Midlands Home Care Limited

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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?	**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

This was an announced inspection carried out on 11, 12, 17 and 19 January 2018.

Midlands Home Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to adults of all ages and children between the ages of 13 and 18 years. It can also care for people who need assistance due to living with dementia, mental health needs, a learning disability and/or physical adaptive needs. At the time of our inspection the service was providing care for 75 people most of whom were older people. The service's administrative office was in Nottingham and the service delivered care calls to people living in the city of Nottingham and surrounding villages.

The service was run by a company who was the registered provider. The chief executive of the company was also the nominated individual. This is a legal role that means the chief executive was responsible for assuring us that the service was well run. There was also a registered manager. 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. In this report when we speak both about the company (as represented by the nominated individual) and the registered manager we refer to them as being, 'the registered persons'.

We carried out an announced comprehensive inspection on 10 and 11 August 2017. This was the first inspection we had completed since the service was registered with us on 24 July 2017. At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

One of these breaches was because the registered persons had not reliably ensured that sufficient care staff were deployed in the right way to ensure that care calls were carried out as planned. In particular, some care calls had not started at the right time and others had not lasted long enough. This had resulted in some people not always promptly being given all of the assistance they needed to receive in order to be safe and comfortable at home. Another breach was due to the registered persons not making suitable provision to ensure that care was always provided in a lawful way. This is a necessary safeguard when people are considered to be at risk due to not having the mental capacity to make decisions about the care they receive. The third breach was because the registered persons had not told us about some of the significant events that had happened in the service. This oversight had reduced our ability to quickly make sure that people were kept safe.

After the inspection the registered persons wrote to us to say what actions they intended to take to rectify the breaches we had identified. They said that all of the necessary improvements would be completed by 31 December 2017.

At the present inspection we found that sufficient progress had still not been made to meet the breach of

the regulations relating to staffing. This was because suitable arrangements had not been made to deploy staff to reliably ensure that care calls were completed in the right way. This shortfall had resulted in a number of care calls not being completed at the right time and/or not lasting for the correct amount of time. This had resulted in the people concerned not promptly receiving important parts of the care they needed.

We also found that the registered persons had continued to not always tell us about significant events that had occurred in the service. However, the third breach had been resolved. This was because suitable arrangements had been made to protect people's legal rights by obtaining consent to care and treatment in line with legislation and guidance.

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At the present inspection, we also identified three additional breaches of the regulations. One of these related to the registered persons' failure to consistently deliver safe care and treatment. Another breach involved shortfalls in the arrangements that had been made to safeguard people who used the service from the risk of abuse and improper treatment. The third breach was because the registered persons had failed to ensure that the service had all of the systems and processes it needed to learn, innovate and ensure its sustainability. In particular, there were oversights in the systems used to assess, monitor and improve the quality and safety of the service. This included not having suitable arrangements to enable people and their relatives to be consulted about making improvements in the service.

Full information about CQC's regulatory response to the breaches of regulations described above will be added to our report after any representations and appeals have been concluded.

As a result of these breaches of regulations 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. If we have not taken immediate action to propose to cancel the registered persons' registration of the service, will inspect again within six months. The expectation is that registered persons 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 registered persons 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. When 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 registered persons from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Our other findings at the present inspection were as follows. Background checks had been completed before new care staff had been appointed. Care staff had not always been fully supported to deliver care in line with current best practice guidance. However, people were helped to eat and drink enough to maintain a balanced diet. In addition, suitable steps had been taken to ensure that people received coordinated and person-centred care when they used or moved between different services. Also, people had been supported to live healthier lives by having suitable access to healthcare services so that they received on-going healthcare support. In addition people had been supported to maintain their accommodation so that it met their needs and wishes.

Suitable arrangements had not been made to support care staff to consistently deliver the caring and respectful service they wanted to provide. However, there were arrangements to give people extra support if

this was needed for them to be actively involved in making decisions about the care they received. This included them having access to lay advocates if necessary. Furthermore, confidential information was kept private.

People had not been fully supported to receive personalised care and information was not always presented to them in an accessible manner. Some people were not confident that their complaints and concerns had been managed in the right way so that lessons could be learned to improve the quality of care. However, the registered persons recognised the importance of promoting equality and diversity. This included but was not limited to supporting people who were gay, lesbian, bisexual and transgender. Furthermore, suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

There was a registered manager. However, most of the care staff with whom we spoke said that the service did not have a positive culture that fully supported them to focus upon achieving good outcomes for people. Care staff had not been fully supported to understand their responsibilities to develop good team work and to speak out if they had any concerns. However, the registered persons had taken a number of steps that were intended to enable the service to work in partnership with other agencies to develop the provision of joined-up care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Suitable arrangements had not been made to deploy sufficient care staff to enable planned visits to be completed in the right way.

Suitable arrangements had not been made to ensure that people consistently received safe care and treatment. There were shortfalls in the management of medicines, the prevention of untoward events and in the promotion of good standards of hygiene.

People had not always been suitably safeguarded from the risk of abuse including financial mistreatment.

Background checks had been completed before new care staff were employed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Suitable arrangements had not been made to ensure that care staff were fully supported to consistently deliver all of people's care in line with current best practice guidance.

People had been supported to eat and drink enough to maintain a balanced diet.

There were suitable arrangements to enable people to receive coordinated care when they used different services and they had received on-going healthcare support.

Suitable arrangements had been made to protect people's legal rights by obtaining consent to care and treatment in line with legislation and guidance.

People had been supported to maintain their accommodation so that it met their needs and wishes.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The registered persons had not made suitable arrangements had not been made to support care staff to consistently deliver the caring and respectful service they wanted to provide.

There were arrangements to offer people extra help if they needed help to express their views about the care they wanted to receive.

Confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not consistently received responsive care and their needs information was not always presented to them in an accessible manner.

Some people were not confident that their complaints and concerns had been managed in the right way so that lessons could be learned.

Care staff recognised the importance or promoting equality and diversity.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Inadequate

The service was not well led.

The registered persons had failed to ensure that the service met regulatory requirements. This included not notifying us about the occurrence of significant incidents.

It also included shortfalls in assessing, monitoring and improving the quality and safety of the service. Full information about CQC's regulatory response to this concern will be added to our report after any representations and appeals have been concluded.

Care staff had not been fully supported to understand their responsibilities to develop good team work and to speak out if they had any concerns.

A number of steps had been taken that were intended to enable

the service to work in partnership with other agencies to develop the provision of joined-up care.

Midlands Home Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered persons were 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 undertook a comprehensive inspection of Midlands Home Care Limited on 11, 12, 17 and 19 January 2018. We completed the inspection to follow up on three breaches of legal requirements that had been identified at our comprehensive inspection on 10 and 11 August 2017. We wanted to check that the registered persons had ensured that there were enough care staff who were deployed in the right way to enable people to reliably receive all of the care they needed. We also wanted to check that the registered persons had made suitable arrangements to ensure that care was always provided in a lawful way. In addition, we needed to establish that the registered persons had promptly told us about any significant events that had occurred in the service.

Before our inspection visit we reviewed information we held about the service. This included the information we had received from the local authority who contributed to the cost of some of the people who used the service. It also included information shared with us by or on behalf of some of the people who used the service.

Due to technical problems, the registered persons were not able to complete a Provider Information Return. This is information we require registered persons 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.

We visited the service's office on 11 January 2018. The inspection team consisted of two inspectors. The inspection was announced. The registered persons were given three days' notice because they were

sometimes out of the office supporting care staff or visiting people who used the service. We needed to be sure that they would be available to contribute to the inspection.

During our inspection visit to the office we spoke with the chief executive of the company who runs the service and with the registered manager. In addition, we met with the care coordinator who was responsible for deploying the care staff. We also examined records and documents that described how care calls had been completed, the recruitment and training of care staff, the obtaining of consent and the management of medicines. Furthermore, we looked into the way in which complaints were handled and the steps taken to complete quality audits.

On 12 January 2018 our inspectors spoke by telephone with eight care staff, six people who used the service and with one relative.

The inspection team also comprised an expert by experience. This is a person who has personal experience of using this type of social care service. Our expert by experience was based at another location and on 11 and 12 January 2018 they spoke by telephone with 12 people who used the service and one relative.

On 17 January 2018 one of the inspectors accompanied two members of care staff when they completed two care calls. During these care calls we spoke with one person who used the service and with two relatives. We also observed some of the care that was provided and examined records relating to the completion of care calls.

On 19 January 2018 one of the inspectors completed a further visit to the service's office when they met again with the chief executive and the registered manager. They also examined additional documents and records that related to the provision of care calls and related matters.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection on 10 and 11 August 2017 we found that there was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because suitable arrangements had not been made to ensure that sufficient care staff were deployed to ensure that care calls were reliably completed at the right times and lasted for the correct amount of time. In addition, we identified concerns in relation to care calls that should have been completed by two members of staff. These calls usually involved assisting people who had significant physical adaptive needs and needed to be helped to mobilise using hoists and other equipment. We found examples of some of these care calls being completed by only one member of staff. We concluded that although these various shortfalls had not directly resulted in people experiencing actual harm, they had increased the risk of this occurring. In addition, the disruption caused by late and rushed care calls had resulted in people experiencing unnecessary distress and inconvenience.

At the last inspection we asked the registered persons to take action to make improvements to the deployment of care staff. After the inspection the registered persons wrote to us and said that they had taken a number of steps to address our concerns. These included appointing more care staff and re-arranging how care staff were organised so that care calls were completed in a more efficient way.

At the present inspection we found that care calls were not being completed in the right way. The registered persons again assured us that as a result of the improvements they had made care calls were being completed in the right way. They told us that this meant no care calls had been missed altogether. They also said that care calls had been completed on time and had lasted for the correct amount of time. However, all of the people who used the service with whom we spoke voiced concerns about the reliability of the service they received. Although people felt safe when in the company of care staff, they told us that care calls were still not being completed in the right way. One of them summarised this feedback saying, "My care worker very rarely arrives on time. They can be 30 minutes late every time, but it's not unusual for them to be one and a half hour's late. Sometimes my morning care worker has just left when the lunchtime one is arriving."

The registered persons told us that every care call completed by the service had been carefully planned. This was so that care staff had enough time to deliver all of the care a person needed in an organised and relaxed way. They said that it was important for care staff to stay for the full amount of time planned for each call. They also told us that if visits were completed in too short a period of time there was an increased risk of care not being delivered in a safe way. This was because care staff could become rushed. As a result of this, there was an increased risk of mistakes being made and people not receiving all of the care they needed and which the registered persons had agreed to deliver. In relation to this the registered persons told us that only in the most exceptional circumstances would it be safe and appropriate for a care call to be completed in less than its allocated time. However, when we examined records that described how 35 care calls had been completed in November and December 2017 we were concerned to find that 21 of these care calls were completed in less time than had been allocated for them. Indeed of this total, three care calls had been completed in only half of the time that they were supposed to take.

We saw that in the welcome pack which people had received when they started using the service, the registered persons had committed themselves to ensure that all care calls were started within 15 minutes of their allocated time. However, when they spoke with us the registered persons said that they had revised this figure to 30 minutes for most care calls. They said that this latter measure was 'more achievable' than the former one and still meant that people could be confident that they would promptly receive all of the assistance they needed. They informed us that a number of systems were in place to ensure that care staff were consistently deployed in the right way to enable this to happen. These steps included carefully establishing how many care staff needed to be employed. It also included organising care staff so that there was enough capacity to complete care calls when colleagues were absent due to ill-health or leave.

However, when we examined records of the 35 care calls described above we noted that only 17 of these calls had started on time. Furthermore, we were concerned to find that eight of these calls were started an hour or more early or (more usually) late. People who used the service consistently voiced concerns about this matter. One of them remarked, "I always end up calling the office. I wait until 30 minutes after their due time and then I call. I can almost guarantee that I'll be told 'we were just going to phone you to let you know they're running late'. I think that they think, I'm stupid." Another person told us, "So many care workers have left in the last six months that it's not surprising that all the calls run late, because they don't have enough care workers to do all of the calls on time."

We asked 10 care staff how their work was organised and nine of them voiced significant reservations about how their work was organised. Summarising this feedback one of them remarked, "It's pretty dreadful really in that you get additional calls put on you by the office at short notice and they know you can't get round to them on time. There's sort of an expectation that you rush through them so that you can get the new ones done. Indeed, I've actually been told by office staff to cut them short and move on as quickly as possible. I've even had three calls put on me all due to start at the same time which is ridiculous isn't it."

We concluded that the registered persons had still not made sufficient progress to meet the legal requirement that sufficient care staff be deployed to consistently deliver care calls in the right way so that people reliably received all of the care they need. This had increased the risk that people would not consistently receive safe care in line with their expectations. Furthermore, the registered persons were not able to give us a clear account of any further improvements they intended to make to address our concerns. Therefore, we concluded that there was no realistic prospect of this shortfall being rectified in the immediate future.

Failure to deploy sufficient numbers of care staff to provide the regulated activity 'personal care' was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found that risks to people's safety had not consistently been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. There were shortfalls in the provision that had been made to support care staff when managing medicines. These included care staff not being given clear guidance about how to safely administer medicines that can be used on a discretionary basis as and when they are needed. Another shortfall was that some care staff had not been given the correct guidance and the documents they needed to accurately record each occasion on which they administered a medicine. These oversights had increased the risk that mistakes would be made when people were being supported to use medicines.

There were shortfalls in the provision that had been made to assist people who had sore skin or who were at risk of developing this condition. We reviewed the way in which care had been provided for two people who

had developed sore skin and who needed special assistance to help their recovery. In both instances the registered persons had not arranged for care staff to complete a nationally recognised assessment tool. The tool is designed to ensure care staff receive the right guidance when supporting people who have sore skin. We were also concerned to note that care staff had not been given the written guidance they needed to fully support them to provide the particular assistance the two people needed to receive. Although in practice other records showed that care staff had provided the right care, shortfalls in assessment and planning had increased the risk of mistakes being made.

Suitable provision had not been made to safely support people who lived with reduced mobility. The registered persons told us that it was necessary to carefully ensure that care staff used the right equipment and followed the correct procedures when assisting people with these needs. However, records showed that the registered persons had not always made the provision that they said was necessary. We were told that senior care staff were expected to confirm that the equipment care staff were expected to use such as hoists and other standing aids were well maintained and in good working order. However, records showed that a number of these checks had not been completed at all and that others were significantly overdue. We also noted that some of the guidance care staff had been given about the particular assistance people needed to receive was incomplete, inaccurate or out of date. An example of this was the arrangements that had been made for two people who lived with reduced mobility and who were at high risk of experiencing a fall. We noted that the risk had not been properly identified in the relevant care plans so that care staff had all of the guidance they needed to provide the right assistance. Although other records showed that in practice care staff were helping these people in the right manner, the shortfall in question had increased the risk that care staff would not always consistently provide the right support.

Care staff had not consistently supported people to maintain good standards of hygiene in the home. The registered persons assured us that they had assessed, reviewed and monitored the provision that needed to be made to ensure that people who used the service received all of the help they needed in this respect. They said that an important part of this was care staff being provided with easy-clean uniforms and personal protective equipment such as disposable gloves and antibacterial soap. However, we were concerned to receive feedback from three care staff who told us that these arrangements were not robust. Two of these care staff told us that they had not been provided with a uniform when they were first employed. In addition, all of them said that on occasions the supply of disposable gloves and antibacterial soap had run out. People who used the service also voiced reservations about this matter. One of them remarked, "I don't understand how they can be sent out without uniforms. It just starts everything off on the wrong foot. I very often have to remind them to wash their hands as well, not that it ever takes them very long to clean them, even after prompting." Another person said, "The care staff are rather lax about both the wearing of gloves and the changing of them when they're about to go and sort some food out, for example." A third person told us, "When they go to empty my commode bowl, they take it out and sit it on my bedside table before taking it to the toilet. I'm forever telling them not to do it, because I have my drinks and food on the same table. It's just common sense, isn't it?"

Although there was a system to analyse accidents and near misses when they actually occurred, the shortfalls we identified relating to managing medicines, promoting skin care, helping people with reduced mobility and promoting hygiene had resulted from the registered persons' failure to assess and mitigate risks to people's health and safety.

Failure to provide safe care and treatment for people was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Robust steps had not been taken to safeguard people from the risk of abuse. The registered persons told us

that it was important to operate 'fail-safe' procedures to safeguard people from situations in which they may be at risk of experiencing abuse, including financial mistreatment. However, we were concerned to note that the registered persons had not promptly notified the local safeguarding authority about an incident in which a person allegedly had been at risk of financial abuse. This had reduced the local authority's ability to quickly assess what action needed to be taken to keep the person safe.

We were also concerned to note that most of the people who used the service were invoiced for the planned duration of care calls rather than for the amount of time care staff actually spent providing them with personal care. Three people told us that they did not agree with this arrangement. One of them summarised this feedback saying, "In life you don't expect to pay for things you don't get. Why should I be expected to pay the full amount for visits completed in half the proper time. It's just not right or fair but the attitude from the service is take it or leave it." In addition, we were concerned to find that one person had been invoiced for a care call that had missed altogether due to an administrative mistake.

Another shortfall related to the arrangements that had been made to enable people to be secure in their homes. The registered persons told us that it was important to have fail-safe arrangements to enable people who used the service to only allow legitimate members of care staff to enter their homes. Therefore, we were concerned that two care staff told us that they had not been provided with an identity badge even though they had asked about the matter on several occasions. In addition, we noted that action had not been taken to provide a member of care staff with an identity badge even though the need to do so had been identified by the registered persons' own quality checks over a period of months. Some people who used the service also voiced concerns about this matter. One of them remarked, "Just recently, a young girl let herself in with my key safe, and she had no uniform, or identity badge and she told me that she come from another part of the service."

Failure to establish and effectively operate systems and processes to safeguard people who used the service from the risk of abuse was a breach of relation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We examined records of the background checks that the registered persons had completed when appointing two new care staff. We found that in relation to each person the registered persons had undertaken the necessary checks. These included checking with the Disclosure and Barring Service to show that the applicants did not have relevant criminal convictions and had not been guilty of professional misconduct. In addition, references had been obtained from people who knew the applicants. These measures had helped to establish the previous good conduct of the applicants and to ensure that they were suitable people to be employed in the service.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection on 10 and 11 August 2017 we found that there was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because suitable arrangements had not been made to obtain people's consent to the care and treatment they received to ensure that it was consistently provided in a lawful way.

At the last inspection we asked the registered persons to take action to make improvements to the systems and processes used to obtain consent. After the inspection the registered persons wrote to us and said that they had taken a number of steps to address our concerns. These included developing the systems and processes they used to assess people's mental capacity to make particular decisions. This was so that when necessary suitable arrangements could be made to provide people with the extra support they needed.

At the present inspection we found that suitable provision had been made in relation to this matter. 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 law 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 make 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 Mental Capacity Act 2005. We found that suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. The registered persons and care staff were supporting people to make decisions for themselves whenever possible. They had consulted with people who used the service, explained information to them and sought their informed consent. Records showed that when people lacked mental capacity the registered persons had ensured that decisions were made in people's best interests. An example of this was the registered manager liaising with relatives and healthcare professionals when a decision needed to be made about how best to ensure that a person only used their medicines in a safe way. Records showed that this had enabled careful consideration to be given to the matter enabling effective steps to be taken to keep the person safe.

These measures had resulted in suitable provision being made to obtain people's consent to their care and treatment. Therefore, the breach of regulations had been met.

However, most of the people who used the service with whom we spoke expressed reservations about the effectiveness of the care they received. Summarising this feedback one of them said, "Since my regular care workers left last year, it is one long succession of different care workers who I will probably only see once every 10 days or so. The poor girls don't come regularly enough to have a chance of remembering who I am or what I need help with."

Care staff had not received all of the training and guidance the registered persons said they needed in order to consistently deliver care in line with national guidance. The registered persons told us that it was

important for new care staff to receive introductory training before providing care. They said that this was necessary so that care was provided to achieve effective outcomes. They also told us that new care staff had received comprehensive introductory training when they started to work for the service. This included attending training courses and shadowing a more experienced colleague. However, the records relating to this training were not comprehensive and so we could not be confident about how well it had been delivered. The registered persons also said that all new care staff had completed the Care Certificate. This is a nationally recognised system that is designed to ensure that people working in social care know how to provide care in the right way. However again, some of the records we needed to see were not to hand and so we could not be sure that this training had indeed been completed in the manner described to us. Furthermore, three of the care staff with whom we spoke stated that they had not completed the Care Certificate.

In addition, the registered persons also said that it was important for established care staff to receive refresher training in a number of key subjects to ensure that their knowledge and skills remained up to date. These subjects included how to safely assist people who experienced reduced mobility, delivering basic first aid, supporting people to promote their continence and infection control. However, records showed that some care staff had not received all of the training intended for them. In addition, although most care staff knew in practice how to provide care in the right way, some of them did not have all of the knowledge and skills they needed. Examples of this included care staff who were not confident that they knew about the correct use of different types of continence promotion aids and others who said they needed more guidance about the safe use of specialist hoists.

Documents showed that the registered persons considered that each member of care staff needed to receive individual support from the care coordinator. This included having the opportunity to contact the care coordinator on an informal basis when advice and assistance was needed. However, it also involved each person being invited to participate in more formal 'supervision meetings'. We were told that these supervision meetings were necessary so that performance and professional development of each member of care staff could be discussed and reviewed. However, records showed and most care staff confirmed that in practice most supervision meetings were considerably overdue. In relation to this a care worker said, "I've worked here for more than a year and have never had a supervision session. Things are too rushed for that sort of thing as we're all trying to keep our heads above water and cover the calls. Supervision sessions are a luxury." Another care worker remarked, "We should have a supervision meeting once a quarter I think but to be honest it doesn't happen that much." This shortfall had reduced the registered persons' ability to ensure that all care staff were working in the right way to provide people with safe care.

Some care staff told us that they needed to have more guidance and training about how best to support people who were at risk of not eating and drinking enough to maintain their good health. They said that this would better enable them to recognise if someone was becoming unwell so that advice could be sought from a health care professional. Nevertheless, we found that in practice people were reliably being provided with the assistance they needed to eat and drink enough to have a balanced diet. Records showed that care staff were helping people by make meals and drinks. They also showed that care staff were gently encouraging people to have enough nutrition and hydration when they were at risk of not doing so. In addition, we noted that the registered manager was aware of the need to liaise with healthcare professionals if someone was at risk of choking and needed to have their meals and drinks modified so that they were easier to swallow.

We found that suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. These included the registered manager liaising with relatives to pass on information about their family member's wellbeing. It also

included arrangements being made for care staff to accompany people to hospital appointments to pass on important information if requested to do so.

In addition, people were supported to live healthier lives by receiving on-going healthcare support. An example of this occurred during the first day of our inspection visit. We heard one of the registered persons making a long telephone call to a person's doctor because care staff had raised concerns about their wellbeing. We noted that the registered person persisted with the telephone call until they were satisfied that the person would promptly receive all of the medical attention they needed.

We also noted that when necessary care staff had liaised with relatives so that they knew about important developments in a person's health care needs. In addition, they had contacted health and social care professionals when a person needed their assistance.

Suitable provision had been made to assist people to maintain their accommodation in a way that was right for them. An example of this was a member of care staff who had liaised with a person's relatives so that arrangements could be made to prevent the garden from becoming overgrown. This had enabled the person to continue to take pride in their garden.

Requires Improvement

Is the service caring?

Our findings

Most of the people who used the service with whom we spoke said that the registered persons did not give care staff all of the guidance and resources they needed to consistently deliver the caring service they wanted to provide. Summarising this feedback a person said, "I think most of the care workers want to do a good job, there's no malice in them. But I think they get disheartened by the way the service is run and the disorganisation of the thing." Another person said. "The care staffs' job is just impossible because of all the care calls they have to do and they just lose heart and leave in the end."

People were not always told which member of care staff would complete their care calls. The registered persons told us that it was important for people to feel completely comfortable with the care staff who called to their home. They said that to achieve this it was necessary to introduce people to new care staff before they began completing care calls. However, people told us and records confirmed that the registered persons had not established robust system to enable this commitment to be honoured. People consistently told us that they were not usually introduced to new care staff before they completed their care calls. Speaking about this a person said, "When I started with the service I always received introductory visits. Occasionally now, a new care worker will come with a more experienced colleague first, but that doesn't happen often and of late it can be anybody coming in to see me."

The registered persons also said that everyone was provided with a written statement informing them of the care staff allocated to complete their next week's care calls. They said that it was important for people to be informed about who would be calling to see them so that they knew who to expect and who to safely invite into their home. However, people consistently told us that in practice this arrangement was poorly organised and so was of little value to them. Commenting on this a person said, "I get sent a roster every week, for what it's worth. Some of the calls will just have the word 'unallocated' next to them and then I find that others will have changed by the time a care worker actually walks through the door. On top of that, the timings are never accurate, so to be honest, they might as well stop providing these and use the time to better organise how they run the service." Another person said, "Probably about a year ago, it was useful to receive the list every week. But to be honest now there are more blank spaces and inaccurate information, than anything else, so I hardly even glance at it anymore." A third person said, "Sometimes a new care worker will be introduced before she comes on her own, but other times, they'll just turn up unannounced and certainly not as detailed on my roster." When we called to speak with two people in their homes we looked at records for two care calls to see if the care staff that had completed them were those named on the roster. In both cases the roster was not accurate.

We were also concerned to note that neither of the people to whose homes we called had been asked if our inspector had their permission to visit them. This was the case even though we had been assured by the registered manager that the people concerned had been consulted and had given their consent to us calling to their home.

Suitable arrangements had not been made to enable people to quickly contact the service. The registered

persons said that it was important to have effective arrangements to enable people to quickly contact a senior member of staff to tell them if something had gone wrong with one of their care calls. They said that these arrangements were reliable because there was always at least one member of staff on duty in the office during normal working hours. In addition, we were told that there was always a senior member of staff 'on call' during out of office hours. The arrangement was that telephone calls made to the service's main business line were automatically routed to them. They assured us that these arrangements ensured that people always received an immediate response to any telephone enquiries they made. However, people consistently told us that in practice these arrangements did not work in a reliable way. Speaking about this a person told us, "I've only had to phone the out of hour's number a couple of times. I think it was answered once and went to answerphone the other time." We telephoned the service on three occasions over the weekend at times when care calls were being completed. On each occasion we were not able to speak with a member of staff and so we concluded that the system was not working in a reliable and customer-focused way.

People did not always receive dignified care. In their Statement of Purpose the registered persons committed the service to enabling care staff to respect people's right to privacy and to promote their dignity. However, most of the care staff with whom we spoke told us that too often this commitment was compromised by the way in which the service was organised. They said that a combination of being rushed and not knowing the people whom they visited resulted in them delivering a service that was not as person-centred as they would wish it to be. Most people who used the service were consistently critical about this matter. One of them said, "The young care workers will put dirty wipes back into the bowl of clean water whilst they are washing me. I keep telling them to throw used wipes away and only wet fresh ones in the clean water." Another person remarked, "It's little things like throwing my dirty clothes anywhere they like, when I have a laundry basket in the bathroom. Or running the water in the kitchen sink so I think they're washing up, but instead, they just hide the dirty plates back in the cupboard. I'd never dream of doing that to someone." A third person commented, "They never ask if there's anything else I need help with. If I dare ask for some help with something, I sometimes get a stroppy teenager response."

However, we found that arrangements had been made to support people who needed extra help to express their views when making decisions about their care and treatment. Most people had family, friends or solicitors who could support them to express their preferences. In addition, records showed and relatives confirmed that the registered manager had encouraged their involvement by liaising with them on a regular basis. Furthermore, we noted that the service had developed links with local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes.

We also found that suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

Most of the people who used the service with whom we spoke said that they did not consistently receive a responsive service from the registered persons. Expressing this view one of them said, "I think that the service is chaotic and unreliable." Another person remarked, "If I'd have run my business like they run theirs, I'd have gone bankrupt with this minimal level of customer service. I keep telling them that I pay for their service, not the other way around."

Suitable provision had not been made to review people's care to ensure that it continued to meet their needs and expectations. The registered persons said that it was important for people to be actively consulted about all aspects of the care they received. They told us that this involved the care coordinator regularly visiting them at home to check that the care they received continued to meet their changing needs and expectations. However, we found that in practice this system was poorly organised. We looked at the records of the reviews that had been completed for three people. In relation to each person we noted there had been periods of time when reviews had not been undertaken. We also found that even when reviews had been completed some of them had not been recorded fully while the records of other reviews were not fully legible. These shortfalls increased the risk that important developments in a person's care needs would go unnoticed. None of the people who used the service with whom we spoke could recall being regularly consulted about the care they received. One of them summarised the feedback we received when they said, "No, I've only seen a manager when they've been here covering for a sick care worker and they've never even asked me if I'm happy with everything." Another person remarked, "I can't recall sitting with anyone from the office to talk about my care plan. I can't remember when I would have looked at it last, to be honest."

We asked eight care workers if they were informed about the outcome of care reviews so that they knew about any changes they may need to make to the care they provided. Only one of them said that they had been informed about the outcomes of care reviews. The remaining care staff felt that they should be given this information so that they were fully briefed about the care they needed to deliver.

We also noted that care plans and other documents had not always been written in a user-friendly way so that information was presented to people in an accessible manner. Older people who have sensory adaptive needs and people who live with dementia often benefit from having information given to them through multi-media tools such as graphics and colours so that it is easier to understand. This oversight had reduced people's ability to be fully involved in the process of recording and reviewing the care they received.

In their Statement of Purpose the registered persons commit themselves to dealing with complaints and concerns in a positive way. This is so that lessons can be learned and mistakes put right. We were told that everyone who used the service had a copy of the registered persons' written procedure that explained how complaints could be made. However, we noted that both of the people we visited at home did not have a copy of the document in question. In addition, they were not confident that they knew how to make a complaint should the need arise.

Robust arrangements had not been made to resolve complaints and concerns. We examined records of the

complaints and concerns that the registered persons had received since our inspection on 10 and 11 August 2017. We noted that records of how complaints and concerns had been resolved were poorly organised, confused and often incomplete. These shortfalls had increased the risk that effective action would not be taken to address people's individual concerns. They had also reduced the registered persons' ability to ensure that lessons were learned more generally within the service so that there was less chance of the same mistakes happening again.

Furthermore, most of the people who used the service with whom we spoke had little confidence in the registered persons' management of complaints. Speaking about this a person remarked, "I've only complained to the office staff, but nothing's ever been done about my concerns." Another person told us, "I've got fed up complaining to the office as nothing ever happens". A third person said, "There's no point complaining, because nothing ever improves." Given this feedback, we concluded that the registered persons had not made the necessary arrangements to give people confidence that lessons would effectively be learned through the management of complaints.

However, we found that the registered persons had provided care staff with training and written guidance about how to promote equality and diversity. Care staff told us that they recognised the importance of respecting people's cultural identities, spiritual needs and life style choices. We saw examples of this commitment in action in that care staff recognised that people had different family networks. This enabled them to effectively liaise with people's partners, relatives and friends about the respective contributions they wanted to make to a person's care. Another example was care staff recognising that some people wished to spend quiet time during the course of some care calls in order to watch religious television programmes. Furthermore, care staff had been given guidance about the importance of appropriately supporting people if they were gay, lesbian, bisexual or transgender. This included being aware of how to help people to access social media sites that reflected and promoted their lifestyle choices.

We also found that suitable arrangements had been made to support people at the end of their life to have a comfortable, dignified and pain-free death. We noted that the registered persons had consulted with people about the support they wanted to have at the end of their life. In addition, they had recorded this information so that care staff could refer to it when giving people and their relatives comfort and reassurance.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection on 10 and 11 August 2017 we found that there was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered persons had not promptly informed us about the occurrence of incidents in the service in line with legal requirements.

At the last inspection we asked the registered persons to take action to make improvements to the arrangements they used when submitting notifications to us. After the inspection the registered persons wrote to tell us that they had strengthened systems and processes to ensure that in future notifications would be submitted to us in the correct way.

However, at the present inspection we found that the registered persons had not promptly told us about two significant events that had occurred in the service. Both of these events involved situations in which people who used the service had been placed at increased risk of experiencing abuse due to a combination of alleged neglect and improper conduct by a small number of care staff. It is a legal requirement that we be told about these and other events so that we can promptly check that suitable action has been taken to keep people who used the service safe.

Failure to notify the Care Quality Commission without delay of incidents that occurred while services were being provided in the carrying on of the regulated activity or as a consequence of the carrying on of the regulated activity was a continuing breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

Suitable arrangements had not been made to enable the service to learn, innovate and ensure its sustainability. None of the people who used the service with whom we spoke considered it to be well run. They all rated it as, 'requires improvement'. One of them summarised their views as follows, "Requires improvement because of lack of regular care workers who know me, care workers not arriving on time, insufficient training before care workers visit people and the need for better organisation." Another person told us, "Requires improvement because of unreliable timings, rushed care, no regular care workers and office staff who can't be honest about the difficulties in the service."

Although there was a registered manager in post the registered persons had not been able to consistently promote a positive culture in which care staff were clear about the contribution they needed to make to achieve good outcomes for people. In relation to achieving these goals we were told that it was essential to invite care staff to contribute to staff meetings. This was so they could discuss and resolve any problems they were experiencing. However, we found that these meetings were infrequent and were poorly organised with low attendance. In addition, we noted that most of the recent meetings were not well recorded and that little effort had been made to share information with care staff who had not attended. This was the case even though important subjects had been discussed. One of these involved concerns about incidents when records of the care provided to people had been written before care calls had actually been completed.

Most of the care staff with whom we spoke said that morale in the service was very low. They also said that they were not confident that the registered persons were fully committed to developing the service. We were concerned to hear members of care staff commenting in this way on their experience of working in the service. Summarising these views one of them said, "To be honest, I advise people never to use Midlands Home Care Limited because the service they'll get is just so dreadful. Care calls won't be on time, or they'll be missed altogether and if they complain no one will really listen. The service just isn't right and shouldn't be allowed to continue."

We were also concerned to note that the registered persons had not taken all of the steps necessary to ensure that the service met with regulatory requirements. This included the registered persons not suitably displaying the quality ratings we gave to the service at our last inspection. This is a legal requirement and is necessary so that people who may wish to use the service can be fully informed about the quality of the care they can expect to receive.

In their Statement of Purpose the registered persons state that they are, 'Whole heartedly committed to providing top quality services and to continuous improvement. (This includes) welcoming feedback from our service users (with) quality questionnaires being given to (them) quarterly to assist us in our objective'. However, we noted that people had not been invited to complete any quality questionnaires in the 12 months preceding our inspection visit. In addition, we noted that there were no plans to address this shortfall in the foreseeable future.

Robust provision had not been made to assess, monitor and improve the service. The registered persons told us that a number of audits were regularly completed to ensure that the service ran smoothly so that people received high quality care. One of these measures involved the completion of frequent 'spot checks' when the care coordinator called on an unannounced basis to see care staff while they were providing care. These checks were intended to make sure that care was being delivered in the right way. However, records showed that in practice this system was poorly organised. We reviewed the spot checks that had been completed for three care staff and in each case we found that they had not been completed as frequently as intended. In addition, we noted that even when the checks that had been completed records showed that some of them had not been undertaken in a comprehensive way.

The registered persons also told us that they completed weekly audits of the records created by care staff to describe the time when care calls had been completed and their duration. However, we found that these checks were not being completed in a robust way to quickly identity problems. This was because some parts of the checks were too general to reliably identify the shortfalls we had noted in the completion of care calls. Furthermore, there was no clear evidence to show that effective steps had quickly been taken to address problems when they occurred.

We also noted that other audits had similarly not led to the prompt resolution of the other shortfalls we have described in our report. These included oversights in the arrangements used to safeguard people from the risk of abuse and to support people to receive safe and harm-free care. They also included shortfalls in the delivery of training and guidance for care staff, the arrangements used to provide care that respected people's dignity and the systems used to deliver responsive care. In addition, quality checks had not identified shortfalls in the management of complaints and concerns that had contributed to people expressing a lack of confidence in the system used by the registered persons.

Furthermore, we were not given the assurances we needed that there were robust systems to ensure the financial sustainability of the service. There were no records to show how the service's income was balanced against expenditure. In addition, the registered persons did not respond to our request to see records of the

regular financial updates they said were completed to show how much money had been spent and how much was left for the remainder of the financial year. These shortfalls reduced the confidence we could have that sufficient income was being generated to support the continued operation of the service.

Failure to establish and operate effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity 'personal care' was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we found that there were examples of the registered persons working in partnership with other agencies. There were a number of examples to confirm that the registered persons recognised the importance of ensuring that people received 'joined-up' care. One of these involved the registered persons liaising with commissioners to enable them to develop a clear understanding of how many people they could support in the community. This helped to ensure that there was enough capacity in the system to support cross sector working. One of the benefits of this was helping to ensure that there were enough resources in community care services to enable people to quickly be discharged from hospital after their treatment had been completed.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person had failed to notify without delay of the incidents which occur whilst services were being provided in the carrying on of a regulated activity, or as a consequence of this.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to provide safe care and treatment for people. Risks to people's safety had not been consistently assessed, monitored and managed

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had failed to establish and effectively operate systems and processes to safeguard people who used the service from the risk of abuse

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to establish and operate effective systems to assess, monitor and improve the quality and safety of

	the services provided in the carrying on of the regulated activity.
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had continued to fail to deploy sufficient numbers of care staff to provide the regulated activity, 'personal care',