This was a risk to people's safety. However we concluded this was not a full reflection of the actual situation due to the comments received from people about specific missed calls not on the list, and missing entries we found on care records. For example one relative told us there had been 10 occasions in the last month when only one carer had visited to operate the hoist which was a two person job, compromising their relative's safety. However on the missed calls list there were no missed calls recorded to this person.

Risks to people's health and safety were not always appropriately assessed. Although some people had fully completed risk assessments in their care files this was not consistently so. For example we looked at one person's care file. The environment risk assessment was blank and the identified risks section had not been filled out. The risk assessment contained a lack of personalised information on how to keep the person safe. There was a more detailed moving and handling plan with pictures of equipment and advice on how to safely handle this person, dated February 2014, however when we visited this persons home this was not in the file. This person's relative told us they had concerns that moving and handling techniques were not correct and that a number of different staff provided care who were not familiar with the care and support required. Without a clear plan in place of how staff should mitigate the risks of unsafe care, there was a risk that unsafe care would be provided.

We found risk assessments had not been put in place following incidents to ensure safe systems of care were followed. For example in one person's record we saw there had been two safety related incidents, one involving choking on food and another involving entrapment between bed rails. We were concerned that these incidents had not been formally reported or investigated, or care records updated with a risk reduction strategy. Of particular concern was the fact that the manager and a care co-ordinator gave us two different versions of events regarding the choking incident which highlighted the need for a robust reporting and investigatory procedure. Despite staff supported this person with food, there was no risk assessment in place detailing how to prevent future choking and support this person safely with meals.

We found examples of risk assessments not being consistent followed. For example one person's risk assessment stated that when staff supported the person in the community, they must take a syringe with them to

administer a medicine if the need arose. The risk assessment stated they must be trained in this procedure. We identified three staff who had taken the person out for a walk in November 2015 but had not received the required training. This showed the risk assessment designed to keep the person safe was not being followed. Some other staff attending to this person on a daily basis had also not received this training which posed a risk that unsafe care or treatment would be provided should the person have a seizure.

This was a breach of Regulation 12 (1) (2a&b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We found poor channels of communication increased the risk of unsafe care. Relatives told us that getting through to the emergency phone line was often impossible. For example one relative told us, "The emergency line is atrocious." They told us they recently rang the emergency line but kept being cut off, as if someone was deliberately cutting it off and then switching the call to answering machine. Another person told us, "This morning it went straight to voicemail, rang three times nobody answered." Some staff also told us they had problems getting through to the office in an emergency situation. For example one staff member told us how following a deterioration in one person's health, they had not been able to get through to the office to receive instruction. This was a safety concern because it meant key information and advice could not always be sought to help keep people safe.

We found there was a lack of sufficient staff to meet people's needs. People and their relatives told us there were not enough staff. For example one person told us, "They don't have enough carers" and another person told us, "No there's never enough staff. Always someone different turning up. The staff turn up separately. I'm lying there waiting for them in the morning, over an hour sometimes." People and staff repeatedly told us that when two care workers were required the second care worker turned up late, meaning the first care staff member was waiting around and this had a knock on effect for the rest of the day. People said staff didn't stay for the correct amount of time. Staff told us this was because of a lack of travel time between calls. For example one staff member told us how they were expected to finish a call on one side of Bradford at 4.30pm and get to the other side of Bradford one for 4.30pm. They told us as a result they couldn't stay the full amount of time and were often late. Rota's we viewed confirmed this was the case. The care co-ordinator who managed the rota's agreed that currently there was a lack of travel time on rota's and agreed this had a knock on effect on other visits for the day. They said that people therefore received shorter calls. This showed there were insufficient staff deployed at the right places and times to ensure an acceptable quality service was provided.

We discussed recruitment with the service director, who told us recruitment had been a challenge. We saw a plan was in place to recruit an additional 10 care workers from an agency. However at the time of the inspection this was not yet fully in place.

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

We checked to see whether staff had been recruited safely. We saw evidence staff were required to complete an application form, attend an interview, provide references and complete a Disclosure and Barring Service (DBS) check before their employment began. However we found one staff member had not declared a criminal history on their application form but their DBS check revealed a criminal history. There was no risk assessment in place detailing how the risks associated with this conviction were to be managed.

Agency staff delivered care and support to a significant number of people on behalf of the provider. This involved the delivery of care to vulnerable people often in their own. However the provider was unable to demonstrate to us that any checks had taken place on these staff to ensure they were of sufficient character to be caring for vulnerable people.

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

Staff had received training in medicines. This was comprehensive training provided face to face by an external training provider. Staff told us this training had been useful and we found staff demonstrated a good knowledge of the medicines we asked them about for example in ensuring medicines to be given before food were given at the correct time. We found the provider maintained a record of Medicine Administration Records (MAR) in some people's homes. However this was not consistently applied. We saw evidence in one person's daily records that a MAR chart was unavailable, so care staff were

Inadequate

Is the service safe?

recording very brief details about administration of medicine within the person's daily records. This does not meet the requirements stated in professional guidance on the safe management of medicines in community settings and meant there was not a clear record of the medicines this person had taken. In addition, a staff member told us how a MAR chart had disappeared from another person's house so they were not able to consistently record medicine administration to that person.

The service was not able to produce MAR charts for some people we asked for. We found there was no system in place to bring MAR's back regularly to the office and check that people had received their medicines as prescribed. This demonstrated a lack of safe systems to manage medicines.

This was a breach of regulation 12 (1) (2g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Requires improvement

Is the service effective?

Our findings

Staff told us they had been provided with a range of training which included medication, manual handling, challenging behaviour and safeguarding. Records we viewed confirmed the provider had taken steps to ensure staff were provided with mandatory training and addressed recently identified shortfalls in training provision. Inexperienced new staff were required to complete the care certificate as part of an induction process. This helped ensure they had a comprehensive induction to key areas of care and support.

The provider used a care agency to provide care and support to a cover a number of care visits especially at night. However the service was unable to provide assurance that these staff had been provided with adequate training particularly given the complex needs of some people who used the service.

11 people or their relatives we spoke with raised concerns that staff did not have the required skills and knowledge to care for them effectively. People reported that new staff turned up without any formal introduction or shadowing of the tasks they needed to do. For example one person told us, “They used to do shadowing, for the new staff, but they don’t even do that anymore.” People said effective care was compromised by the lack of familiar and regular staff.” Records demonstrated a lack of continuity of staff, for example we looked at one person’s records and saw 15 different carers visited in a 15 day period between 1 and 15 September 2015. The manager told us they had problems with continuity of carers and it had been particularly different for some of the shorter visits to get staff who consistently wanted to attend these types of visits.

A number of people raised specific concerns about lack of staff skill and knowledge. One person told us staff, “Didn’t know the basics of using a hoist or how to put the belt around [their relative].” Another relative told us when they had complained to the office they were told by the service, “We can train them but we can’t give them a better brain.” Another relative told us, “No skills and knowledge of staff. They are scared, as they don’t know how to care for (person), they don’t read the care plan.” Another person told us, “The two permanent staff were great, but now they don’t move me properly. They don’t use the slide sheet properly. They don’t have any training.” One person told us that staff did not always put their oxygen mask on correctly at night. We spoke with a member of staff who confirmed to us there had been problems with some staff not doing this correctly. We looked at the persons support plan and saw there was a lack of information recorded on how to undertake this task effectively.

The service director told us there was currently a lack of competency checks in place to monitor staff skill and knowledge but this was something they were planning to introduce in the near future.

Most staff told us they had not received recent supervision. We spoke with the service director who showed us a plan was in place and supervisions were beginning to take place, however most staff were currently still outstanding.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Some people told us staff gave them choices as to how they spent their time and how they liked their care to be delivered. However others raised concerns about a lack of choice and creativity when it came to the provision of activities. People and their relatives said they did not get a choice as to their care workers and it kept changing. Relatives said that consistency of staff was very important particularly as a number of people didn’t communicate verbally. We concluded the lack of continuity of carer workers was a major barrier to effective care

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. We found where people lacked mental capacity, there was a lack of information recorded within some people’s care records on how staff should support them to make decisions for themselves. Where people lacked capacity, there was a lack of evidence that care and support decisions had been made as part of a best interest process.

Requires improvement

Is the service effective?

We recommend the provider consults appropriate guidance to ensure it consistently acts within the legal frameworks of the Mental Capacity Act (MCA) 2005.

Policies were in place detailing how to support people effectively at mealtimes. People generally told us, where required, they were supported appropriately at mealtimes. However we found there was a lack of information present on how to support some people properly, including their likes and dislikes and how to mitigate any risks. We saw some of the call times were not conducive to providing appropriate support at lunchtime. For example one person told us how they had to wait for lunchtime support on a number of occasions due to a lack of staff for this call which left them hungry. A staff member we spoke with told us that visits to that person were late as they didn't have any permanent staff for the short lunchtime call.

We saw evidence the service had liaised with health professionals were appropriate and recorded their views to help ensure effective care. One relative told us how a hospital trip had been managed well by the provider. However there was a lack of person centred information in some people's care about how to manage their individual health conditions.

Inadequate

Is the service caring?

Our findings

Prior to the inspection, we asked people to complete questionnaires about the quality of the service. 83% of people told us that their care and support workers were kind. During the inspection, some people described individual carers as caring and respectful and said they had developed good relationships with them. A number of people who cited other problems with the organisation said these relationships were the main reason they had chosen to stay with the care provider. However overall, most people told us they felt they were not treated with dignity and respect by the provider as a whole. One person told us, "I don't feel cared for. They're not compassionate" and another person told us, "No I'm not treated with dignity and respect."

A number of people told us about specific examples where staff had been rude or not treated them well. From these comments we concluded there was a large variation in the manner and attitude of staff who worked on behalf of the provider. For example one person told us, "some carers shouldn't have been given jobs." Another person told us, "They wear their coats in the bedroom; they don't even take them off. I want to feel cared for." A relative told us of an instance when they had raised an issue with a care staff member that they were not carrying out the required care task, after which the staff member had stormed out of the house and not completed the care shift. They said they hadn't been apologised to appropriately by the provider following this and other complaints.

Another relative told us of a recent example where a member of the management team came to their house to take pictures for a manual handling risk assessment but they had failed to engage with the person or their relative. They said as a result they felt unvalued and felt it was more of a paper exercise.

Three relatives complained to us that staff were often on their mobile phones rather than interacting with their relatives. For example one relative told us, "The carers just sit there on their mobile phones, they don't interact with [relatives name]." Another person complained of a care worker taking calls during care and support and another said that staff were, "Always texting" during care and support. Another person told us how during the hoisting of their relative, staff had been talking amongst each other. This showed a lack of respect towards people that used the service.

We looked at daily records of care and saw a recent incident occurred in one person's house where two care workers had an argument in front of a person receiving support causing distress. In addition to being concerned that this incident took place at all, following the incident the relative told us they were very unhappy as they had not yet been apologised to by the service or even asked for their version of events as part of an investigation.

During the inspection the service director said that they had identified some issues with some staff attitude and practice, but were taking action to address this.

Questionnaire responses received before the inspection showed 67% of people said that they were not introduced to care workers before they provided care. This was confirmed by people and their relatives we spoke with who told us, "Strangers" delivered care regularly. Relatives told us how uncomfortable this made them and their relatives feel particularly as these people were delivering intimate personal care often to people with learning disabilities who liked a fixed routine. One relative told us how they were so uncomfortable with strangers assisting with personal care that they now refused access to the house to anyone who hadn't been before. They told us they had no doubt that the organisation would keep sending unfamiliar workers if it wasn't for them taking this stance. We saw comments from relatives recorded in care plan reviews confirmed these sentiments. For example in one person's records it was recorded "[person] is very distressed and I am shocked that you are continually sending new carers knowing that [person] will get upset and distressed."

The manager told us staff were currently not provided with a uniform but this was something they were due to implement shortly. Relatives told us this was problematic and that staff often did not carry ID and were therefore unsure who was coming into their house. One person told us, "They don't have a professional appearance. No they don't wear a uniform or anything." Another relative told us how, "Inappropriately dressed ladies" had come into the house to deliver care to their relative and another person told us staff on occasions arrived in nightwear. This highlighted the need for an appropriate and consistent standard of dress.

Inadequate

Is the service caring?

People told us when they had requested female care workers this choice was respected by the company. However two people told us that they had repeatedly asked for male only workers but the service was not consistently providing this. During a home visit we saw a female member of staff attending to a visit where male only staff had been previously requested. This showed a lack of respect of people's choices and preferences. People told us that they did not find out in advanced who was to deliver their care and support. For example one person told us, "We never get any information. No, no rotas, no phone calls." Another person told us, "No we don't get a rota. No we don't get a choice." People said this caused anxiety for them, for example one person said change and unfamiliarity led to their relative becoming distressed. A number of people told us due to their relative's complex needs they could not verbally communicate. They told us that unless consistent staff came, they would not have the knowledge to communicate effectively. On reviewing one person's records we saw care and support was provided by 15 different staff members in a 15 day period in September 2015. The person's relative raised continuity of carers as a concern. This showed a lack of respect from the organisation towards this person.

A consistent complaint raised by people and their relatives was that people told us they were never informed if staff were going to be late. People and their relatives told us they told us they constantly had to ring the office to find out what was happening and they didn't get a satisfactory response. For example one person told us, "If I ring the office they just say 'we will see where they're at'." Another person told us, "No, no one rings to tell me they are going to be late or who will come, no." Staff we spoke with confirmed this was an issue and there were not systems in place to inform people if care workers would be late. This showed a lack of respect from the organisation towards people and their relatives.

This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We saw people's views had been asked for as part of care plan review. These were clearly recorded. However there was evidence people's views had not been acted on. No plan was in place to address negative comments recorded by people as part of these reviews. Where concerns had been raised previously, all the people we spoke with said their concerns had not been acted on. People told us they did not feel valued by the organisation and they weren't listened to. This demonstrated the organisation was not caring in addressing the issues important to people.

Inadequate

Is the service responsive?

Our findings

People's needs were assessed prior to the delivery of care. A detailed assessment of needs document was produced for each person and a summary sheet for quick reference. The manager told us that the summary sheet was the main source of information for staff during care visits. However, these did not contain enough person centred information for staff to deliver appropriate care; for example one person's summary sheet we looked at was missing details of the emergency medication arrangements needed to help keep the person safe. Another two people's assessment of needs documents said that staff should read to them if they had time after delivering personal care. However this was not on those people's summary care sheet and one person's relatives told us that staff never read to them and often left early instead. Daily records we viewed confirmed this.

Questionnaire responses showed that only 50% of people thought that staff completed all the required tasks during care visits and people we spoke with also said this was the case.

Some people spoke positively about the care and support received, especially when familiar staff provided care. They said these staff provided a consistent routine in the delivery of appropriate care. However other people raised concerns about some staff. For example one person told us, "Yeah, they'll wash my top half one day and bottom the next. I should have got a wash today but I didn't," This person also told us, "They put my sock on the wrong way, it was blocking the circulation. I had a black line on my leg." A relative told us how care staff had not monitored their relative's foot properly resulting in an infection. We concluded that a lack of personalised information in care plans and constant changes in staff contributed to this suboptimal care.

15 out of 16 people or relatives that we spoke with raised the timeliness of care staff arrival as an issue. Care review documents we looked at also showed this was people's primary concern. Care workers were required to write the time they entered and left people's homes in the daily log of care. We saw examples in daily records of carers arriving late and/or not staying for the correct amount of time. For example one person was required to have an hour call by two care workers between 8am and 9am. Records showed the first care staff arrived at 8.00 and left at 9.10am but the second care staff arrived at 8.30am and left at 9.10am. This showed a reduction in the call time and disruption caused by the second carer arriving late. Evening visits for this person were regularly less than the agreed hour, for example just 35 minutes on 4 October 2015 and 45 minutes on 3 October 2015. As another example on 1 October 2015, one care staff arrived at 5.50pm and another at 6pm, but both left at 6.20pm. The person's relative told us they were very concerned that staff were always late, and they didn't stay the right amount of time. The person's care plan said that if there was time carer workers should read to the person. The relative told us this did not ever happen. This showed the agreed care was not being delivered.

In other daily records we saw similar occurrences. For example in one record a care worker arrived at 2pm and the other carer was an hour later. In another record we saw an instance where one carer arrived at 12.00pm and the other at 12.45, this meant a delay for 45 minutes as two staff were needed for moving and handling. We also saw an instance in this person's records where the carer did not turn up at all, which meant the person's relative had to assist in providing the required care. We spoke with this person's relative who told us late staff and lack of a second care worker was a regular occurrence and that the records did not reflect the extent of the problems. This demonstrated inappropriate care and treatment.

A high proportion of people who used the service lived with relatives and we were informed of similar experiences from other people and relatives. Relatives told us consistently that where two care staff were required, the second care staff often turned up late, meaning they had to step in to provide care. Another person told us, "Two carers were due to come at 8 pm and only one turned up on time but she was not trained on how to operate or push the wheelchair. The next care came at 8.45 pm and blamed the company for not sending transport to pick her up. This meant that there was only ten minutes where there were two carers which meant [relative] had to do most of the care call herself."

Another person told us that in the last month there had been 10 times were carers had not turned up at all and 50% of the time they did not turn up together (meaning one care staff was at least 10-15 minutes late).

However, we were concerned that the times written in the daily records were often not correct, masking the extent of the problems. Four relatives independently told us that the

times staff wrote in the book were not always correct and that staff were covering up the lateness of calls or the fact that only one care staff had been present. For example one relative told us, 'If you see the timesheets, according to them they arrive bang on time every visit and leave bang on time. Well, you know, no one is ever anywhere bang on time every time. That should be a warning bell to the office." We viewed the daily records of another person whose relative told us had major concerns about timings. Visits were scheduled to happen three times a day. Arrival and departure times were often recorded exactly as per the agreed time with no deviation at all. From this, the testimony of this person as well as, other people's relatives and staff we concluded these times were unlikely to all be correct.

The manager told us they currently didn't have double up runs which meant staff were coming from different places to attend double up calls. They told us this was why they experienced issues with the second care worker arriving late. We identified from care rota's and speaking with staff that staff were often not provided with travel time. Seven staff we spoke with told us this was an issue. For example one staff member told us how they had to finish a visit at 4.30pm and then get to other side of Bradford for 4.30pm meaning they were often very late and the other carer was waiting for them. This meant staff could not arrive on time and stay for the correct amount of time.

We found people's preferences were not always respected with regards to care and support. A number of people who used the service had complex needs and their relatives told us familiarity of care staff was essential. People, staff and daily records confirmed that there were a number of different carers turning up. We found this was a barrier to providing responsive and personalised care.

People told us that language barriers were dealt with effectively with a number of staff working for the provider who could speak with them in their native south Asian languages. The service took some steps to meet people's religious needs for example planning visits around religious services. However we concluded the service had not taken adequate steps to make reasonable adjustments to meet people's individual needs. For example we saw one person had signed to say they consented to their care and support, yet we were told they did not read or speak English. We saw the service had started producing laminated pictorial sheets to assist this person however at the time of the inspection they were not in place. During a home visit another relative told us they did not understand the care and support plan as it was in English and they did not speak English. There was nothing provided in an appropriate language or pictorial plans of care. This showed a lack of making reasonable adjustments to meet people's individual needs

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

Although people told us they knew how to complain, they consistently told us that their complaints were not appropriately managed by the service. One person told us, "There was supposed to be a meeting, but no one turned up. When I rang to see where they were, they just said they had a lot of training on that day." Another person told us it had been six months since they made a complaint and there had been no response. They said then they rang the office they were told it was because managers kept leaving and there was no management to deal with their complaint. A third relative told us they had made a complaint about poor care and support three months previously, they had a letter acknowledging but never a proper response. Questionnaire responses received prior to the inspection, showed that only 20% of people thought "The staff at the care agency respond well to any complaints or concerns I raise", with 60% stating they were not and 20% saying they did not know.

Records we viewed confirmed complaints were not appropriately managed. We found many issues raised in care reviews and people's care records were not logged as complaints on the complaints log and appropriately responded to, and these people told us the concerns had not been resolved. For example in one person's records we saw that it had been reported that a carer fell asleep on shift. We raised this with the HR manager who knew nothing about this and it was not logged as a complaint.

Staff we spoke with also raised concerns with us that the office did not effectively deal with complaints. People, relatives and staff reported that the office did not respond to phone calls.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Some people receiving personal care were also taken out into the community for activities and social inclusion. However relatives we spoke with raised concerns that staff

Inadequate

Is the service responsive?

were not all trustworthy and they did not know what took place when they were taken out into the community. One person raised concerns that their relative was taken to the supermarket for the benefit of staff rather than to meet their needs. We saw there was a lack of structure to care and support with regards activities, for example a lack of aims, objectives and checks to ensure that the service was meeting people's needs in this area.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in place. The previous registered manager had deregistered with the commission in August 2015. A new manager had been recruited and told us they were in the process of applying to become the registered manager for the service.

The provider had correctly submitted a number of statutory notifications to us. However the service had failed to notify us of two allegations of abuse which found when reviewing records. We warned the provider of its need to ensure these types of incidents were promptly reported to us in the future.

Most people or their relatives we spoke with raised concerns about the overall quality of the service. For example out of the 16 people or relatives we spoke with who received personal care, 15 raised concerns about some elements of the service and 12 expressed major dissatisfaction with the service. A number of people told us they had either made arrangements to leave the service or were in the process of doing so due the level of dissatisfaction. Re-occurring concerns people raised centred around timeliness of carer workers, care workers not arriving at all, a lack of response from management to their concerns, and poor working practices delivered by staff unfamiliar with the care and support required. Some of the comments from people included: “In some ways good, in most ways very bad”, “Complete disorganisation,” “Bradnet don’t know where staff are and what they are doing” and, “I’m really not happy. Even if I had a full day I couldn’t tell you how much is wrong.”

During the inspection, the manager and service director told us they recognised there were a number of quality issues which needed to be addressed. The management were open with us about the improvements that needed to be made. The service director told us, “We are transitioning and fully accept it’s not a fully completed job, we are two thirds of the way through the process.” We saw a structured service improvement plan was in place with the aim of ensuring key improvements were made across the service. Some recent improvements had been actioned, for example in the provision of additional training and recruitment of senior care staff to help ensure more oversight and monitoring of care and support. However when we asked people, their relatives and staff whether any recent improvements had been made to the quality of the service they told us they had not with a number of people saying the outcomes for people had become progressively worse. For example, a staff member told us that the service had been fixated on improving documentation but the delivery of care had suffered as a result. This demonstrated the improvement plan had not yet been effective in improving people’s experiences of the service.

Of particular concern was people’s perceptions about the effectiveness of management. A number of people told us that when they complained, the office would encourage them to stay with the service and make promises about how it would improve, only for the problems to resurface a few weeks later. One relative told us, “We have had a few meetings; they tell us things are going to change but they don’t.” Another relative told us, “This has been going on so long. Four months ago we asked to leave. They came and asked us to give them one more chance.” Another person told us, “This place has gone down the toilet; I rang and said, how can you call yourselves a care company, there is no care.”

People and relatives told us when they did raise concerns, management did not get back to them and meetings failed to materialise. For example one person told us, "I get sick of telling them (about staff not arriving, poor training and lack of rapport"). People and relatives consistently told us it was difficult to get in touch with the office. For example one person told us, “Trying to call out of hours or their emergency line is not the best. They leave the phone off the hook.” Some staff also confirmed it was difficult to get in contact with the office. Some staff also raised concerns that management did not meet with people and address their concerns properly.

This demonstrated to us that effective action had not been taken to listen to people and improve the quality of the service.

Systems to assess, monitor and improve the quality of the service were not adequate. Some quality assurance reviews and telephone monitoring visits were undertaken by the provider. However following these, we found the service had not acted on people’s feedback about the quality of the service to ensure continuous improvement. For example we looked at quality reviews that had been carried out with people and their relatives in July and August 2015. These raised concerns about a number of issues, for example around lateness of calls. However where issues

Is the service well-led?

were identified, there was no action plan in place detailing how the issues were resolved and the timeframe. When we spoke with these people or their relatives they told us these issues had not been resolved, showing improvement had not been made.

Although the management told us concerns people raised helped inform the service improvement plan, there was a lack of mechanisms to respond and action specific improvements in response to people's individual experiences.

Due to people's complex needs, a large proportion of the people supported were unable to express their views in relation to the care and support received. Some relatives raised concerns that they did not know where staff took their relatives when they took them out in the community for care and support. One person expressed concerns that they were taken to the supermarket for the benefit of the carers rather than their relative. There was an absence of spot checks to confirm that the correct level of support was being provided. Systems were not in place to review daily records of care to ensure they were completed correctly, people were receiving the correct care and support and their objectives were being met. Similarly there was no structured approach to reviewing medication records to ensure people were receiving their medicines as prescribed. Accidents and incidents were not routinely recorded, for example we found two incidents which had not been recorded as accidents. Without knowing the number of accidents and incidents the quality and safety of the service cannot be appropriately assessed, monitored and improved.

On the Provider Information Return (PIR) submitted to the Commission prior to the inspection, the provider stated that five visits were missed in the seven days before its submission. However when we asked the manager for the source of this information and whether they maintained statistics on the number of missed calls for the purpose of monitoring the quality of the service they told us they did not know. Following the inspection we requested this information. However the fact that it was not being routinely monitored and clear action plans put in place where calls were missed showed a lack of systems to assess, monitor and improve the service. In addition, the PIR stated that there had been 17 medication errors in the previous 12 months. When we asked about this there was no log of this information or any actions or learning to prevent a re-occurrence. There was no routine analysis of complaints by the provider to look for trends and themes.

In addition, four relatives told us they were certain that late call times were not recorded in their relative's daily records and therefore daily records masked the extent of the timeliness of care staff visits. There was a lack of systems in place to verify whether staff were attending to calls on time. The provider planned to introduce an electronic call monitoring system but this was not in place at the time of the inspection. In addition, there was a lack of routine spot checks on staff visits. Given that we identified a number of problems with timeliness of calls, appearance, dignity and respect, this was of great significance. These issues could have prevented and rectified by the operation of an appropriate system of quality assurance. The service director told us extensive spot checks could now be carried out as they had recruited senior care workers who started the week of our inspection.

In addition to a lack of spot checks, staff told us they had not had a recent supervision, although we saw there were plans in place to address this with supervisions now booked in. One staff member told us how they had to consistently chase senior management to request a supervision. Given concerns raised about staff quality, a robust system of supervision could have helped address this.

Some people told us that care records were not always in place. For example one person told us, "I only got a care plan two weeks ago and it's already out of date. During home visits we identified missing documentation. For example one person we visited didn't have a support plan identifying the tasks required at each visit, and another person was missing one page of their support plan.

We looked at daily records of care. A number of these showed gaps where we could not establish whether people had received visits. In a number of cases after speaking with people we confirmed people had received visits but these had not been documented. This meant there was not a complete record of the care each service user had received.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) (2a)** **There were insufficient quantities of suitably qualified, competence and experienced staff deployed.** **Staff had not received recent supervision.**

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) (2a),(2b),(2g)** **People who use services and others were not protected against the risks associated with unsafe care and treatment because medicines were not managed safely. The service had not done all that was reasonably practicable to assess and mitigate risks to people's health safety and welfare.**

Regulated activity	Regulation
	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19 (2) (3)** **Recruitment procedures were not established and operated effectively.**

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (1)**

This section is primarily information for the provider

Action we have told the provider to take

Service users were not treated with dignity and respect by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (2b)(2c) Care and support was not appropriate and did not meet people's individual needs. Steps were not taken to enable and support relevant persons to understand the care available to the service user.

The enforcement action we took:
We issued a warning notice to the provider requesting them to make improvements by 15 January 2015.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 (1) (2) Complaints were not investigated and necessary and proportionate action taken in response to any failure identified by the complaint or investigation. The registered person was not operating effectively a system for receiving , recording, handling and responding to any complaints.

The enforcement action we took:
We issued a warning notice to the provider requesting them to make improvements by 15 January 2015.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2a)(2b)(2c)(2d)(2f) Systems were not in place to assess, monitor and improve the quality of the service. An accurate and complete record of each service user was not maintained.

This section is primarily information for the provider

Enforcement actions

The service had not acted on feedback from relevant persons for the purposes of continually improving the service.

The enforcement action we took:
We issued a warning notice to the provider requesting them to make improvements by 15 January 2015.