Tailored Care Limited

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Inspection report

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16 October 2017
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18 October 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection site visit took place on 12 and 13 October 2017 and phone calls to people, relatives and staff began on 16 October 2017. The inspection was unannounced. Tailored Care provides personal care to older people, people living with dementia, people with mental health concerns, people with sensory impairments, people with a learning disability and younger adults in their own homes. At the time of the inspection, 56 people were receiving a service from the provider.

There was a registered manager in post. A registered manager is a person who has registered with 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.

People did not receive support from sufficient numbers of staff. People told us they felt safe with the staff, however people were not always safeguarded from abuse. Risks to people were not always managed to ensure they were kept safe. People did not always receive their medicine as prescribed and the medicine administration records did not reflect the support people needed.

People did not always receive support from knowledgeable staff with the skills to provide their support. People were not supported in line with the principles of the Mental Capacity Act. People did not always have support to meet their nutritional needs. People were not supported to monitor and maintain their health.

People were not supported by a consistent staff group which meant building caring relationships was difficult. People were not always able to choose for themselves and express their preferences about when their care and support was delivered. People did not always receive support in a way, which protected their dignity and privacy.

People were not supported by staff who understood their needs and preferences. People were not asked about their preferences. People understood how to make a complaint, however people felt their complaints were not listened to.

People, relatives and staff told us they felt unable to raise their concerns with the registered manager. Staff felt unsupported by the registered manager and did not feel they could approach them with their concerns. The quality of the service was not assessed effectively and there was no identification of the concerns we found during the inspection or any action taken to make improvements.

During this inspection we identified nine breaches of the Health and Social Care Act 2008. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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

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.

People were not supported by sufficient staff

People were not always protected from the risk of harm

People were not always supported to take their prescribed medicines

People were not always safeguarded from potential abuse

Is the service effective?

Inadequate

The service was not effective.

People did not always receive support from staff that had sufficient training.

People were not supported in line with the principles of the Mental Capacity Act.

People did not always have effective support with nutrition and hydration.

People were not supported to monitor their health and wellbeing.

Is the service caring?

Inadequate

The service was not caring.

People did not have consistency with the staff supporting them and had not developed caring relationships.

People were not always able to choose when they received their care and support.

People did not always have their dignity and privacy respected by staff.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care and support that was responsive to their needs.

People did not feel as though their complaints were responded to and complaints were not used to improve the service.

Is the service well-led?

Inadequate

The service was not well led.

People, relatives and staff told us they did not find the registered manager approachable or the service well led.

The registered manager did not have systems in place to check the quality of the care people received and make improvements.

Tailored Care Ltd

Detailed findings

Background to this inspection

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

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older people, people living with dementia, people with mental health concerns, people with sensory impairments, people with a learning disability and younger adults.

This inspection site visit took place on 12 and 13 October 2017 and phone calls to people, relatives and staff began on 16 October 2017 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Why we inspected – The inspection was prompted in part by information we received from people that used the service sharing their experience. The information shared with CQC indicated potential concerns around insufficient staffing available to meet people's needs. This inspection examined those risks.

Prior to the inspection, we reviewed the information we held about the service. This included any statutory notifications we had received, which are notifications the provider must send us to inform us of certain events such as serious injuries. We also contacted the local authority and commissioners for information they held about the service. We used this information to help us plan our inspection.

During the inspection, we spoke with 11 people who used the service and five relatives. We spoke with the nominated individual, the registered manager, 18 care staff, two drivers, and the care coordinator and administration staff. We reviewed a range of records about how people received their care and how the service was managed. These included seven care records of people who used the service, three staff records and records relating to the management of the service such as, diary records for people and staff, medicine audits, care plan audits, safeguarding investigations and complaints.

Inadequate

Is the service safe?

Our findings

People told us staff were often asked to come at times much later or earlier than those they had requested. One person said, "The worst is the weekends, they don't phone us to let us know, we then have to phone them". Another person said, "On Monday I had to call them, sometimes they are very late. It should have been half past seven and it was about half an hour late. It happens quite a bit". One relative told us, "The calls are all over the place; on some occasions my relative has been left in bed for over 10 hours between their last call and the morning one". People also told us they had experienced calls that were missed. One relative told us, "Call times are erratic; they rang the other day to say they couldn't arrive until after ten, it is as if they know I will cancel the call and manage myself, they often don't turn up at all on a Sunday and they don't call, It's just substandard service and we need better. I do sometimes just get tired". This showed us people and their relatives had not received a good quality service and people's safety had been compromised.

Staff told us, there were insufficient staff to support people safely. One staff member said, "The turnover [of care staff] is huge. They have no time to do anything in the office other than recruit so they have no interest in trying to keep existing staff". Staff told us there was insufficient travel time allocated between calls and gave examples of having 15 minutes allocated for a 45 minute journey. Staff said this meant they were always late to calls. Staff told us they made contact with the office when they were going to be late, but people were rarely informed of this. Staff told us the office staff often added additional calls to their PDA (personal digital assistant). This is a device that tells staff where to go and what to do on the call, it also logs the duration of the call. We saw records which supported what we were told. This meant people were receiving late calls. Staff told us there were too many calls allocated to them on a regular basis. One staff member told us, "I realised that I would never be able to finish at my contracted time and so I start two hours early every morning on my own time. If I don't do this I'd never get everything done". However staff also said they were aware that some staff could not stay over their planned time and any visits not complete would be missed. Some care workers felt the working environment, including their own and that of people they provided care for, was unsafe due to time pressures. One care worker said, "It is ridiculous. Weekends are far worse. It is just a horrible experience with nothing nice about it. Carers cut corners and miss calls and don't tell anyone. The weekend office coordinators are the staff with no care experience so you know if you need help you won't get it. It can feel very isolating". We found evidence which supported what staff told us.

People told us staff did not always stay for the duration of the calls. One person said, "On one occasion staff arrived at the property and waited outside for 20 minutes, when they logged the call they put the time they arrived outside, I reported this to the office, they just said it would be noted".
Staff told us they were pressured to cut calls short and cut corners with visits due to the lack of staff. They said they had significant concerns for people's safety as a result of the pressure staff were under. Almost all staff we spoke with told us they felt the office staff were untrustworthy and they would never raise a safety concern with them.

Some staff raised concerns that colleagues missed care tasks in people's homes, missed visits altogether or were pressured to cut corners by the management team. One staff member said, "Staff often falsify care

records to make it look like they've been when they haven't or that they spent longer there. The office [team] pressures us to finish the calls in less time. They encourage corner cutting to fit more in". We saw records in three different systems often showed different calls times and durations. This meant the provider could not be assured staff were staying for the full call time.

We spoke to the registered manager about these concerns and they told us they felt there were sufficient staff in place to provide care. The nominated individual told us there was no current shortage of staff however there was sometimes a high turnover of staff in this sector so they took the approach to continually recruit new staff. The registered manger told us there were systems in place which identified where calls had been late and in some cases so late they would be considered as missed calls. The registered manager said until recently they had relied on people alerting them to missed calls, but now they had a team in place to monitor and take action where calls were late or missed and someone would be deployed to attend the call so this had improved. We saw there were a number of entries in the system which showed the staff monitoring the calls had to contact people and inform them their calls would be late, for some people this was happening regularly. This showed the provider did not have sufficient staff in place to ensure people had their needs met safely.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

People were not always safeguarded from the risk of harm. People told us when staff were assisting them they felt safe and had no concerns about the staff, however we found people had experienced unsafe care as a result of the staff being late or missing their calls or not having the knowledge to meet their needs effectively. One person told us, "I've had sores due to staff not knowing how to dry me properly. The person went on to say they had received medical treatment for the sores. We discussed this with the person and they confirmed they were being supported by relatives to look for alternative care.

Staff could describe abuse; they told us they had received training which helped them to identify signs of potential abuse. However not all staff understood what action they would take if they identified abuse. One staff member said, "I don't know what I'd do if I suspected abuse. I don't think our training included that." We were unable to confirm what training staff had as the registered manager had not provided us with records. We asked staff about their understanding of whistleblowing and how they would raise urgent safety concerns anonymously. One care worker said, "I know the whistleblowing procedure but I'd never use it. The office team gossip openly. Nothing you say is confidential or anonymous. It's hard enough to speak up when something is wrong but actual whistleblowing is impossible. I'll call you [CQC] or the police". Another staff member told us, "We can do safeguarding training but it's offered on our days off and is unpaid so I don't think many people would do that".

We found the registered manager had not investigated incidents of alleged abuse. We looked at the records of communication with people and found three incidents which should have been investigated, two were of allegations from people about property being stolen and the third was about a missed call which resulted in missed medicines. This meant the allegations had not been investigated and had not been raised with the local safeguarding team. The registered manager understood what should be reported but these had been missed. We raised these concerns with the local safeguarding team as an alert during the inspection. We found a number of complaints the registered manager had investigated which indicated that people had been at risk of harm. The registered manager had not raised these with the local safeguarding body to allow for investigation. This meant the local authority had not been able to investigate these concerns and we could not be assured that people had been safeguarded from harm. This showed the provider had failed to ensure incidents had been reported to the local safeguarding team and people were left at continued risk of

harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding people from harm.

We looked at how risks to people were assessed and what actions were taken to mitigate the risks. We found risks to people were not always appropriately assessed or managed. Whilst most people told us they felt safe with the staff that visited them, people and their relatives did share some concerns about risk management. One relative told us not all staff understood the risks, they said, "Some staff have no idea and this could be a risk to [person's name], other staff who do are ok, some get prepared to help [person's name] safely, some don't". The person had not come to any harm as the relative ensured the staff did things safely.

We found one person had a pressure sore, treated by the district nurse service; we found there was no references to this in the persons care plan and no guidance for staff about what actions to take to prevent this from getting worse. The person's relative told us the provider did not take account of this when the persons care calls were scheduled. Calls were often left for 14 hours which meant the person was not able to be repositioned, which left the person at increased risk of harm and further deterioration of their skin. We spoke to staff about this person and they confirmed that they were unaware of the risks associated with the pressure sore or what actions they may need to take. This meant the person was left at risk of their pressure sore becoming worse.

We found people that required hoists to help them move did not feel safe with staff. One person said, "The staff just don't know how to use my sling when they first do it. It needs two staff and there have been times when staff that are shadowing have struggled". The person went on to say their relative had tried to show staff and they always make sure they are around when the hoist is in use to make sure they are safe. Another person told us, "I have had occasions with just one member of staff arriving which is not good, it's been about three times this year". We saw records which confirmed the person had complained to the registered manager about this. Staff told us, they had experienced being under pressure by the office staff to complete hoist calls alone. Some staff said they would insist there were two staff attending, but not all staff would do this. We could not be assured that two staff had always attended calls where this was required. The staff could give examples of calls which required two staff to attend and only one had arrived. One staff member said, "I have had to insist another staff member be sent as I felt it was unsafe, someone came eventually but the person was very late going to bed". Another care worker said, "We're supposed to have two [care workers] for hoisting but this doesn't always happen. The office [team] tells us we have to manage alone. This meant people were at risk from inappropriate moving and handling.
We looked at the monitoring system for calls and found that many people were regularly having calls up to 1 hour late and sometimes these calls were missed. Concerns; complaints and safeguarding alerts had been made as a result and people were at risk of this impacting on their health. For example, we found people had been left without access to their medicines and had been left without access to food and drinks leaving them at risk of dehydration. We found people had been left in soiled clothing, this was undignified for the person and this could cause a risk to their skin integrity.

Where risks were identified for people, guidance was not always in place to enable staff to mitigate the risks. For example one person was identified as sometimes displaying behaviours that challenged. There was no guidance for staff to tell them what the triggers for this might be and no plan in place for how they would manage it. We spoke with the registered manager about this and they told us staff would contact them immediately for advice if they had any concerns. When we spoke with staff about this person, they confirmed they were unaware of the risks. One staff member said, "I am due to go to this person for the first time, and I have no idea what their needs are until I arrive". This showed staff did not know how to manage

behaviours that challenged and people were at risk of not being supported effectively when displaying behaviours. This meant the person and staff may be at risk of harm.

We found where people had an accident; staff were reporting this to the provider immediately. Staff were also ensuring peoples relatives were informed and any medical attention was sought. However, we found there was no investigation undertaken to establish the cause of the accident. The registered manager confirmed there was no investigation or analysis undertaken and the only records were entered into a diary contact system for the person. One person had fallen twice in one month. Both falls were documented in the diary for this person and staff took immediate action, however there was no investigation of either fall. The person's relative instigated a review after the second fall but the provider had failed to take action initially to review the risks or take steps to prevent the person from having the same thing happen again and the person remained at risk of harm.

Some people received support to take their medicines. People told us that medicines were not always given at the right time; this was because of the call time changing. One person told us, 'I have to take tablets at a particular time and with food, because the calls are either late or early this means I have to take the tablets without food and feel bad that day or, I risk making my own meal to have with my tablets". This meant the person had not had sufficient gap in between doses required throughout the day. One relative said, "I have gone twice and found tablets sat on the side, not given to my relative". This meant staff did not always ensure people had taken their medicine.
Staff told us there were times when people received their medicines late or were missed taking them. Staff confirmed guidance from doctors and pharmacists was not always sought when this happened. One staff member told us they raised missed medicines with the office staff and were told to base their decision about whether to contact a doctor on the person's behaviour. One staff member said, "I've called the office with medicine errors but I have zero confidence they do anything. Instead I phone the pharmacy or [the person's] GP myself."

We found people had experienced medicine errors and appropriate advice had not been sought. For example, one person had experienced four errors with their medicine. Only on one occasion was medical advice sought from the person's doctor. The registered manger confirmed these incidents were not investigated and the audit of medicines which was carried out had not identified these issues and as a result no actions had been taken to prevent this from reoccurring. This meant people were at risk of not receiving their medicines as prescribed.

The guidance for staff was not always clear. For example, we found there were no instructions for staff about how and when to give medicines to people that were prescribed on an as required basis. This meant people were at risk of being over medicated. We found allergies to medicines were not recorded on one person's medicine administration records (MAR). This meant staff would not be aware of the risk this posed to the person. One member of staff told us they had not had training in medicines, they had learnt how to do this by shadowing other staff. We found these MAR charts were not always signed by staff members which showed there was no record the person had received their medicines. For example, one person required a thickening agent in their drinks as they were at risk of choking. We found there were a number of occasions where this had not been recorded as used by staff. We asked the manager what checks were done to ensure people had their medicines as prescribed and they told us they were reliant on other staff identifying where people had not received medicines. This meant the provider could not be assured people had received the medicines they needed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

The registered manager told us checks were carried out before people could start work to make sure they were suitable to work with vulnerable people. They told us their policy was to obtain three references before appointing new staff. We looked at three staff records and found the provider had only obtained two references. We spoke to the registered manager about this and they confirmed they had identified this in a recent audit of staff files. They said there had been an oversight with the policy which would be reviewed. We found records of when references had been received were not always in place, in particular where these had been given verbally. We saw Disclosure and Barring Service (DBS) checks were completed before care staff commenced employment. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. This showed the provider was not always following their policy in relation to safely recruiting staff and some improvements were needed to the records of employment checks.

Inadequate

Is the service effective?

Our findings

People told us staff did not always have the skills and knowledge required to meet their needs. Some people felt this was because there was no continuity of staff, whilst other said they thought the training was poor. One person told us, "The new staff don't seem to have been really pre briefed and they turn up not ready. They have to read the notes and I also have to tell them, we are not introduced first and they do not do shadowing". A relative told us, "The staff do seem not brilliantly trained. Some staff have shadowing whilst others just turn up and don't know what needs to be done".

We spoke to staff about their induction into the role. Those staff that had joined the company over the last 12 months were not confident about their induction. One staff member, new to a caring role, said, "I was surprised they were happy with me after two weeks. I thought I needed at least a month but [the management team] wanted me to start as soon as possible." Another staff member told us they had asked for extra induction and training time because they did not feel confident when a senior member of staff signed them off after two days. We spoke to more experienced staff and they told us they had significant safety concerns; due to the lack of training for inexperienced staff. For example two care workers said they had provided ad-hoc training to new colleagues on using continence equipment because they had arrived in peoples' homes without an understanding of how to provide appropriate care. Staff told us they had not escalated their concerns to the registered manager as they felt these would not be addressed. This showed staff did not feel confident to support people following their induction.

Almost all the staff were critical of standard of the training they received. Staff could not tell us what training they had received. One member of staff said, "None of the training is specialised, I don't know anything about diabetes, dementia or Alzheimer's yet I look after people with these conditions". This meant staff would not understand how to provide care and support to people with particular conditions. Staff told us training was scheduled for their days off and they were not paid to attend. This meant some staff were unable to attend due to other commitments or were not prepared to be trained for a day without pay. Staff reported not having any training in some aspects of their role. One staff member said, "I wasn't told at the interview my job would include personal care and it's a very personal thing to do for people with no training but I've had to find a way".

The registered manager told us staff received an induction which included working towards the care certificate and regular updates to their training, we saw records which showed staff had received an induction. The care certificate is a set of standards that health and social care workers work within. It gives staff the knowledge and skills which they need to do their job safely. They said competency was checked through supervisions and spot checks, again records supported these were taking place. The records lacked detail and did not identify any of the concerns we found during this inspection and not all staff had received a spot check. Staff told us they had occasional spot checks carried out, however they did not understand the purpose and they had not received any feedback from the managers that had completed them. One staff member said, "I'm surprised no one has been out to check on me since I started. Not even a phone call supervision to see how I'm getting on." Staff told us they had not received any formal supervision or appraisals. Staff were not always knowledgeable and did not demonstrate they had the skills to meet

people needs. For example, with medicines administration, safe manual handling and working within the principles of the Mental Capacity Act (MCA). We asked the registered manager to provide us with a list of the training staff had received and the dates they had received it. However they were unable to provide this during the inspection. This meant we could not be assured staff had received training to support them in their role.

This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

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

People and their relatives told us staff asked for consent before providing care and support. One relative said, "The staff always ask [my relative] what they want to do and if it's ok to start their care". We asked staff how they obtained consent from people before providing care. They told us they based their approach to this on how well people could communicate. We found there were no signed consent forms as part of people's care records and no consideration of whether people had the capacity to consent to their care. This meant whilst staff sought consent from people were not always supported in line with the principles of the MCA.

The registered manager and staff team confirmed the service provided support to people who lacked capacity to make certain decisions or provide consent to their care. We found the registered manager and staff did not have sufficient knowledge of the requirements of the MCA. The registered manager did not understand their responsibilities under the MCA and confirmed they did not undertake capacity assessments or best interest decisions for people where appropriate. Staff told us they had not received formal training in mental capacity and could not demonstrate understanding of how to provide safe and effective care to people with reduced capacity. One staff member said, "I don't know what the MCA is, I've never heard of it. I don't know what a mental capacity assessment is". Another staff member said, "If a person doesn't have capacity. I just try and persuade them and try and get them to do what we want".

Where decisions were being made on behalf of people, the registered manager had not ensured their capacity had been assessed and decisions made in their best interests. People's rights were not protected as decisions made on their behalf were not made in line with the MCA. For example one person was regularly refusing care and support, a relative was being contacted by staff and they were convincing this person to receive the care. We checked with the registered manager to see if the relative that was making decisions on behalf of this person was legally able to do so. The registered manager could not confirm this. The registered manager confirmed they had not assessed the person's capacity to see if they were able to decide for themselves when they could go to bed. This meant the person was potentially having restrictions on decisions placed on them.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

People and relatives shared mixed views about the support people had with meals. For example one person said, "The staff check what we want for meals and mainly use microwave meals, they are mostly ok and nicely served. However some staff leave the kitchen in a mess". One relative told us due to the short periods

between calls often their relative would miss a meal. The person had told them the timing of the calls to provide meals meant they were not hungry and so they would refuse for staff to make them a meal. The relative told us this was impacting on the person's appetite. Another relative told us. "The staff provided [my relative] with a meal which was not properly cooked, the meal wasn't eaten as a result and staff just recorded refused to eat, without discussing why with my relative".
Staff were providing support to people with specific health conditions and dietary requirements, for example diabetes. However, they told us they had not received any training in how to support people with these, which meant staff may not have the skills to support people safely. Risks associated with food and drinks were not effectively managed. We found one person was noted as requiring a speech and language therapy team (SALT) assessed diet, it was not clearly documented on the persons care plan the reason for this, however the registered manager confirmed the person was at risk of choking. The provider had not ensured staff had access to specific guidance from the SALT team. The person was noted to require a thickening agent in all drinks however, records did not show this was given at all times. Staff we spoke with told us they were aware of the person's choking risk and how to use the thickening agent for the person's drinks. However there was no specific guidance from the SALT team about what this person could eat. Staff told us the relatives of this person insisted they were given sandwiches; however the person chokes when eating these. We saw in the person's daily records they were having sandwiches given to them and we were unable to confirm this was safe as there was no guide from the SALT team available for review. This meant we could not be assured that this person would receive the support they required and they were left at risk from choking.

People's food and fluid intake was not monitored where required. We identified one person's care plan stated they needed to be encouraged to eat and drink at all calls. We found there were some gaps in the care records which indicated that drinks may not have been offered. There was no chart in place to monitor the fluids this person had received during the day, despite the care plan indicating this was important. There was no guidance for staff about what they should do if the person continued to refuse drinks. This meant people could be left at risk of dehydration. We also found where people had food allergies identified these had not been recorded in the person's care plan and staff had not been made aware of the risks associated to ingesting this food. This meant the person was at risk of receiving food items which could create an allergic reaction.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Meeting nutritional and hydration needs.

Some people told us staff had been helpful in supporting them to access professionals when needed. One relative said, "The staff alert us or get the nurse if they spot anything that might cause problems". One staff member told us, "I organise medical appointments for people when I think they need them because if I ask the office to help they just tell me to do it myself anyway". Staff felt that matters raised with the management team to be escalated to other professionals did not always get actioned. The registered manager told us they made contact with health professionals when required, we did see records which supported this, however this was not consistent. We found advice was not sought from health professionals when people had not received the correct prescribed medicines. We found there were no plans in place to support one person with maintaining their skin integrity, advice from the district nurse had not been sought and this person was left in bed for long periods of time in between calls. This meant the person was at risk of their health deteriorating. This showed people's health was not always monitored and support sought where needed.

Inadequate

Is the service caring?

Our findings

Some people had felt their privacy and dignity was compromised as the provider had not asked them about their preferences for the gender of their staff. One person told us, "Whilst I was using the bathroom a male staff member entered my property, it was not very dignified, we had never been introduced and the registered manager had not checked with me if I was ok having male staff attend my calls". The person said on another occasion they had sent one male staff member away as they were uncomfortable. The person went on to say they had now got used to seeing male staff and most were very respectful and polite so they felt more comfortable. Another person told us, "They can't keep to times even when I ask especially for times to attend an important event, they were late and I had to go without having had a wash that day; it was a real lack of dignity".
Staff told us they often had to rush and "cut corners" with people's care. They told us that they felt pressured to do this by the management team. One staff member said, "If I have time I clean their house and chat to them and just try to make them feel wanted. I want them to feel like I'd want my own family to feel". We found records which showed people had experienced undignified care. We saw staff had reported finding one person not fully dressed and sitting in their lounge with the curtains open when they arrived on a call. The record said the person had refused their care at the previous call and the worker had left without contacting anyone. We saw no evidence of an investigation or any action taken about this. This showed people received care that was not dignified and respectful.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

However, we did receive some positive comments about dignity. One person told us, "The staff are polite and my care is done with dignity. They take the time to do it, they don't rush". Another person said, "The staff check with me first if they are going to go into another room".

People told us there was little continuity in the staff that attended their calls. People told us this made it difficult to build relationships and trust with the staff. One person said, "They keep changing staff". Another person said, "You never know who is coming, they don't send a list any more like they used to, although the lists didn't really work anyway". One relative told us, "Staff turnover is bad. We get a variety of staff not real regulars, some are not brilliant and some are sloppy in their approach". Staff told us they did not feel people were always treated with compassion or were made to feel important. Staff told us they struggled to have time to make meaningful conversations and build relationships. One staff member said, "I do not have time to get to know people well. But we all encourage them to better their situation and to see the positive side of things". Another staff member said, "Weekends are just rushing about. We have no time to chat with people". Another staff member told us of one occasion when a person was upset and they rang the office to see if they could stay with the person, but they were told just to leave. The registered manager said the rotas were not able to identify staff to attend calls sufficiently in advance to allow the information to be sent to people. They confirmed there had been a number of staff leave the company over the last six months which had affected continuity of staff. We saw from the call records that people had large numbers of different staff attending their calls. This meant people were unaware which staff were providing their care and this

impacted on their ability to build trusting relationships with staff.

People were not always able to make choices about their care and support. One person said, "When they are late it's hard for me to get out, I get really fed up with them". Staff told us they gave people choices about their care delivery and asked them what they had planned for the day to encourage independence. Staff told us choice was limited by the amount of time they had available to support people. For example one staff member told us about arriving three hours late to prepare someone's breakfast. In another example three staff told us they only ever prepared porridge for breakfast but didn't know if this was each person's preferred choice or offer them an alternative. People were not involved in discussions about the timing or duration of visits. For example one staff member told us they were contracted to start work at 7am but were routinely given visits starting at 6am. They had raised this with the management team. The staff member told us, "I was told to just go late. This doesn't seem right because [the person] wants to get up at 6am so going an hour late isn't very respectful". We found people were not always able to choose when to get up, have meals, or go to bed because staff were not arriving at the times of their choosing.

We saw people had made complaints about having calls for shopping moved due to staffing issues and calls for domestic support cancelled. However people did tell us that staff offered choices about things such as what to wear and what they wanted to eat. One person said, "The staff are pleasant and nice to have calling, they check with me about what I want to eat". The records we saw confirmed people had been able to make these choices. This meant people did not consistently have their choices observed.

Inadequate

Is the service responsive?

Our findings

People told us staff were not always aware of how to meet their assessed needs and preferences. They told us the constant changes to staff meant they were having to continually tell staff how to do things. One person said, "I sometimes need to point out how to wash me which is embarrassing for me". Staff told us, they were not aware if people had assessments before using the service and confirmed they had not had introductions to people before they began providing care on a long-term basis. The registered manager told us, people were involved in their assessments and developing their care plans. They said people had an assessment when they began their care and a care plan was put in place. The records we saw supported this. However, we found some people's needs had not been assessed effectively. For example, one person was known to have periods of aggression. There was no assessment to identify what this looked like for staff and no plan in place about how this should be monitored. This left the person and staff exposed to a risk of harm. In another example one person was known to refuse their medicines, there was no guidance for staff about what to do when this occurred. This meant people could be at risk of not having their needs understood and met by staff. The registered manager needed to make improvements to ensure people's needs were met.

People were not asked about their preferences or how they would prefer for staff to support them. None of the staff we spoke with said care plans included how peoples' cultural, religious or other beliefs were supported and felt they were only there to provide functional support. Staff said care plans contained very little information about the person's likes, dislikes or their personality. This meant staff did not have the opportunity to build a rapport with people. One staff member said, "The care plans are purely task based, and usually out of date. They include no personal information, not even how they like their cup of coffee in the morning". This showed people's preferences for care were not observed. We found there was a care plan in place and the key needs were also recorded on a hand held device for staff to refer to whilst in the property. We saw the care plans and the instructions in the PDA were task orientated. There was little information for staff about people's preferences. For example, where one person needed support with accessing food, the guide for staff said "support required". There was no description of what level of support the person needed or any information about their preferences.

People told us staff were not attending the calls at their preferred times, which meant they could not have their needs met when they preferred. One person said, "It was brought up a couple of months ago that visits need to be on time and I need regular staff but that does not seem to happen". Staff confirmed people did not receive calls at their preferred times. We found people were not receiving personalised care and support as care was not delivered at the times they needed or preferred it. For example, people could not be assured they would get their visits at times to enable them to attend appointments or go out. People were not able to have their shower calls or shopping calls at the times they wanted them. The provider had failed to ensure people's preferences were understood by staff and met.

People told us reviews of their care and support plans were undertaken however they did not feel these were effective. One person said, "The care plan I had was not right and I got them to retype it and it took four months to get it back. It was not at the house during that time". Another person, "They saw us some time

ago after it started and it was good at first but we were then let down. They've done sketchy reviews since then and they will come and see us after complaints. They agree and commit to changes then it just slips again". The registered manager told us reviews took place on a regular basis and were documented as new assessments in people's care records. We saw this had taken place for some people; however people did not feel the reviews were effective and we saw examples of people not receiving a review. One relative had to request a review as the registered manager had not taken action to arrange a review when the person's needs had changed.
Staff told us when people's needs changed they had developed systems to communicate themselves with other staff as changes were not notified to staff and plans were not reviewed. Staff told us they had concerns that care plans were out of date and although they escalated this to the management team, they did not feel changes were always made. One staff member said, "I don't bother to read care plans; what's the point? They are next to useless. They're either too basic to make a difference or they're so out of date it's best to ignore them. I now don't read any care plans at all." Another staff member said, "Most care plans just tell us what's wrong with [the person], not about how to help them with more than just a task."

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

We found people and their relatives did not feel listened to when they raised concerns. They understood how to make a complaint, however one person said, "I spoke with the registered manager, however they did not really take anything on board". The person went on to say, "They were not understanding at all, even though they knew I was not happy, they do not even apologise, so I don't bother to phone now".
Staff told us, they did not understand the complaints procedure and had little confidence that complaints would be addressed if they were raised with the management team. One staff member said, "I can call the office with a complaint but they do nothing. I'd rather try and deal with it myself". We saw records of complaints that had been investigated and a response had been give and action taken. However there was no analysis of the learning from complaints. We found most of the complaints were about late and missed calls. This was a trend in complaints received for several months prior to the inspection and supported other feedback which had been received by the provider. However action was not taken immediately to address this and people were still complaining about this during the inspection. This meant the provider had not learnt from complaints about the service or taken actions to make improvements.

Inadequate

Is the service well-led?

Our findings

People were not supported by sufficient staff. People, relatives and staff all told us that care was not always delivered on time and in some cases was missed. We saw that reports were available from the management system which showed what time people's calls should have taken place and how long the call should have been and what the actual time and length of the call was. We found the registered manager had not used this information to monitor the calls and make improvements. This meant people were not having the care they needed and were being exposed to harm. The registered manager confirmed that whilst they were made aware of all missed or late calls they had not used these reports to complete any analysis. The registered manager told us they had introduced a live monitoring system from September 2017 and this had begun to prevent calls being late and missed. We found people were still receiving late and missed despite the introduction of this system. The registered manager had failed to monitor the call times which meant people continued to have late and missed calls which left people at risk of harm.

The registered manager and provider had failed to safeguard people and they were left at risk of harm. Whilst staff understood how to recognise abuse and had reported incidents to the registered manager these had not been investigated or reported to the appropriate authorities. The registered manager had not identified these concerns when staff had logged them in the system. There was no audit process for the registered manager shared with us by the provider. We found a number of incidents which we referred to the local authority for investigation.

People were exposed to potential harm from repeated accidents and ineffective risk management and were left exposed to the risk of further incidents. Whilst accidents were reported by staff and staff took the appropriate action to support the person, the registered manager had not put a system in place to investigate and monitor accidents and incidents. The registered manager told us they did not undertake any review of accidents to identify potential 'trends' or actions required to keep people safe and had not identified where people were receiving care which did not support them to manage risks to their safety. In some cases risks had not been assessed and there was no guidance for staff.

The system in place for the registered manager to monitor the management of medicines was ineffective which meant that people were at risk of not receiving their prescribed medicines. The registered manger told us medicine administration audits were carried out monthly. However we found the medicines audits had not identified the concerns we found with missed signatures for medicines, allergies not being identified and guidance not being available for staff. We spoke with the person that undertook the audits and they confirmed these areas were not checked as part of the audit. The audit only looked at whether the medicines list for the person was in place and up to date.

The registered manager and provider had failed to ensure people received care from suitably trained and competent staff. We found staff were not providing care and support effectively. The registered manager had an induction in place and staff received training, they had carried out checks on staff competency but these had not been effective in identifying the issues we found. For example, safe management of medicines, carrying out personal care and applying the principles of the MCA. Newly appointed staff received an

induction, but this was not effective in supporting them in their role.

People remained exposed to undignified care as the registered manager had not identified the issues with staff cutting corners and providing care without consideration of people's privacy and dignity. The spot checks and supervisions carried out, had failed to identify the concerns.

The registered manager did not have systems in place to ensure staff were caring and people received personalised care. The checks which were in place for people had failed to identify the concerns we found. For example some people had needs which were not assessed and planned for; others had not received the care they required. We found the service was not responsive. We saw peoples care plans were not personalised and people did not receive support to identify their individual preferences. This meant people did not feel the service they received was caring or responsive.

People told us they had been asked for their feedback about the quality of the service but the registered manager had failed to take actions to make improvements. One person told us, "They have asked me and they know I'm not happy and I did a questionnaire, things got a bit better for a while but it hasn't stayed much better". We saw people had given their feedback about the services in annual surveys and during spot check visits by the manager. For example, in the annual survey carried out in October 2016 people had identified they felt rushed during their calls, there was poor communication and they had no regular staff. The registered manager told us they had tried to make improvements and would assess their progress when the next survey went out to people. However we saw feedback provided by people in spot check surveys in September 2017 showed people were still experiencing the same concerns. We found people's concerns remained the same at the time of our inspection.

People, relatives and staff told us they did not feel the registered manager was approachable or would take action if they raised concerns. One person said, "A few months ago I told the registered manager about my concerns about the call times but they have not really addressed it, the lunch calls are around lunch time now, but that is all". People told us they did not feel listened to by the office staff and felt their concerns were ignored. One person said, "I even get the impression of the phone being held away from the person as I explain my concerns to them". Another person told us, "I don't feel they were very sincere". Whilst another said, "The office people don't make me feel listened to I feel ignored".

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

People, relatives and staff told us the service was unreliable and there was poor communication with the registered manager and management team. One relative told us they had met with one of the managers to ask that they receive updates about their relative. The relative said, "They are still not phoning me to give me updates on my relative so they are not really taking things I say on board". Another person said, "I would recommend the staff but not the company". Another person said, "The staff sometimes tell the office when they are going to be late but the office then don't always tell us". Staff told us communication was poor, they did not have a trusting relationship with the registered manager and they did not feel comfortable raising concerns. They told us they had stopped giving feedback to the office team because they did not feel respected or listened to. One staff member said, "I feel belittled by the management team so talking about problems or asking for them to change something is difficult". Another staff member said, "This is not a good or safe company to work for. When I joined last year 10 care workers left the same week". We saw staff had raised issues such as people having missed calls, not having their medicine and people being left in undignified situations and there was no evidence that any action had been taken about the concerns staff raised. The registered manager had failed to respond to concerns and this had led to a culture of people and

staff not reporting their concerns.

A provider is required to submit a statutory notification to notify CQC or serious incidents such as injuries, deaths or allegations of potential abuse. The registered manager was aware of their statutory responsibilities. However, we found the registered manger had not notified us of all the safeguarding concerns and alerts which required a statutory notification as required by law.

This was a breach of Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents