Special Seven Limited

Special Seven Care (Beds)

Inspection report

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Date of inspection visit:
22 August 2018

Date of publication:
15 November 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Special Seven is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

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

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

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

Not everyone using Special Seven receives a regulated activity; the Care Quality Commission (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 this inspection Special Seven were supporting 24 people.

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

We carried out a comprehensive inspection of this service on 22 August 2018. We had inspected Special

Seven in March 2017 and then again in December 2017. This was following concerns raised about the quality of care which people were receiving. At that inspection the service was rated as Requires Improvement overall with a rating of Inadequate in safe. The overall rating for this service at this inspection is 'Requires Improvement' with Inadequate in well led.

We found that safe staff recruitment processes were not being adhered to. We also found this at the last inspection, but despite some improvements being made, we still found short falls in this area. Two members of staff did not have up to date disclosure and baring service checks in place. Staff did not have full employment histories. Some staff only had one reference and there was no evidence that second references had been followed up.

A concern about a person's safety had been raised by the service. However, this had not been processed in a safe way with the local authority. There were short falls in staff's knowledge about how to protect people from experiencing abuse and discrimination.

We found that people's risk assessments were not always complete. Some of the risks which people faced daily had not been identified and explored at people's assessments. The accompanying care plans did not fully outline the support people needed to ensure people were safe.

People were not always being supported to receive their medicines in a safe way. The checks the management of the service completed about this were not always effective. We also found examples when the service did not promote people's physical health and respond to situations when people were or could be unwell.

The service was not compliant with the Mental Capacity Act 2005 (MCA). Consent to care and to share personal information with other individuals and organisations was not always fully obtained. Relatives who did not have the legal powers to do so, consented on their relative's behalf to agree to care. Although people said staff asked for their permission to support them with personal care tasks, the management of the service were not fully promoting people's rights in this area. The service had assessed people's capacity to make decisions, but these assessments were not complete.

When something went wrong lessons were not always taken from these situations. The leadership did not consider what went wrong, and what they could do to try and prevent a similar situation from happening again.

The management and the provider of the service were not completing robust and meaningful audits to test the quality of the service provided. When some records were being audited key issues with these documents were not identified and investigated further.

The management team and the provider had not responded to potential concerns about the culture of the staff team. Systems were not in place to ensure poor practices did not happen again.

The management of the service were not sharing certain events which they must do by law, with us at the Care Quality Commission (CQC) or displaying their rating from the last inspection.

The management of the service did not have a clear knowledge of the most vulnerable people the service supported. They did not have a robust emergency contingency plan in place.

We found that there were gaps in staff's knowledge and understanding of certain areas important to their

work. The training provided did not reflect all of people's needs and how to support them

We had some mixed responses when we asked people if they found staff kind and caring towards them. Most people said that staff were kind and caring, but some people had commented that some members of staff were not kind to them. When this was identified or inferred at people's reviews, these comments were not investigated further.

These issues constituted breaches in the legal requirements. There were six breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People and their relatives spoke positively about how the service and the management of the service had improved since last December. People now told us that they received care visits when they generally wanted them to take place. They also confirmed to us that they saw a regular group of staff who they felt knew them well.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Safe recruitment processes were not always being followed.

Processes in place to protect people from avoidable harm were not followed.

People did not have complete risk assessments in place.

Plans to support staff to ensure people were safe were not complete.

People were not always given their medicines in a safe way.

People said they felt safe with staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not compliant with the Mental Capacity Act 2005.

We found shortfalls in some staff's understanding and knowledge of important areas to their work.

The management of the service was not checking if staff training was effective.

Competency checks on staff were not well evidenced.

The service did not always promote people's health.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people told us that staff were always kind and caring towards them. Other people told us that this was not always the case.

When the service identified potential issues with how staff

treated people, they did not follow these situations up and investigate further.

People told us that staff protected their dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have full assessments and care plans which reflected their needs.

Action was not taken when issues were identified at people's reviews.

People did not have end of life care plans in place.

People said that staff visited them when they wanted them to and they saw regular members of staff.

Is the service well-led?

Inadequate

The service was not well led.

The quality of the service was not being meaningfully monitored.

Audits were either not effective in identifying issues or were not taking place.

There was no monitoring of the culture of the service. Actions were not taken when potential indicators of a poor culture were identified.

Improvements had been made to ensure that people received care visits at times they wanted with a regular group of staff.

Special Seven Care (Beds)

Detailed findings

Background to this inspection

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

We gave the service 19 hours' notice of the inspection. This was because we wanted people's permission to talk to them before we telephoned them. The inspection started on 21st August 2018 and ended on 22 August 2018.

The inspection team consisted of one inspector.

Before the inspection we had been in contact with the local authorities' contracts team to ask them for their views on the service. They had concerns about the care people received and how the service was being managed. We looked at the notifications that the registered manager had sent us over the last year. Notifications are about important events that the provider must send us by law.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with seven people who used this service, and five people's relatives. We also spoke with five members of staff, the office manager and the registered manager. We looked at the care records of five people, the medicines records of four people and the recruitment records for three members of staff. During our visit we also reviewed the systems and documents available to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We inspected Special Seven in December 2017 and found that the service was not safe. When we visited in August 2018 we found that some improvements had been made. However, further work was needed to make the service consistently safe.

When we inspected in December the registered manager had not ensured that there were safe recruitment practices in place. At this inspection we also found unsafe recruitment practices. For example, out of the three staff files we looked at two members of staff did not have full employment histories. One member of staff had had a Disclosure and Baring Service (DBS) check completed when they first applied to work at the service. They soon left the service and returned some months later. A new DBS check was not carried out. We needed to explain why this was important, to the registered manager. Another member of staff who had access to sensitive information did not have a current DBS. This was only identified when we asked the registered manager if the office staff had DBS checks.

One member of staff had only one returned reference from their previous employer which the service checked. There was no evidence that the service had tried to pursue the second referee for a reference. Another member of staff also had only one reference. Again, no attempts had been made to obtain a second reference.

The above issues constituted a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff had identified a potential safeguarding concern earlier this year. We saw recorded that they had e-mailed the local authority safeguarding team about their concerns. This is not safe practice, they should have telephoned their concerns to this team and completed a formal process for reporting these concerns. There was no further action recorded regarding this matter. This person's relative later gave an explanation for these concerns. Safe processes had not been followed in this situation.

When we spoke with staff about protecting people from potential harm and abuse, we found that not all staff had a clear understanding about this. Three members of staff who we spoke with needed to be guided about what abuse could look like, and how they needed to be mindful of these potential signs of abuse. None of the staff we spoke with knew about the local authority safeguarding team, which they could also report their concerns to. One member of staff said they would inform a relative or a member of staff about their concerns. This is not safe practice and this could undermine a potential safeguarding investigation.

Three members of staff out of the five we spoke with did not have a clear understanding about what discrimination could look like in relation to the people they supported. We asked staff if they were aware that certain groups of people were more vulnerable to experiencing discrimination than others. Only one member of staff was aware of this and could explain this to us. No member of staff told us that older people were vulnerable to experiencing discrimination because of their age, even though the service was

predominately supporting older people.

At this inspection we found that people did not have robust risk assessments in place. We looked at a sample of six people's records. We found that the risks which people faced were not explored in any detail. The potential impact of these individual risks were not considered. For example, one person was living with a breathing condition that was not considered at their assessment. In other cases, people's risks were identified but they were not fully explored. For example, one person was living with advanced dementia and could express aggressive behaviour to staff. They were also at risk of self-neglect. Their behaviour was identified, but how staff should manage these situations and this risk of self-neglect was not explored.

When we looked at people's risk assessments, there was some contradictory information. For example, two people were at high risk of falls and then in another section of their records, it said they were not. Some of people's needs were not explored. One person wore a catheter, but this was not identified at all in their assessment or care plan. We only found this information out by looking at this person's daily notes. This could put people at risk of unsafe care. There was no clear and detailed plan for staff to follow or to be shared with staff before they started providing care to people.

People's accompanying care plans did not identify all the needs which people had with a step by step guide for staff to follow. The purpose of these plans was to support staff to keep people safe. We looked at two people's records who were at risk of a break down to their skin. There was reference to creaming their skin but it did not tell staff where to apply the cream. On one of these people's care plans it did not advise staff to be mindful of a potential breakdown to a person's skin. This person's skin had only recently just recovered from a breakdown to their skin which required district nurse intervention. The positioning of their reclining chair and hospital bed was not identified in their care plan. Some people wore catheters but there was no guidance for staff about what good catheter care looked like. Some people were being hoisted in order to move from one position to another. No reference about how staff should go about this was made in people's plans. This could put people at risk of injury through unsafe moving and handling practices.

We looked at people's Medication Administration records (MAR) to see if people had been given their medicines as prescribed. One person's MAR had gaps in it where staff had not signed to say the person had had their medicine. We spoke with the registered manager about this and they were unable to offer us an explanation. We also noted that this person had started taking a new medicine but it was not recorded on the MAR with the date this should have started from. We showed this to the registered manager and they agreed this should have been recorded on this person's MAR. This person's MAR had not been audited, but it had been returned to the office and filed with no action taken to address these matters.

A person had been unwell and a member of staff had recorded that a district nurse had told them to stop giving this person a particular medicine. It was recorded on this person's MAR that, "District nurse said not to give [name of medicine] for the moment." This was on 5th July and this practice of not giving this medicine continued until the 31st July. There had been no contact made with the GP on this person's behalf about when or if the administration of this medicine should resume. We needed to ask the registered manager to follow this up. This person could have been placed at risk of being unwell and the service had made no attempts to clarify this situation. This person's MAR had been audited but these issues had not been identified at that point.

The service was not consistently recording and acting on incidents that took place. Some events that occurred were not being identified as an 'incident' with action taken to respond to this incident and reduce the likelihood of it happening again in the future. A member of staff told us that a person had recently fallen and paramedics were called. How this situation was initially dealt with was positive. However, this event was

not identified as an incident with action taken to see if the service could prevent this from happening again. Staff told us that one person who they supported who was living with advanced dementia regularly hit or threatened staff. These were not recorded as incidents. There was no analysis of why these events had taken place to support the service to learn from these events and make improvements to the care provided.

There was an emergency contingency plan in place. However, when we looked at this we found that it was not robust. It did not give clear and specific guidance to ensure people could remain safe in particular emergencies. For example, in the event of severe weather, the service did not have a record of the most vulnerable people who would require attention first. Their plan said that these people should be made a priority, but the service did not know who these people were. The service had also not shared and explained this plan with the staff who may have to deal with or be part of those dealing with certain emergencies. When we discussed this with the registered manager we saw them making plans to address this issue.

There was also no plan in place to deal with a sudden reduction of staff. The registered manager told us that Christmas time can be difficult as in the past some staff leave the service to work elsewhere. The management of the service had not created a plan to manage this situation. This meant that people were at risk of potentially not receiving care visits during this time, as there was no robust plan in place to manage this known situation.

The above issues in relation to risk assessment and medicines management constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe around staff. People's relatives who we spoke with also said this. One person said, "Oh yeah, they [staff] always treat me alright." Another person told us, "I feel safe with them [staff]." A person's relative said, "I have no concerns (about their relative's safety)."

People told us that staff arrived on time and staff stayed their allotted time. Staff confirmed this and told us that they did not feel pressured to rush a care visit or leave before they ought to. Staff told us about examples of when they needed to stay longer in order to support certain individuals. We concluded that there were sufficient numbers of staff to support the people who used this service.

Staff told us that they wore particular gloves and aprons to prevent the spread of infection. Staff were clear with us about the importance of this and the processes they go through to protect people against poor hygiene and infection. One person told us, "Oh they [staff] always have gloves on."

Requires Improvement

Is the service effective?

Our findings

When we inspected Special Seven in March 2017 we found that staff were providing effective care to people. However, we needed to inspect the service again in December 2017 because of concerns raised about the service. When we inspected in August 2018 we found areas which required improvements to be made.

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.

When we looked at people's records we saw that, in some cases, their relatives had signed consent on their relatives' behalf to receive care and to share their personal information with others. However, the service had not checked if these relatives had the powers to do this, such as Power of Attorney for health and welfare matters. One person's file contained a consent form signed by the person themselves. In this consent form it identified the professionals who this person was giving permission to share information with. This is good practice. However, other people's records which we looked at did not have this information contained in their consent form. The consent form also did not explain in what circumstances the service would be sharing people's information with professionals. When we spoke with the registered manager about these issues of consent they agreed that the service needed to review how they gained and recorded people's consent.

The service had completed mental capacity assessments in some cases. In these the assessor was making a judgement that these individuals did not have capacity. However, these capacity assessments were not robust. They did not explain how the assessor had reached this decision. Nor were the assessments decision specific. There was also no plan to support the service to manage how decisions would be made on behalf of the individual lacking capacity. The rationale provided by the assessor was that a relative had needed to intervene and answer questions on their relative's behalf. We spoke with the registered manager about this. From looking at the examples of capacity assessments we showed them, they agreed these were not appropriately completed assessments.

When we spoke with staff about MCA staff said they had received training in this area. However, with the exception of one member of staff, staff struggled to explain how they promoted choice when they supported people. These members of staff had not fully considered the significance of this. When we asked one member of staff about how they encouraged choice when they supported people they said, "How do you mean?" As a result of all of these issues we concluded that the service was not compliant with the MCA.

The above issues constituted a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff were uncertain about how they promoted choice and sought consent, people told us that staff did ask their permission to complete certain tasks. People also said staff offered them choices. One person said, "They [staff] know what I like, but they still ask."

During this inspection we considered if staff had the training and knowledge to perform well in their work. We could see that staff had up to date training in key areas of their work. This included infection control, health and safety, medication administration, safeguarding and equality and diversity. However, we found shortfalls in staff knowledge and understanding of some of these areas. The staff we spoke with spoke positively about the training they had received, but they could not tell us how or why the training was good. We also noted that staff did not receive training in some areas relevant to the people the service supported. For example, in dementia care, Parkinson's disease, and pressure care.

Staff spoke positively about their inductions to their job. They received training face to face over five days and then spent time shadowing experienced staff. New staff would generally continue to work as part of a 'double up' with another experienced member of staff. However, we looked at one member of staff's training record which contradicted this. They had completed their training as part of their induction in the August. They had then left the service before they provided support to people. They later returned in January after submitting a new application to work at the service. They did not receive this training again. They had not worked in the care sector before. There was no checking to see if they had retained this training. We were told that this member of staff's first care visit was on their own.

We could see that staff had regular competency observations in relation to their daily work. People also told us that these checks took place. However, when we looked at these competency records, the assessors had not evidenced why or how the member of staff was competent. Examples where not given to evidence the outcome that the member of staff was competent. We spoke with the registered manager about this who agreed that these records lacked detailed examples.

At no point were staff being asked questions about their work to see if they had understood and retained the training in certain areas of their work.

Staff did have a competency check during their induction. Again, this was not evidenced to show how they were competent. These members of staff only had one competency check during this time. We were told by the registered manager that staff were spoken with to see if they felt confident to start working. However, this conversation was not formalised or recorded. No further checks were completed to satisfy the registered manager that individual new staff were ready to start working.

Alternatively, when we looked at staff's medication competency assessments these were detailed assessments. The assessor had evidenced how the member of staff was capable in this area. However, staff only had one competency check to see if it was safe for them to administer people their medicines. One member of staff's medication competency implied that they had been supporting people with their medicines before their competency assessment took place. This issue had not been identified by the registered manager.

In conclusion systems were not in place to test the effectiveness of the training that staff received. Nor to give the registered manager assurances that staff were competent in their work.

The above issues constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day we visited Special Seven's office we heard that a member of staff had called the office to share their concerns about a person being unwell. The office manager then contacted the family to share this concern. When we looked at another person's care record we could see that a member of staff had spoken with their relative to advise them to call their relative's GP because they were also unwell. We later saw recorded that their GP had visited them. However, during the inspection we became aware of two other occasions when action should have been taken about a person's ill health and the level of pain they were in, but no action was taken. We spoke with the registered manager about these two situations and they agreed action should have been taken and this should have been recorded.

We looked at one person's record who was at risk of being an unhealthy weight. We could see that the member of staff had recorded what this person liked to eat, and how they liked to eat their food. We saw examples of what other people liked to eat and drink in people's care assessments. However, this was not always consistently the case.

People told us that when applicable staff supported them to have enough to eat and drink. We asked one person if the food looked appetising when staff prepared them a meal, they said, "Oh very." Another person said, "They make me sandwiches with spreads and give me fruit, it always looks nice." A person's relative told us how staff stayed with their relative to check they were ok and if they needed support. They said, "If [name of relative] is having soup, they [staff] will help. They keep an eye on [name of relative]."

Requires Improvement

Is the service caring?

Our findings

When we inspected Special Seven in March 2017 we found that the service was caring. We needed to inspect the service again in December 2017 because of concerns raised about the service. At this inspection in August 2018 we found that improvements were still required and although people and their relatives told us that the service had improved, the feedback we received still varied.

One person's relative said, "They [the management] have really pulled their socks up since Christmas." Another person's relative said, "I wouldn't have recommended them [Special Seven] then (last year) but I would now." This told us that people's relatives were now happy with how the service treated their relatives.

We asked people if staff treated them in a kind and caring way. One person said, "They [staff] are brilliant, I have no complaints." Another person said, "I'm very happy with them, they always ask if I need anything else." Another person's relative said, "The staff, have all been lovely."

Alternatively, two people we spoke with were not so positive. One person said, "They [staff] are fine, mostly." Another person said, "[Name of member of staff] is good, [member of staff] is the best one. They [staff] are ok, alright." These people did not want to elaborate further.

A further person said, "Not always, it's the way they [a member of staff] treated me, they weren't rough, but I did ache." This person said they spoke about this to the office. They also said that this member of staff returned to support them after this, which they were not happy with.

When we looked at people's care reviews we saw some similar comments. One person had said that a member of staff was not polite and they did not want them providing support to them. In another person's review it stated that staff are, "Usually" polite. These issues had not been explored fully by the assessor completing these reviews. The management of the service had not responded to these comments which indicated that some staff were not kind towards the people they supported.

We therefore concluded that the management of the service needed to complete further work in how they deal with these issues, in order to, promote a caring attitude and practice among all the staff.

People told us that staff treated them with respect and promoted their dignity. One person said, "Oh yes very respectful." One person's relative told us how staff always close their relative's bedroom door when they supported them with personal care.

When we spoke with staff we asked them how they promoted people's dignity and privacy. One person told us how they leave the bathroom to give a person some privacy, when they are supporting them. However, when we spoke with two other members of staff, they struggled to tell us how they promoted people's dignity and privacy when they provided people with personal care. We spoke with the registered manager about this and explained that staff should be clear on this issue. We noted that this was not being checked

as part of staff's competency assessments.

Staff did not always use language that promoted dignity when completing records. When we looked at one person's daily notes completed by staff we noted that staff described the intimate support they received in a non-respectful way. We showed the registered manager this and they agreed this was not respectful. However, no plan was formulated to address this issue.

People's relatives told us that staff supported their relatives to maintain their independence in certain areas of their daily life. One person's relative told us how staff would walk with their relative around the ground floor of their home to help improve their mobility. Another person's relative told us how staff encouraged their relative to eat independently.

Requires Improvement

Is the service responsive?

Our findings

When we inspected Special Seven in March 2017 we found that the service was responsive to people's needs. We needed to inspect the service in December 2017 because of concerns raised about the service. At this inspection in August 2018 we found that the service was not always responsive to people's needs.

When we looked at people's care records we found that these documents did not always reflect what people's physical, emotional and social needs were. Often, important information about people's care needs were not explored and detailed. This called into question how robust the assessments of people's needs were that were completed by the service. Some personal information was captured such as what people liked to eat and drink, but this was not consistently the case.

Records did not contain information about people's backgrounds, achievements, their interests, or what was important for them as a person. Occasionally the service had stated that the person liked watching TV and reading. However, it had not outlined what TV programmes individuals liked to watch or what they liked to read. By not trying to gain more information about the person the service was not facilitating the match of compatible staff with people. This also did not equip staff who were providing social support to people with sufficient information to do this well. We spoke with the registered manager about this and they agreed that people's assessments and care plans needed further work. The office manager also told us that they had identified this issue. However, no action had been taken, nor was there a plan in place to tackle this.

The service was completing regular reviews of people's care and support which they received. When we looked at these documents we saw that they did ask a series of relevant questions. However, people's responses were not fully documented often just a tick was given beside the question. On two people's records issues had been raised by the person. The review did not record what action had been taken in response to these issues.

We also noted when action had been taken at these reviews this action was not robust. For example, one person had said a member of staff had been rude to them. The response was to remove this member of staff from this person's care visits. No meaningful investigation had been completed to explore this issue and try and prevent it from happening again. By not addressing this issue appropriately, as the registered manager acknowledged that, "We are just moving the problem on." We also noted that in one person's review the person had answered "Usually" to most questions about staff practice. The assessor had not addressed this with the person, especially when it referred to staff being polite and kind to them. It implied that this person felt that staff were sometimes not polite and kind to them. This issue was not explored further.

During this inspection we found that the service was not developing end of life care plans with people. One person had become very unwell and professionals believed that this person had now entered the end part of their life. No planning took place to manage this situation. The service had not made attempts to consider how people wanted to be supported at this important part of their lives.

We found that when people had communication issues this was not explored in people's care plans, outlining to staff how they should manage this need. However, when we spoke with one person's relative they did tell us how their relatives regular staff managed their communication difficulties. They said, "[Staff] take their time to check they have understood [name of relative]."

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

There had been no formal complaints made at Special Seven when we looked at the service's complaints record although issues raised by people were documented in the complaints record. There was no documentation to say if people had been asked if they wanted to make a formal complaint or if the service had considered this. We asked the registered manager what could people do, if people were unhappy with the response to a complaint they raised. Both the registered manager and office manager were unaware that people could contact the local Ombudsman. The service had not obtained the local Ombudsman's office contact details to enable them to share this with people after an investigation was carried out. When issues had been identified as a potential complaint, there was no investigation being completed, and no robust action taken in response to the issues raised. We concluded that the registered manager did not have good systems in place to manage complaints.

The service was using an electronic system to monitor people's care visits. We were shown this and we were told about how this was being checked and monitored throughout the day, and out of office hours.

People told us that they received care visits at their agreed times with regular staff. When staff were running late people also told us that they received a phone call to tell them this. One person said, "They [staff] say, sorry [name of person] won't be too long, come when you're ready I say." Another person told us that, "I have set times, but there are occasional times when they are late…I have to be ok about it, I don't have much choice." One person's relative said, "They [staff] usually arrive on time." People and their relatives told us that there had been a notable improvement in this area recently.

When we asked people if staff responded to their social needs and chatted to them when they visited them, people said that staff did. One person said, "We [person and staff] usually chat about all sorts of things." Another person told us that, "Yeah, you can have a laugh and a joke with them [staff]." One person's relative told us how staff were responded to their relatives' individual physical and emotional needs.

Inadequate

Is the service well-led?

Our findings

When we visited in March 2017 we found that the service was well led. Following concerns in December 2017 we inspected Special Seven again. We found that the service had improvements to make in how it was managed. At this inspection in August 2018 we found that there were elements of how the service was being managed which were inadequate.

There were multiple breaches of the Health and Social Care Act 2008 identified at this inspection. There were also repeated breaches of regulations from the last inspection. We therefore concluded that people were not receiving a safe, effective, caring service that was responsive to their needs because the management oversight of the service was not adequate.

The registered manager was not keeping a review of the day to day culture of the service. At people's reviews and when a complaint was raised about staff practice in relation to how people were treated, this was not followed up. No investigation was completed. These were potential indicators of poor staff practice and culture among the staff team. However, the leadership of the service did not respond appropriately to these situations. They did not investigate to find out what had happened and then put measures in place to prevent this from happening again. During this inspection we found three recorded examples which raised questions about how some people felt they were being treated by staff. The leadership of the service had seen these documents but had not taken action.

We found that there were poor and incomplete systems in place to monitor the quality of the service provided. There was no quality auditing taking place in relation to people's care assessments, care plans and reviews. No one within the leadership of the service were checking these documents. We found significant short falls within these documents which the registered manager and provider were not aware of. These shortfalls related to conducting full risk assessments for people, a robust care plan for staff to follow, and obtaining people's consent for support and to share information with others.

Staff personnel files were not being checked to see if safe recruitment processes had been followed. Despite finding this at the last inspection. At this inspection we again found short falls with the safe recruitment of staff.

The leadership of the service were auditing some documents such as people's MAR charts. However, we found issues with two people's MARs, one which had been audited and another which had been filed without being checked by the registered manager or the provider. The issues we found in these two people's MARs had the potential to cause these people harm. This had not been identified with action taken to address this.

When we looked at the competency checks completed on staff we found that these were not well evidenced. Staff were not being asked questions about their training to see if they had always understood and retained this training. When we spoke with staff we found gaps in staff's knowledge and understanding

of important parts of their jobs. The registered manager and provider were not checking to see if the training was always effective. It was unclear if staff were fully competent after the inductions to their new job.

Systems were not in place to ensure any safeguarding concerns identified by staff were managed appropriately. The service also did not have a robust system to manage issues raised by people or process a complaint. No one within the leadership of the service was checking how these situations were managed.

There was not a culture of learning from mistakes made leading to the development of new systems to prevent these errors from happening again. Systems that were in place were not being checked to see if they were adequate at identifying issues.

There was no partnership working with local organisations to improve the quality of the care provided.

Following our last inspection, we had asked the registered manager to send us an action plan, responding to the breaches of the regulations in the Health and Social Care Act 2008. They did not do this.

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

The service was not displaying their ratings from their last inspection.

The above issues constituted a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager what important events they must notify us about by law. The registered manager had a good knowledge of this. However, we identified a safeguarding concern identified by the service which we were not informed about.

The above issues constituted a breach of Regulation 18 of the Care Quality Commission (Registrations) Regulations 2009 (Part 4).

People had told us in December 2017 that they had had a poor experience of Special Seven. This related to late and missed care visits or not having two members of staff visit them when they needed this level of support. At this inspection both people and their relatives told us that these issues had been resolved and had not happened again.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments Regulation 20A HSCA 2008 (RA) Regulations 2014: Requirement as to display pf performance assessments. The provider had failed to display their rating. Regulation 20A (1) (2) (a) (b) (c) (3) (5) (a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 HSCA (Registration) Regulations 2008 (part 4): Notifications of other incidents. The provider had failed to notify the commission about all the important events they must notify us about by law. Regulation 18 (1) and (2) (e)

The enforcement action we took:

Issue NOP

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (RA) Regulations 2014: Person-centred care The provider had not ensured that people's care planning and assessments was always provided in a person-centred way. Regulation 9 (1) (c) (3) (a).

The enforcement action we took:

Issue NOP

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA 2008 (RA) Regulations 2014: Need for consent. Consent to share personal information was not always obtained in line with current legislation. Regulation 11 (1) and (2)

The enforcement action we took:

Issue NOP

Regulated activity	Regulation

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was always provided in a safe way. They had not assessed all the risks to people's safety or taken appropriate actions to mitigate these risks. Regulation 12 (1) and (2) (a) (b).

The enforcement action we took:

Issue NOP

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Well Led. There was a lack of systems and effective auditing of the service with appropriate action plans put in place. There was also a lack of transparency with management of the service. Regulation 17 (1) and (2) (a) (b) (c) (e)

The enforcement action we took:

Issue NOP

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA 2008 (RA) Regulations 2014: Fit and proper persons employed. The provider had not ensured that all staff employed had the appropriate pre-employment checks in place. Regulation 19 (1) (a) (2) (a) (3) (a).

The enforcement action we took:

Issue NOP