Friends Care Ltd

# Friends Care Limited

**Inspection report**

Suite 7
Marshwood Business Park
Marshwood Close
Canterbury
Kent CT1 1DX
Tel: 01227 200582
Website: www.friendscare.co.uk

Date of inspection visit: 11 and 17 June 2015
Date of publication: 03/08/2015

## 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 |

## Overall summary

The inspection took place on 11 and 17 June and was announced. We gave '48 hours' notice of the inspection, as this is our methodology for inspecting domiciliary care agencies.

In December 2013 the provider registered with us to provide a domiciliary care service. The service was located at Canterbury Enterprise Centre. In December 2014 the service moved to its current location at Marshwood Business Park. However, the service was not registered with us until 17 March 2015. This is the first inspection of the service at its location at Marshwood Business Park.

Friends Care Limited provides personal care and support to people in their own homes in Canterbury and surrounding areas. At the time of the inspection it provided a personal care service to three older people.

The service did not have a registered manager. A registered manager is a person who has registered with

# Summary of findings

the Care Quality Commission (CQC) 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. At the time of this inspection, the provider was managing the service. In the absence of a registered manager, the provider was undertaking this role, but they did not have the skills, knowledge or experience to do so.

There was not an effective system in place to assess and monitor the quality of the service. There were no formal checks in place to ensure that staff had received effective training, that there training was up to date, that medicines were administered safely or that care plans and assessments were comprehensive.

There was a risk of people not receiving their medicines as prescribed by their doctor because there were not effective systems in place for the management of medicines. Staff had only received on-line training in how to administer medicines and had not been observed by a competent person to make sure that they were giving and recording medicines safely. Medication administration records were unclear so it was not possible to ensure that people were receiving the right medicine at the right time. No one employed at the agency had a comprehensive knowledge of the management of medicines and there were no formal systems in place to check if medication errors had been made.

Staff had not undertaken comprehensive training, nor had their competency been assessed by a qualified person, to ensure they had the required skills and knowledge in essential areas such as how to move and handle people safely, how to administer first aid and fire safety. Staff were helping one person to transfer and move and had not received practical training or written or verbal guidance in how to do so safely. Four weeks previously, the administrator had qualified as an assessor in how to move and handle people. However, staff who supported people to move, had not received any practical training, nor had their competency to move and handle people safely been assessed.

Staff had received training in how to safeguard people, but it was not effective in giving them the knowledge and competence in recognising the signs of abuse. The provider did not have a comprehensive understanding of what constituted potential abuse.

Staff and the provider had not received training in the Mental Capacity Act 2005. They were unable to tell us anything about its principles or how it affected their practice. The Mental Capacity Act aims to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making.

Assessments of risks had been undertaken in relation to the person's home environment. However, action to minimise potential risks to people had not always been undertaken nor had guidance been provided to staff in relation to how to minimise risks that had occurred.

People's needs had not been assessed by a person who did not have the required level of skill and knowledge to do so and as a result they were not always comprehensive. Some people required assistance with personal care, but this was information was not contained in their initial assessment. Plans of care did not contain detailed guidance for staff in how to move and handle people safely.

Before staff worked at the agency some checks were carried out, including identity and criminal record checks. However, for two staff no references had been recorded to check that they were suitable to work with the people that they supported.

There was not an effective complaints procedure in place. A serious concern raised by one person who used the service had not been identified or recorded as a complaint and as a result no action had been taken to this person's concerns.

Staff knew people's routines, preferences and family life. People said staff were kind and caring. At the time of the inspection people were supported by regular staff. However, one person had been supported by six different members of staff in the first six week of their care package, which did not result in continuity of their care. Most people said that they were treated with dignity and respect. However, some people who used the agency had not had their privacy and dignity respected and this had resulted in one person leaving the agency.

Staff received supervision, but most did not feel supported in their role. Staff worked alone and had little or no contact with other members of the staff team. There were no agency policies in place to give them guidance in areas of their work.

# Summary of findings

People's needs in relation to food were assessed, and one person was encouraged to drink adequate amounts of fluid to keep them healthy.

Staff knew to contact the provider if they had any concerns about a person's health. One member had called an ambulance when the person who used the service was seriously ill on arrival at their home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated activities 2014).

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was not safe.

Comprehensive checks were not carried out on all staff before they worked independently.

People could not be assured that they were protected from potential risks.

Staff were not all aware of their individual responsibilities to prevent, identify and report abuse.

People were at risk of not receiving their medicines as prescribed by their doctor.

**Inadequate**

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

Staff were not provided with the essential skills and knowledge that they required to support the people in their care.

Although staff had supervision, most did not feel supported in their roles.

People who lacked mental capacity could not be assured that they would be supported to maximise their ability to make decisions or participate in decision-making.

**Inadequate**

**Is the service caring?**
The service was not always caring.

People were not treated with dignity and respect at all times.

People could not be assured that they were always supported by a consistent staff team.

People said that staff were kind and caring and knew their routines.

**Requires improvement**

**Is the service responsive?**
The service was not responsive.

The assessment process was not comprehensive as it did not identify all of people's care and support needs.

People's assessments and plans of care did not contain detailed guidance about how to move and handle them safely and appropriately.

People's concerns and complaints were not always listened to so that action could be taken to address them.

**Inadequate**

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

**Inadequate**

# Summary of findings

The service was managed by the provider, who did not have the necessary skills, knowledge and experience to do so effectively. Staff did not feel well supported and they were not given guidance about their responsibilities.

People were asked for their views about the service.

Quality assurance and monitoring systems were not effective in identifying shortfalls in the agency and areas needing improvement.

# Friends 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 and 17 June and was announced with 48 hours' notice being given. The inspection was carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR within the set time scale. Before the inspection, we looked at information about the registration of the agency and notifications about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the provider, administrator and three care staff. We visited three people in their own homes and obtained feedback from three social care professionals and one health care professional.

During the inspection we viewed a number of records including three care plans and daily notes, eight staff recruitment records, staff training, staff induction programme, supervision notes, policies and procedures, complaints logs, medication administration records and quality assurance questionnaires.

.

Inadequate

# Is the service safe?

## Our findings

People told us they had regular care staff, who they trusted and made them feel safe. One person told us they did not feel confident about staff when their service first started; but they were now supported by staff with whom they felt safe. However, the provider and the staff team did not understand what they needed to do to ensure people were kept safe from harm or abuse, and they did not know or understand their responsibilities towards people when they suspected abuse had taken place. The provider had failed to ensure that they or the staff team had received adequate training in safeguarding the health, safety and welfare of people they provided a service to. The provider had poor knowledge of safeguarding. Despite this, the provider delivered safeguarding training to staff, and then assessed their competencies.

Staff training in how to safeguard adults was delivered to staff through watching a DVD or video on- line and completing a worksheet to test their knowledge. The provider then asked staff if they had any questions about the topic area. Most staff did not feel this gave them the knowledge and skills to safeguard people and said they needed and would like more training in this area. Staff were able to identify different types of abuse, but most staff did not feel they had the knowledge to recognise the signs of abuse. Staff said they would report any concerns to the provider of the agency.

The provider had a copy of the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway'. This contained guidance for staff and managers on how to protect and act on any allegations of abuse. The provider stated he knew how to contact the local authority safeguarding team if any concerns were reported to him, but only one member of staff knew that safeguarding concerns should be reported to the local authority safeguarding team. The provider said they had raised safeguarding concerns with the local authority. However, a representative from the local authority informed us that an issue that the provider had raised with the safeguarding team had not been a safeguarding concern. The agency did not have a policy or procedure on safeguarding adults or how to 'blow the whistle'. This is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith.

The lack of staff knowledge and skills in how to keep people safeguard people is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of not receiving their medicines safely, and a risk of not receiving their medicines at all. Staff training in how to administer medicines was delivered to staff through watching a DVD or video on- line and completing a worksheet to test their knowledge. Staff did not receive practical training in how to administer medicines, nor was their competency in giving medicines observed or monitored regularly by a qualified person to ensure that it was carried out safely. The agency did not have a medication policy in place which set out the responsibilities of the provider and care staff when supporting people with their medicines.

The provider did not have a comprehensive understanding of the management of medicines and the responsibilities and risks involved. One person's medicines were stored in their original containers with the name of the medicine and the directions for administration. Staff looked at the medication administration record (MAR) sheet to see the name and dosage of the medicine and the time that it should be given. They then took the correct medicine out of the medicine container and recorded on the MAR sheet, the medicine that the person had taken. Another person's medicines had been placed into a dossette box, which is known as 'secondary dispensing'. This is where staff rely on the person who puts the medicines in the dossette box to have done so correctly, as they do not know what medicines they are giving the person. These method of giving medicines, have a higher risk of errors occurring, compared with using a monitored dosage system, where medicines are pre-dispensed by a pharmacist. The provider was not aware of these increased risks, or alternative methods which had a lower risk.

One person's MAR sheet contained eleven medications that the person had been prescribed. The medicines listed in their care plan and emergency medical information form, were not the same as those listed on their MAR sheet. This indicated that the provider was not aware of any changes in this person's medication and health care professionals would not be given the correct information about the person's medicines, in the event of an emergency.

The MAR sheet was not a clear record of the medicines the person had in stock or the medicines that they had been

supported to take. For some medicines no entries had been made indicating that for the person had not received medicines they required that month. For some medicines prescribed as 'once daily' there were two staff signatures, indicating that the person had received their medicine twice for that day. The provider said that a new MAR had not been available, so staff used the record for the previous month. There was no written explanation for this on the MAR and no blank MAR sheets available to prevent this inaccurate recording from occurring.

For other medicines there were gaps in the record, indicating that medicines had not consistently been given as prescribed. The provider could not explain the reason for these gaps and said there was no system in place to follow this up, to ensure that people received the medicines they had been prescribed. There was no system in place to regularly check the amount of medicines that the person in stock. Therefore, it would be difficult to establish if gaps in the MAR sheet were due to the medicine not been given or whether the staff member has omitted to sign the MAR sheet. The time that staff should give the person their medicines was also not always recorded to ensure that medicines were given at the right time. This was particularly important as one medicine needed to be taken 30 minutes before their first food of the day.

Some medicines prescribed as twice daily, had only been given by staff once a day. The provider stated that as care staff only visited this person once a day, they were not able to support the person with their medicines at other times. The person who used the service told us they did not know what their medicines were for or when they should be taken. Therefore, there was a high risk that this person was not receiving their medicines as prescribed by their doctor, to maintain their health. The provider had failed to alert other agencies (such as the person's G.P, or the local authority safeguarding team) that this person's health was at risk. The provider did not take any steps to ensure this person was safe other than when they received a service from the agency. They had not raised concerns with the person's representative or with a health professional.

One person had been assessed as being able to take their medicines independently and the provider told us that staff had not been authorised to give them any medicines. Their care plan had been reviewed in May 2015 and no changes had been made regarding their medicines. However, staff told us that they gave the person their medicines from their dossette box and recorded that medicines had been given in the daily notes. But staff were not sure what the medicines were prescribed for and therefore, did not know what signs and symptoms to look out for if any side effects occurred. Staff told us they left this person's evening medicines out for them to take by themselves, but that they rarely took them. They said that they informed the person's relative, but that they did not make a record that this person had refused their medicines.

The provider told us sometimes one person who used the agency did not have sufficient quantities of medicines in stock. He said that on one occasion he had had to go out and obtain this person's medicine at short notice and that on another occasion a person from a different organisation had obtained their medicine. There was no system in place to make sure that people's medicines were always available in the necessary quantity to prevent the risks associated with medicines not being administered as prescribed.

Two people had been prescribed creams to use by their doctor. However, neither the name of the cream, nor the directions of where to apply it were contained in the person's care plan. Staff also did not record when or where they had applied the cream. Therefore, it could not be assured that creams were applied consistently and appropriately by the staff team.

The failure to ensure people were protected by the safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records of all staff that had been recruited by the agency. Some staff were supporting people at the time of our inspection and the provider informed us that other staff were available to support people when they were required. Staff had completed an application form and attended an interview, where they were asked how they would support people through the use of scenarios. Application forms contained information about the applicants' qualifications, skills and experience. However, one person's application form did not include the dates of their s employment so it was not possible if there were any gaps in their employment history, or the reasons for these gaps.

The provider told us that it was the practice of the agency to obtain two references, before a person worked

unsupervised. This could include one professional and one character reference. However, two staff did not have any references and one staff had been supplied with only one employment reference. Checks of the person's identity and a Disclosure and Barring Service (DBS) check were undertaken. A DBS identifies if prospective staff had a criminal record or were barred from working with children or vulnerable people. If people had a positive criminal record, a risk assessment was put in place

The failure to ensure people were protected from harm by an effective and safe recruitment processes is a breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not managed appropriately and because of this people were not protected from potential harm. Risks to people's safety in their home environment were assessed before they received a service. This included a person's risks of slipping on uneven flooring, steps that needed to be negotiated and that there was safe access to the person's home. Assessments of potential risks to people had also been undertaken in relation to their continence needs, memory, nutrition and skin care. Moving and handling assessments had been carried out and included when people needed support, such as with walking, standing, turning in bed and getting on and off the bed. However, the assessment did not include essential information such as if the person was able to stand by themselves. One person's risk assessment stated they had blemishes on their legs and the cause was unknown. Staff told us that this person had very delicate skin which bruised easily. Their care plan stated they had 'bed sores' for which they were receiving treatment. A body chart had been completed to show the location of a pressure area. There was no assessment of risk or guidance in place for staff to follow to minimise the risk of their skin being damaged when providing personal care.

Staff recorded information about any accident that had occurred. This information was passed to the provider. The provider had updated one person's assessment of risk as a result of an accident that had taken place. However, this guidance was stored on the office computer. The person's care plan had not been updated to ensure that staff were aware of the action that they needed to take to minimise the potential risk to the person's safety.

The failure to conduct an assessment of people's needs and risks, and a lack of guidance for staff about how to keep people safe from individual risks is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider showed us a number of staff files and said they had recruited these additional staff so they were available to support any new packages of care. The provider also supported people when required, such as to cover any staff sickness or annual leave. People were given the telephone number of the on-call system for the agency, operated by the provider. However, people told us that they had had no need to call the agency office out of hours.

Inadequate

# Is the service effective?

## Our findings

People said they were supported by regular staff that knew their routines and knew how to support them. However, most staff said the agency induction programme was not effective in providing them with the skills, knowledge and confidence they required to support people in their own homes.

Staff told us their induction consisted of watching DVD's about a range of topics on their own and "writing things down", which they did not think was a good way of learning. However, one member of staff found this method of training suited their learning style. Two members of staff had no previous training in working in a social care setting and one member of staff had received training ten years ago. Only one staff member told us they shadowed more experienced staff before working by themselves in the community. Most staff said they were introduced to a person who used the service and then started straight away to support them without effective induction or training. The provider told us, "We know training as it is, is not perfect. We will do a two day induction"

The provider told us that they and the office administrator would deliver the new induction programme and training to the staff team. We asked the provider what qualifications they and the administrator had to deliver training in the above topics. The provider told us they had watched DVD's in all topic areas and singed themselves off as competent, after completing the related workbook. The administrator had a training certificate which showed that they were a certified trainer in moving and handling people safely. The provider told us that this gave them the skills and knowledge to train staff in all other subject areas. However the certificate only detailed that the administrator had been assessed as competent to train people in moving and handling. At the time of the inspection, the administrator had not delivered any moving and handling training to the staff time. This meant that staff who moved and transferred people were relying on their knowledge gained from watching a DVD.

The provider said they assessed staff as trained in each topic area after checking their answers in their completed worksheets against the answers given by the training company. There was no independent verifier to make sure that the providers' assessment met the standard required. When the provider was asked who signed their training off to ensure they were competent, the provider responded, "I am not sure. No one". It was suggested that an external person should check the provider's competence in each training area and that self-validation was not a safe or robust process. The provider responded, "That is a very fair point".

The failure to ensure staff had the necessary qualifications, competence and skills to effectively carry out their roles and responsibilities is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the provider information return that the provider sent us, the provider stated that they were a member of Skills for Care. Skills for Care works with adult social care employers to help ensure staff have the right skills and values to deliver high quality care. The provider told us they did not find Skills for Care useful as they had asked for advise on the exact training they should provide for staff and they were unable to do so. Skills for Care advised that the training staff required was specific to the nature of the service and the individual needs of the people who used it. The provider was not aware of the new Care Certificate, introduced in April 2015, which sets out all that a new member of care staff needs to know, before they start to work independently. None of the staff employed at the agency had completed a National Vocational Qualification or Qualification and Credit Framework (QCF) in Health and Social Care. These are nationally recognised qualifications which demonstrate staff's competence in health and social care.

The provider had carried out a formal supervision with most staff which included discussions around performance and health and safety. He also kept in contact with staff by phoning them. However, most staff said that they did not feel supported by the provider. One person told us, "I don't get much support really". Supervisions were not effective in identifying staff training needs as they stated that staff had received all relevant training. This is despite the provider telling us he recognised that the current training was not fit for purpose, and that he was in the process of developing a more robust training package for staff. In addition, none of the staff had received practical manual handling training or any training in the Mental Capacity Act 2015.

Neither staff nor the provider had received training in the Mental Capacity Act 2005. The provider and staff were not able to tell us anything about the Act or its principles, and

Inadequate

# Is the service effective?

how it affected their practice. The Mental Capacity Act aims to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. The provider told us that the previous manager was a train the trainer in the Mental Capacity Act. They said that as they were no longer working at the agency, no staff had received in this area. The provider had not sought any training for themselves or for staff to ensure they understood and applied the principles of the Act. A social care professional told us that the provider did not understand that he could not act on a person's behalf without first seeking their consent.

It was recorded in one person's care file that they had a Lasting Power of Attorney. However, the provider was not aware that a Lasting Power of Attorney could be in relation to the person's finances or welfare. The provider said that they had taken this information on trust and had not obtained or seen a copy of the office of the public guardian authorisation letter. This could mean that a person is making decisions on behalf of another in the absence of legal authority. Another person who used the service had a court appointed deputy to help with more complex decisions. The provider had communicated with the court appointed deputy on a weekly basis when the service had first started to ensure that it met their needs.

The failure to ensure staff had appropriate knowledge in relation to the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs in relation to whether they required staff to prepare food were discussed as part of their initial assessment. One person's care plan stated that the person should be encouraged to drink more as they are not good at drinking sufficient amount of fluids to keep them healthy. Daily notes showed that staff made drinks for this person at each visit. People did not require any assistance with meal preparation.

People's health needs were recorded in their plan of care. Staff were not directly responsible for providing health care for the people they supported. One person required verbal prompts to ensure they attended to their own health condition. The staff member that supported this person was knowledgeable about recognising any warning signs in relation to their condition. Staff were aware of their responsibility to report any concerns about a person's health to the provider.

This was so that swift and appropriate action could be taken, such as informing the person's relative or doctor. One member of staff told us that they had called an ambulance for a person when they arrived at their home and was seriously ill. A record of the event was held in the person's care file at their home. Another member of staff told us they liaised with the district nurses when people received their support. Feedback from the district nurse team was that individual staff cared for and supported people in an appropriate manner.

Requires improvement

# Is the service caring?

## Our findings

The provider told us they were confident they were providing good care to the people who used the agency. However, our inspection demonstrated that the provider had failed to ensure people's needs were properly assessed, had failed to ensure that people were safe, and had failed to ensure that staff were trained. Care being delivered to people was not caring because the provider

did not recognise people's needs, and people were, and continued to be at risk of harm because of this.

People did not always know what staff member would turn up to support them and they said this caused them anxiety. One person told us they had had a lot of staff when they first started to use the agency. This person had had six different staff supporting them in the first six weeks of their care package.

This lack of an effective system to assess, monitor and improve the agency is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A social care professional told us that two people who used the agency had not been treated with dignity and respect. One person had discontinued using the agency because staff did not respect their privacy and dignity.

People told us that staff were kind. "Staff are lovely", one person told us. People said they could talk to staff and that they listened. Two people told us that one particular member of staff was a very caring person. They said that they looked forward to seeing this member of staff as they enjoyed talking with them and said that they cheered them up. Another person told us this was the first agency where they had received support from a regular member of staff.

One social care professional told us, "Staff are genuine; they really care for the people they support. However, they also said that one member of staff rushed when supporting people. The agency had received a compliment for the care that they had provided. One person wrote, "Friends Care provided sympathetic and professional care. I felt I could totally trust my Dad's carer and a good relationship was quickly established between them. As a family we are extremely grateful for the support we received".

People said they were always treated with dignity and respect and this was reflected when the provider asked people about their experiences in April and May 2015. When talking about the people they supported, staff spoke about each person in a positive way. They described people as 'lovely' and said how much they enjoyed spending time in their company. One member of staff explained that they were upset when a person they had cared for passed away. They had attended their funeral to pay their respects to the person with whom they had developed a good and caring relationship. The agency also provided companionship for people whereby staff developed friendly relationships with people over time and took them out into the community.

Information about people's past history such as their family and past employment was recorded in their care plan. Staff also had guidance on people's choices and preferences such as their preferred morning and evening routine. This was to ensure that staff cared for people in the way that they liked and preferred. Staff demonstrated that they knew people well.

Inadequate

# Is the service responsive?

## Our findings

People told us that the provider came to visit them and/or their relative before they received a service from the agency. During this meeting people said they discussed what their needs were and how the agency could meet them. The assessment of people's needs included information about each person's health, social and personal care needs such as their mobility, medication, communication and likes and dislikes. However, all assessments were undertaken by the provider who did not have any experience or qualifications in this area. Because of this, people were at risk of receiving care that did not meet their needs. Our inspection identified that the provider had put people at risk of harm because the assessments he carried out were incomplete, and he had not ensured that people received an assessment which was accurate.

One person needed assistance with moving and transferring. The Manual Handling Operations Regulations 1992 require that each person's moving and handling needs are individually assessed. This includes identifying the tasks that are necessary and how the person should be moved, including the ways the person may assist. This person's care plan stated that they were "unable to move a great deal and therefore will be fully relying on the carer to move them off and onto the bed". However, staff told us that they had not had any practical training or been given any verbal or written guidance about how to move and transfer this person.

We saw a member of staff moving a person in their wheelchair along a corridor, without using any footplates. The meant that the person was not able to rest their feet on the footplates, but had to raise them to stop them from scrapping the floor. Therefore, there was a risk that this person may damage their feet or catch them under the wheelchair. A social care professional told us that one person who used the agency had to show staff how to use the hoist as they did not know how to use it, and that staff had placed them in the hoist sling incorrectly. The administrator had completed a train the trainer course in moving and handling on 15 May 2015, which was four weeks before our inspection visit. However, they had not visited this person to assess their individual needs and to give guidance and support to staff to ensure that they were moving them safely.

One person had been assessed as not requiring any personal care. The assessment stated that the person required companionship and prompts to enable them to manage their health needs independently. However, staff and this person told us that they did require personal care and that they were receiving personal care. A staff member told us that they were introduced to a person who had been assessed as requiring companionship only. However, this person also required personal care.

A plan of care had been developed from the initial assessment of people's needs. However, as people's personal care needs, such as supporting people with a bath, had been omitted from people's assessments, these care needs were also missing from people's plans of care. Staff told us that they did not usually look at people's care plan and relied on what the person told them and any guidance from other staff. The care plan for one of the people that we visited was not available at their home to give guidance to staff about how to support them. The care plan for another person had been updated on the office copy, but not on the copy at the person's home.

The failure to undertake a comprehensive assessment of people's needs is breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information that people received from the agency when they first started to use the service stated that, "At Friends Care we attach a great deal of importance to listening to your views on any matters relating to the service you receive from us. Whatever your comments, good or bad we will acknowledge them within 2 working days and in the case of a complaint, the matter will then be investigated and reported back within 28 days".

We asked the provider to show us a record of any complaints that people had made about the agency. They showed us a record of one complaint. This had been investigated and records kept of the action taken, including feedback to the person who had made the complaint. However, this person had also contacted the provider to say they did not want any more support from the agency. They said this was due to the lack of skills and competence of its care staff in supporting them with their personal care. The content of what this person had communicated to the provider was that of a serious complaint, as they no longer wished to use the agency. However, the provider had not recorded their views as a formal complaint. Nor had they

Inadequate

# Is the service responsive?

taken any action to try and address their concerns. Therefore, the service did not have an effective system in place to listen to and act on concerns and complaints made by people who use the service.

This failure to identify, record and take action to address concerns and complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection people told us that they did not have any concerns or complaints about the service. They were given information about how to make a complaint when they first started to use the service. It explained who to contact at the service if they had a complaint. However, it did not inform people that they could contact the local government ombudsman. This is an independent organisation, which can look into complaints once a care provider has been given a reasonable opportunity to deal with the situation. Staff responded that if a person raised a concern with them, they would pass this on to the provider, but that they had not needed to do so.

People said that staff always arrived on time and stayed for the required amount of time. One staff member told us that the provider had transported them to a person's home, when they had found the journey difficult to manage.

Inadequate

# Is the service well-led?

## Our findings

People told us that they were happy with the care they received but did not have any views on the management of the service as they said they did not have reason to contact the office. Some people told us they were concerned that a member of staff who supported them was leaving and they had not been informed of their replacement.

Social care professionals said that the provider sometimes acted in an 'unprofessional' manner and did not always understand their responsibilities and duty of care to people who used the agency. This meant that when problems arose the provider transferred any responsibility onto other people or agencies, rather deal with the situation themselves.

The agency had been operating at its location since 2 December 2014, but the provider did not submit an application to register the location and a manager until 22 December 2014. The agency had not had a registered manager since the agency was registered on 17 March 2015. In the absence of a registered manager, the provider told us they had not considered employing someone with the necessary skills and knowledge to manage the service, but were managing the service themselves. The provider did not have previous experience of working in social care, nor a social care qualification. The provider had undertaken the same training as their staff team in relation to essential subjects such as moving and handling, safeguarding and medication. The provider had assessed themselves as competent in these areas, without any external verification of their skills and knowledge. The provider had not kept up to date with current practice and was not aware of our inspection methodology which is available on our website. The provider told us that he had started a Level 5 Diploma in Leadership for Health and Social Care.

The agency did not have any policies or procedures. The provider showed us policies and procedures but they belonged to another organisation with which the provider was no longer doing business. These polices had not been personalised to relate to the specific nature of the agency and the provider did not know their content. For example, the quality assurance policy stated that managers and staff should meet the 'national occupational standards for care industry set by Skills for Care'. However, the provider did not use training guidance from Skills for Care and said that he did not find them a useful organisation to contact in relation to his staff training needs. An overview of policies and procedures was not part of induction or the new induction programme. Policies and procedures were posted on the computer for staff to read. However, staff said they had not read them and there was no system in place to ensure that staff knew their content. Therefore, staff did not have guidance in areas of their practice, to support them to understand their roles and responsibilities.

The agency did not have an effective system in place that assessed and monitored the quality of service that it provided. The provider was not aware of shortfalls in relation to the management of medicines, assessment and risk assessment processes, staff recruitment; and the lack of staff skills and competence in moving and handling people, safeguarding people and in understanding the principles of the Mental Capacity Act 2015.

There was no system in place to alert the provider to when the training of staff who were supporting people, needed to be refreshed, to keep them up to date with current practice. The provider also had a number of staff, whom they had recruited and trained over a period of time. The provider said that these staff could be called on at any time, but there was no system in place to ensure that their training was in date.

Although we saw that staff had used accident forms and body charts to record incidents, blank copies were not kept in each person's care file at their home, so that they were available when needed.

Information on the agency website states that, "Staff are able to participate in the decisions, that affect their working lives. In our experience, this produces a higher level of commitment to the organisation, and to the quality of the services that we deliver, because every employee is supported to achieve their personal and professional best". The provider had put a risk assessment in place for supporting a member of staff who required this to enable them to work more effectively. However, most staff told us that the service was not well led and they did not feel supported. Two members of staff told us they were leaving the agency and one of the reasons was due to lack of training and support. One staff member told us this prior to the inspection and another during the inspection visit. Staff worked as individuals rather than as part of a team. There were no formal staff meetings where staff could meet and

Inadequate

# Is the service well-led?

discuss any concerns or best practice or regularly communicate with one another. Staff said they only met each other if they worked together and although the agency only employed a small number of staff, they had not all met one another.

Staff were not provided with important information such as the aims and objectives of the agency, useful contact numbers and a summary of the agency policy and procedures in an accessible format, such as in a staff handbook.

In the agency's provider information return, the provider had identified ways that it could improve. This included working more closely with social services, using personality trait questionnaires to match staff to people and creating anonymous feedback for staff and people who use the service. However, progress had not started in all these areas. The provider had not identified any ways that it could improve to make the service more caring or responsive. Therefore, it was not seeking ways to continuously improve for the benefit of people who used the service.

This lack of an effective system to assess, monitor and improve the agency is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The views of people who used the service had been sought by the provider in April and May 2015. People responded that they were very happy with the support they received from staff. People were asked if they were happy with the staff member/s that supported them, whether staff arrived on time and completed all expected tasks, if assistance was provided in a safe way and if they thought the service could improve in any way. Comments included, "I am very happy with the staff and I think they are lovely"; and "I am very happy with my carers". They did not communicate any ways the agency could improve.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were not protected from abuse as safeguarding training was not effective in ensuring that staff were aware of their individual responsibilities to prevent, identify and report abuse.<br><br>Regulation 13 (1) (2) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br>People were not protected by robust recruitment procedures as references were not sought for all staff to ensure that they were of good character.<br><br>Regulation 19 (1) (2) (3) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The management of medicines did not ensure that people were protected from the risks associated with medicines not being administered as prescribed.<br><br>Regulation 12 (1) (2) (f) (g)<br><br>People were not protected against the risks of unsafe care and treatment as the provider had not ensured that comprehensive risk assessments were undertaken and shared with staff.<br><br>Regulation 12 (1) (2) (a) (b)<br><br>Staff did not have the qualifications, competence, skills or experience to support people safely, including when moving and handling them.<br><br>Regulation 12 (1) (2) (c) |

This section is primarily information for the provider

# Enforcement actions

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>It could not be assured that decisions were made with people and in their best interests because the provider and staff had no knowledge of the principles and codes of conduct associated with the Mental Capacity Act 2005.<br><br>Regulation 11(1) (2) (3) (4) |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>Assessments of people's needs were carried out by a person who did not have the required level of skill and knowledge to do so and as a result they were not always comprehensive.<br><br>Regulation 9 (1) (a) (b) 3 (a) |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>People could not be assured that there complaints about the service were listened to and acted upon as there was not an effective system in place for identifying, handling and responding to complaints.<br><br>Regulation 16 (1) (2) |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider did not have systems and processes in place, such as regular audits of the service provided, to assess, monitor and improve the quality of the service.<br><br>Regulation 17 (1) (2) (a) (b) |