

Bojo Care Services Ltd

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Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on the 6 and 7 March 2018. We gave the service 24 hours' notice that we were conducting the inspection to ensure there was someone available at the office.

At this inspection, we found seven breaches of the Health and Social Care Act 2008 in relation to person centred care, consent, safety, safeguarding, good governance, staffing and fit and proper persons employed. Following the inspection, we told the service to take some immediate action to address the issues we found.

You can see what action we have told the provider to take at the back of the full version of this report. We are currently considering our options in relation to enforcement and will update this section once any enforcement action has concluded. As a result of our concerns, the provider agreed a voluntary embargo of new care packages. This meant the provider would not be taking on any new packages of care until it was agreed with the Care Quality Commission (CQC) that the necessary improvements had been made.

BoJo Care Services Limited is a domiciliary care agency. It provides personal care to people living in their own homes in the community. The service provides care to a range of people with different needs including older people, people living with dementia, learning disabilities, physical disabilities and mental health conditions. When we inspected the service, there were 27 people receiving domiciliary care. Calls to people's properties ranged from 30 minutes to two hours per visit. Not everyone receives 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.

This was BoJo Care Services Limited first comprehensive inspection since being registered with the Care Quality Commission.

BoJo Care Services Limited is owned and operated by the registered manager and the nominated individual.

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

People were not safe. There were no risk assessments in place to mitigate risk and support people with moving and handling. For example, there was no risk assessments devised for the care of pressure areas or for people who could be verbally or physically aggressive to others.

Care plans for people were not reviewed or involved people or their representatives. There was no evidence that care plans had been updated.

The service did not follow the principles of The Mental Capacity Act 2005. People did not have their capacity assessed as appropriate. The service did not have a mental capacity policy and was not working within the framework of the mental capacity act.

Prior to agreeing a care package. The service should assess people and the service to ensure that they can meet people's needs. Pre assessments of people were incomplete and did not identify the full needs of people.

Medication was not safely managed. In addition there were no audits in place to monitor the safe administration of medication. There were inconsistencies in staff training in medication administration and medication records were not appropriately recorded. Staff members were not competently assessed to administer medication.

Staff were not supported by robust systems of training and monitoring. Training was not sufficient to enable staff members to carry out their role effectively.

There were no systems in place to assess, monitor and improve the service. There was a lack of scrutiny and oversight by the registered manager to ensure that people received safe care and treatment. The management team did not regularly review people's daily notes so they were unaware of changes to people's support or incidents that occurred and did not follow them up to ensure that appropriate action had been taken.

Recruitment procedures were not followed and new staff members were not always recruited safely.

One allegation of abuse that we are aware of had not been reported to the Care Quality Commission (CQC).

There was a complaints procedure in place and one complaint had been responded to appropriately

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 their service, they will be inspected again within six months. The expectation is that the provider to have made significant improvements within this time frame.

If not enough improvement is made within this time frame so there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to being 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. The service will be continued to be kept under review.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service is not safe

Not all risks to people were assessed and guidance was not available to make sure all staff knew what action to take to keep people as safe as possible.

Medication was not safely managed.

The provider did not have an effective recruitment and selection procedure in place and relevant checks and processes were not carried out on the suitability of staff.

Inadequate ●

Is the service effective?

The service is not always effective

The service was not working within the principles of the mental capacity act 2005. People's capacity was not assessed.

Training was not always sufficient to enable staff members to carry out their role effectively.

Staff members did not always received regular supervision.

Inadequate ●

Is the service caring?

The service is not always caring.

People we spoke we said that staff were friendly and respectful.

We saw kind interactions between people and staff members.

People were not always involved in the planning of their care.

Requires Improvement ●

Is the service responsive?

The service is not responsive.

Pre assessments of people were not fully recorded.

Inadequate ●

People's care plans did not contain necessary guidance to ensure staff gave the personalised care and support people needed.

Care plans were not routinely reviewed and people were not involved in the care planning.

Is the service well-led?

The service is not well led

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service.

There were no systems in place to monitor and improve the service.

We had not always received information about certain events which had occurred at the service to enable us to monitor this.

Inadequate ●

BoJo Care Services Ltd

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 6 and 7 March 2018 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office. The inspection was undertaken by one inspector and an assistant inspector on day one of the inspection. One inspector returned alone for the second day. Furthermore, another inspector undertook phone calls to staff members to seek their views and an expert by experience conducted phone calls to people who used the service to gain their views. An expert by experience is a person who had personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed information we held about the service including statutory notifications sent to us by the provider. Statutory notifications include information about important events that have occurred at the service which the provider is required to send us by law. We used this information to plan the inspection. We did not request a Provider Information Return (PIR) form. A PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with four people who used the service, three relatives, the registered manager, the nominated individual, two senior care workers and four care workers.

We looked at six people's care plans. We reviewed seven staff personnel files and records relating to recruitment, induction, training and supervision. We checked the service quality assurance records. We asked for people's feedback on the service including the timeliness of calls and if people were involved in their care planning. We visited the properties of five people receiving personal care with their prior consent.

Is the service safe?

Our findings

People and their relatives we spoke with had mixed views about the safety of their care while being cared for by the staff members at Bojo Care Services Limited. One relative told us, "[Staff member] is very good with him, [Person's name] is absolutely safe with them." Another relative said "[Person's name] is very safe with them without a doubt. They once rang me to tell me that they'd noticed a window was open upstairs when they left. [Person's name] also has a panic alarm and there's a key safe for Social Services and another one for the carers."

People also told us that they had to wait for staff and that staff were often late. A person who used the service told us, "They're a bit choppy with times. The dinner time call, I can manage, my problem is my late call. Sometimes they turn up at 5.20pm or sometimes 6.40pm. I've asked for a late late call repeatedly, but they just say: 'give us time', eight pm would be good, but I can live with seven pm earlier time".

Whilst some people's views about the service was positive we judged from our inspection that the service was not safe.

We saw on a training matrix and by certification in staff files that staff had received training in safeguarding vulnerable people. Staff we spoke with confirmed that they had received training and were able to describe signs and symptoms that would cause concern and could describe the route they would take in reporting such concerns.

We saw for one person using the service, there had been a number of safeguarding allegations made against one staff member. The allegations had not been reported to the Care Quality Commission (CQC) although the registered manager and the nominated individual did confirm that the allegations had been discussed with the person's social worker it was not evident that a safeguarding referral had been made. We confirmed this information with the social worker shortly after the inspection. Additionally, we found no evidence of any guidance within the care plans of this person or evidence of any risk assessments in place to support the person and staff members. This meant that the service was not acting within the best interests of the person and putting their staff members at risk of allegations. Furthermore, the service was not being open and transparent in reporting allegations of abuse to CQC. We have requested further information from the service to ascertain dates for the allegations and have made a referral to the local authority safeguarding team. We will monitor the outcome of these

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not report safeguarding allegations to the Care Quality Commission.

We viewed five people's Medication Administration Records (MAR) which were not always signed by staff members. There were a number of gaps on the MAR where we would expect to see a staff signature or a reason for non-administration. Furthermore, staff were signing to state they had administered medication, when the person's care plan stated medicines should be prompted or where there was no assistance required with the management of medicines. This meant the service could not be assured that people were

receiving their medication as prescribed, due to the lack of robust systems in place. We did check the blister packs of three people and found that the medication had been given as prescribed from those packs. A blister pack is pharmaceutical packaging for medicines which can identify when they are due to be given. However, we could not ascertain if any boxed medicines such as paracetamol were correct as there was no stock audit trail of how many had been supplied or taken. All staff we spoke with told us that they were aware they had to sign the MAR after administering or prompting medication.

When viewing one person's care plan, there was conflicting information on whether the person required support from care staff with their medication. While the registered manager did not think the person should have been supported, it was documented in the pre-assessment document and subsequent care plan that they required prompting. Additionally, the person did not have an up to date list of medication and was taking an anticoagulant medicine which required the person to have regular blood tests and the service was not aware of any outcomes of these tests. Anti-coagulant medication is used to thin the blood of people who are at high risk of blood clots that can cause a stroke or heart attack. The service did not have the contact details for the person's GP should they need medical advice or assistance. On the second day of the inspection, we found the service had been able to contact the GP for the person and request an up to date list of medicines as well as gain information about supporting the person with their anticoagulant medicine. The senior staff member told us that they will update the care plan to ensure it reflects what care and support is required with the management of medicines. Furthermore, there were no systems in place to determine who was responsible for the management of this person's medicines, whether that be the provider of the person's family.

Staff members we spoke with gave mixed views on medication training. One staff member said, "I have received no training at all and had worked previously for another care company and did a five day training course with that company. Another staff member said, "I've had no real meds [medicines] training – a little bit when I first started from a colleague." A third member of staff had been trained by hospital staff as they were working privately at the time, and another staff member was trained with their previous employer. Some members of staff said they had been observed by senior staff members when administering medication, but new members of staff had not. There was no competency checks documented that staff members had been observed to be able to safely administer medication, however, the registered manager did tell us that it did happen. We did see a training matrix where the provider had documented that staff had received training in the safe administration of medicines. The training was delivered by the registered manager who told us they asked questions on staff understanding but this wasn't recorded. We have requested that the provider sends us copies of the registered managers qualifications to enable them to deliver medication training but this information has not been received.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to have safe and effective systems in place for the management of people's medicines.

People who required moving and handling did not have risk assessments in place implemented by the service. We saw for one person, they had a moving and handling risk assessment completed by the local authority 19 months prior to the inspection; however, this had not since been reviewed so the service could not assure themselves that the information was accurate and the care staff was competent to perform this role safely. Another person who required moving and handling with a hoist, had no assessment in place, nor was their moving and handling needs recorded at the pre-assessment before the person started to use the service. This meant that people were not being appropriately assessed to ensure that the service supported them appropriately and safely with their moving and handling requirements and including any equipment. Staff we spoke with told us they were aware of people's moving and handling requirements and some staff

members had received training from the registered manager in moving and handling people. All staff members we spoke with confirmed they always supported people who required moving and handling in pairs. This was also confirmed on the rota and by the people we spoke with.

Risks relating to people's health and wellbeing had not been considered. We saw one person was being supported to manage a pressure sore which had not been caused while in the care of Bojo Care Services Limited. However, there was no risk assessment in place to score, monitor and evaluate the risk. We did however see that the service had reported the concerns of the person's skin integrity to the district nurses who were implementing the appropriate care.

We saw that only one accident which was related to a staff member and was recorded in the accident book. We were told by the nominated individual that there had been a number of incidents where a person had been verbally and physically aggressive towards staff members, which included threats to safety. We found none of these incidents were recorded within the accident or incident book or within the persons care file. Staff we spoke with told us that they knew they had to walk away from the property should this person become aggressive, but there were no management plans, guidelines, or risk assessments in place to support the person or staff members nor was this information available on the person's pre-assessment.

The above risks had not been identified or anticipated and people were at risk of receiving care and support that was unsafe and did not meet their needs. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed seven staff members' personnel files and found that all had the required disclosure and barring service (DBS) check in place prior to commencing employment. A DBS check assists employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. However, we found five from the seven personnel staff files did not have satisfactory references. Verbal references had been taken for new staff members which had not been verified by the registered provider. This meant the service could not be assured that the reference was who they said they were. There was no audit trail of where the references had been sought from and references did not match the referee name and contact details on the staff members application form. We saw that four staff members had only received one reference prior to starting their employment with Bojo Care Services Limited. This meant the service had not completed the required pre-employment checks sufficiently. However, on the first day of inspection, the nominated individual did show us evidence that they had recognised the service was not conducting references as required and had begun to evaluate staff files to see where references were not appropriate.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure that satisfactory references were sought for new employees and where verbal references were taken. These were not verified

We discussed the rotas with the registered manager and the nominated individual. People using the service had between 30 minutes and two hour calls. Some people had up to four calls a day. The rota was drawn up using a computerised system, which main purpose was to schedule support visits. Staff we spoke with confirmed they had travel time between calls and they had access to the rotas from a mobile app. One relative we spoke with said, "They [Bojo Care Service Limited] are not consistent with their timings. They are supposed to come at five pm to feed [person's name] but I've been told this morning that they'll be coming at 4pm. They give [person's name] their tablets in an evening and they are timed tablets to be taken with food so coming an hour earlier would be a problem because he won't be ready. They've also not turned up for four calls in the last five weeks." A person using the service told us "[Staff members' name] is always pretty punctual, more or less on the mark within five minutes either way. On one occasion, [staff members

name] didn't come about three weeks ago, but he had let us know why in advance, there was just no cover provided by Bojo." Other people or relatives we spoke with were happy with the call times. We did see a record of times staff signed in and out of properties, however, the document was not analysed by the provider for clarity on staff members attending their allocated visits or to assure themselves on the quality of the service being delivered

We saw that the service had recently implemented a traffic light procedure for when calls may not be able to be made such as in extreme weather conditions. Each person was coloured coded with red, amber or green. Red meant the person needed a visit, amber that the person had family support and green that the person could manage with a phone call. The registered manager told us that if procedure was used, it was communicated to all involved and staff were deployed based on being local to where the calls were needed

We saw the service had an infection control policy in place and we saw and staff we spoke with confirmed that they could access personal protective equipment (PPE) such as gloves and aprons at any time.

Is the service effective?

Our findings

A relative we spoke with told us, "They [staff members] come in seven days a week, twice a day, once in a morning and then again at night. It's purely companionship really, watch TV and have a bit of a chat. [Person's name] doesn't like to be on their own. They also help with their nightdress and put [person's name] to bed. There's nothing to criticise really, routine is very important to [Name]. The only thing is we would like to know is who is coming. I would like a rota, so I can inform [Name]".

Another relative said, "[Person's name] has advanced stages of dementia so they do try to send the same carers, but staffing seems to be an issue. We had five different carers in one week and it doesn't help with his confusion. We requested a man and they do send one if they've got one but there is not always one available".

The registered manager told us that they try and keep the same staff member where possible to support and the rota confirmed this. Sometimes, staff had to cover for sickness or annual leave.

Staff members we spoke with had mixed views on the training offered. One staff member said they had recently watched a video on hygiene, but had received no other training in the five months they had worked at the organisation. Another staff member said they had received moving and handling training and the registered manager had asked some questions and they had watched some videos. Three staff members who had worked at the service for a longer period said they had been shown how to use the hoists. Other staff members said they had received training in previous care related job roles.

We saw a training matrix which listed staff as receiving in house training in safeguarding, safe handling of medicines, food hygiene, mental capacity and hygiene. Training was delivered by the registered manager or external person. After the inspection we asked the registered manager for evidence of their training credentials to provide us with assurances that they were competent to deliver this training. We have received this information and we cannot be assured that the registered manager is appropriately trained and competent to deliver refresher training to staff.

The training matrix viewed confirmed staff had not received specific training relating to skin integrity care despite providing care packages to people with this assessed need and other various health conditions, such as pressure ulcers. Advice on the care of someone with pressure ulcers was passed on verbally by other members of staff who were not trained to deliver this specific training.

We asked the registered manager how staff were assessed following the training to ensure they are competent, the registered manager could not evidence that staff were assessed following the training to ensure they were competent or to see if the training had been effective. Therefore we could not be assured that staff had been provided with training that equipped them with the skills and knowledge to undertake their role and responsibilities, meet their personal training and development needs and to ensure people's needs were being met safely and to an acceptable standard.

Staff members told us and we saw that supervision was varied from receiving one supervision a year or every three months. We saw from five staff personnel files that two staff members had received supervision

annually. One staff member had received supervision on four occasions over two years and two other staff members had only ever received supervision once. One staff member we spoke with said, "I can chat with the manager when I collect my payslip, but nothing is formally arranged."

Five staff members we spoke with told us that they did receive induction, however this wasn't recorded. On commencing employment, the employee signed to say they had received a number of policies related to the organisation. Staff members said they were introduced to people they would support by shadowing an experienced staff member for a number of days, but one staff member told us "First day I shadowed and then just chucked in." We saw that the service was supporting new staff to complete the care certificate. The care certificate is a set of standards for new staff members to work towards to support the knowledge, skills and behaviours of people working within social care.

The failure to ensure that staff received an appropriate induction and relevant training and was competent to undertake their roles was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The senior staff and the registered manager told us that spot checks were completed for staff, but this had not been recorded and staff may not have realised they were having their work checked as they could have been working with a senior staff member who was observing their care. This meant that the registered manager could not be assured that staff members were carrying out their role effectively.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who use the service and who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the (MCA) 2005.

We checked whether the service was working within the principles of the MCA. People told us that staff sought their consent prior to supporting them and we saw this in practice. However, the service did not have a mental capacity policy in place and there were no capacity assessments or best interest's decisions for people. We saw that relatives or friends were consenting on behalf of people without the legal power to do so. For example, we saw that a neighbour had signed a consent to care for one person. The person had not had their capacity assessed and the neighbour had no legal power to consent. Family members or people's representatives must have 'lasting power of attorney' for health and welfare decisions before they can consent on behalf of the person. In the absence of an LPA, there must be a best interest's decision. The MCA Code of Practice gives advice about how to reach such a decision. The care records we viewed contained no evidence to show this authority was in place, nor that any assessments of mental capacity had taken place. We saw that where the local authority had placed people within the organisation, a capacity assessment had been included in their care plan. However, this information may not have been current. The registered manager did not demonstrate understanding of the mental capacity act.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did work within the principles of the Mental Capacity Act 2005.

We saw that where people had health concerns such as management of pressure areas or where moving and handling equipment wasn't suitable that the registered manager had spoken to the appropriate professionals such as the district nurses or moving and handling team for advice and support. This was documented electronically.

As part of the pre-assessment, we saw for some people that they had their likes and dislikes recorded. For example, it was recorded how one person liked a particular routine and preferred female staff members and for another person, their food likes and dislikes were noted.

Is the service caring?

Our findings

A relative we spoke with told us, "They [staff members] are very good with [person's name], and [person's name] thinks they're wonderful." Another relative told us, "The care workers are very good, really respectful and always maintain [person's name] dignity when they're doing personal care". A person using the service told us, "They're all polite, friendly, chatty and very respectful. [Name] is a very nice."

We found interactions between staff members and people using the service to be respectful and kind. During one of our home visits we observed one person being able to joke with a staff member and discuss what is happening in a popular TV programme. We also saw one staff member reassure a person who could not remember why the staff member was in their property.

Although we observed positive caring interactions from staff to the people receiving a service at living at BoJo Care Services Ltd, we were not assured staff had received the necessary training and skills competencies to provide people with compassionate care. As reported in the effective domain of this report we found a number of staff had not completed key training in areas such as skin integrity and moving and handling. This meant some members of the staff team were not fully equipped to provide people with personalised care due to not receiving the necessary training.

We saw that people's privacy and dignity was promoted and we observed that staff knocked on doors to enter and let them know who was entering the property.

One person told us that they had refused to sign their care plan as it wasn't correct. The person said the plan described an activity that they couldn't do for themselves but the care plan led staff to believe they could. A relative told us that their parent was encouraged to wash themselves in the shower while staff would be available for support with getting in and out of the shower.

We heard a number of phone calls throughout inspection to the registered manager, the nominated individual and senior care staff from people or relatives. We observed people and relatives being spoken to in a polite and caring manner and the staff team talked as ease.

Some people said that they were involved in planning their care and were able to make their own decisions. Others said that they had not been involved but were able to tell staff what they needed. Some people would not have been able to tell staff about the care that they needed. Care plans lacked information to show that people were encouraged and supported to be involved in the care planning and how they made decisions about their care.

Is the service responsive?

Our findings

We saw that people had pre-assessment documentation in care files. The document was thorough and covered all aspects of care but we found in all care files we viewed that the assessment not fully completed. This meant that people were not receiving a fully, holistic assessment of their needs prior to receiving the service

People had care plans in place which confirmed what care was required on each visit. However care plans were not dated or reviewed and there was no evidence other than during the pre-assessment that people had been involved in their care planning. One staff member told us that they had not been told if care plans had changed.

We viewed one person's care plan that detailed they were known to display behaviours that challenges others. For example, we were told this person was physically and verbally aggressive towards staff members. However, we found no care plan in place to support the person or guide staff members on how to safely manage this person's behaviours. There was no evidence in this person's care plan containing a pre-assessment, that this person required a particular level of support nor was there any recorded evidence of the concerns raised about this person. We did not see any incident reports other than daily notes made in the persons daily records. The daily notes did not express the severity of the risk to the person or staff members. Two staff members told us that they had been verbally told how to care for this person. The response from the registered manager and the nominated individual was that they felt under pressure to support this person as they did not want to leave them vulnerable. However, we did not feel the provider addressed the concerns seriously and we raised a safeguarding referral following our inspection. This is currently being investigated further, the Care Quality Commission (CQC) will continue to monitor this situation.

A relative we spoke with said, "We have mentioned to BoJo that there's not enough detail in the book (care plan) and that has improved slightly, but still not enough." We did see an e-mail in person's file of what relatives would like to see. However, the provider had not assured us they had taken on board this information, which the meant the person's care plan was not accurate.

A person we spoke with told us, "My Care Plan form says that the carers are there to assist me with my food if needed, but I definitely need carers to make my food. I can't reach the worktops or the hot plate. It doesn't match my care needs, so I won't sign it."

The staff members we spoke with said they got to read the care plan before supporting people. One said they would email the office for details of new people so they had information before they went on the visit. Another said they received text messages from the manager about new people and they would go around and introduce themselves.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not fully assess, plan and review people's care and support.

We talked with people and relatives about complaints. All people we spoke with knew how they would make a complaint, and we aware that the contact numbers for Bojo Care Services Limited were listed in their care file. One relative told us, "The first chap was not appropriate, he took [person's name] to the pub which is completely the opposite of what's required, and he also lied about it as well, but after we complained he was very quickly replaced." Another person said, "I've never had a reason to complain."

We saw that the service had received one complaint regarding a late visit which was answered in a timely manner with outcomes recorded and shared with the complainant and the staff team. One person told us that they had complained about their call times in the evening and the service had told them that they will look at it. We did not see evidence of this complaint recorded but the registered manager acknowledged that they were aware of the persons concerns and were looking at trying to rearrange the call times. However, there were no time scales for this to happen.

We saw two compliments which thanked the service for their support when looking after people at the end of life. The registered manager told us that the service always attends the funerals of people who used the service and support the families. We saw that one relative often came into the office to talk to staff after the death of their spouse as this helped with them dealing with their grief.

The registered manager did tell us that the service does support people who require end of life care but there was currently no one at the service receiving end of life support. One person had a Unified Do Not Attempt Cardio Pulmonary Resuscitation (UNADCPR) in place. A UNADCPR is a document put in place by a health care professional such as a GP where resuscitation would likely be unsuccessful or not in the person best interests. We did not see reference to this document in the person care plan, however, the staff we spoke with were aware that the document was in place and that the person was not for resuscitation.

Is the service well-led?

Our findings

A registered manager had been registered with the Commission since November 2016. Our findings from this inspection show that the manager and the provider had little oversight of the service and has not taken timely and robust action to ensure people received safe care and support.

We looked at the service's quality assurance systems to ensure they effectively assessed and monitored the care and support delivered was safe and effective. The registered manager confirmed to us that there were no systems in place to identify, monitoring and improve the service. There were no audits of people's care records, no audits of medicines or medication records, accidents or incidents, safeguarding or staff personnel files. Care and medication records were brought back to the Bojo Care Services Limited office regularly and the registered manager told us that the documents were reviewed but there was no recorded evidence of this. There were no assessments of people's capacity, nor a policy on mental capacity available.

The service did not have an effective system in place for the logging and following up of any incidents. This meant that the registered manager did not have oversight of all the incidents and accidents that occurred at the service and therefore could not respond with corrective actions if necessary.. Accidents and incidents were not managed effectively to monitor trends and patterns or to reduce the risk of further accidents and incidents re-occurring.

This was a breach of regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. The provider did not have audits and systems in place to monitor and improve the service.

The registered manager and provider for BoJo Care Services Ltd had not taken reasonable steps to reduce the risk of harm to people. This included taking steps to ensure safeguarding matters were appropriately followed up with the staff team to ensure people received safe care.

The provider did not have robust procedures to ensure staff remained competent to provide safe care and treatment to people and to take appropriate action where staff were no longer fit to carry out the duties expected of them.

There was a breach of Regulation 19 (Fit and Proper Persons Employed) of The Health and Social Care Act 2008, Regulated Activities Regulations 2014.

We asked people if Bojo Care Services Limited sought people's views on the care and support provided. We saw that surveys had been sent out and six had been returned. The surveys had been analysed and all respondents said they were happy with the suitability and reliability of staff. One person had written that they had concerns with one member of staff who wasn't staying the allocated time. Another person told us, "I know the manager and I've got all the relevant contact numbers, if I need them. They've also sent out a satisfaction questionnaire for completion."

People we spoke with told us, "The service is quite good, a lot better than my previous firm. They're not perfect but definitely better." A relative told us, "To be honest, our previous service was far more professional,

but they could not accommodate the night call. However, it's early days and they've never let us down so far and as I've already said they're very good with [Name] which is the main thing."

Although staff felt supported by the nominated individual and the registered manager, throughout the inspection we raised concerns with them both about our findings. Both were unable to demonstrate that they had been completely aware of the concern's prior to the inspection, although the service had identified that they were not following the correct protocols for obtaining satisfactory references for staff members. However, this was not in line with the organisations recruitment policy. The registered manager told us that they did spot checks on staff members and people in their homes but this was not documented.

We did see that staff meetings were held three monthly and staff signed to say they had been in attendance.

We saw that there was a business continuity plan in place. This confirmed what to do in the event of difficult circumstances such as fire, extreme weather or loss of power.

There were policies and procedures in place in relation to safeguarding, whistleblowing, recruitment, infection control, medication and end of life. We saw that staff were given a copy of the policies as part of their induction. Policies were reviewed annually.

We saw that the registered provider ensured some statutory notifications had been completed and sent to the Care Quality Commission (CQC) in accordance with legal requirements. The registered manager kept a file of all notifications sent to CQC. The provider is legally required to notify us without delay of certain events that take place whilst a regulated activity is being provided. We found during this inspection there had been some events that took place which should have been reported to us that had not been, for example in relation to potential safeguarding incidents at the service. This meant we were restricted in how we monitored the service due to a lack of information received. We discussed with the registered manager that all notifiable incidents should be reported to CQC.

The failure to notify us of certain events which had taken place within the service was an on-going breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider did not fully assess, plan and review people's care and support. Care plans were not reflective of peoples needs and were not reviewed.</p>
Personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider did work within the principles of the Mental Capacity Act 2005. people did not have their capacity assessed by the service. Relatives and friends that were consenting on behalf of people did not always have the legal power to do so.</p>
Personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The provider did not report safeguarding allegations to the Care Quality Commission.</p>
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>The registered manager and provider for BoJo Care Services Ltd had not taken reasonable steps to reduce the risk of harm to people. This</p>

included taking steps to ensure safeguarding matters were appropriately followed up with the staff team to ensure people received safe care. The provider did not have robust procedures to ensure staff remained competent to provide safe care and treatment to people and to take appropriate action where staff were no longer fit to carry out the duties expected of them.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider did not report safeguarding allegations to the Care Quality Commission. The provider did not assure themselves that staff were competent to administer medication safely. The provider did not assure themselves that staff were correctly administering or prompting medication or have adequate information in place to support people to safely take medication. The provider did not assess people to be assisted with moving and handling or monitor the risk of pressure areas. The provider did not safely assess the risk of a person who was verbally and physically aggressive towards the staff team.</p>

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not offer sufficient supervision, training and competency checks to staff members to enable them to fulfil their role satisfactorily.</p>

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider did not offer sufficient supervision, training and competency checks to staff members to enable them to fulfil their role satisfactorily.</p>

The enforcement action we took:

Warning Notice