

CareBility Ltd

CareBility

Inspection report

Piccadilly Business Centre
Aldow Enterprise Park, Blackett Street
Manchester
M12 6AE

Tel: 01618188118

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This inspection took place between 13 and 20 June 2018 and was announced. This was the first inspection we have undertaken of CareBility since the service was registered with CQC in May 2017. At this inspection we identified breaches of the regulations relating to person-centred care, dignity and respect, safe care and treatment, safeguarding, receiving and acting on complaints, good governance, staffing and employment of fit and proper persons. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community within the Trafford Local Authority area. It provides a service to older adults and younger adults with a disability. At the time of our inspection the service was providing approximately 237 to 325 hours of care per week to around 18 people. The service was originally registered in Bedfordshire, but shortly after re-located to Manchester due to being awarded a contract with Trafford Local Authority.

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

All people we spoke with have experienced issues in relation to staff arriving late for their scheduled calls. Records supported people's reports and showed calls were frequently significantly late, and could also be cut-short. This had resulted in some people experiencing anxiety, and put people at potential risk of harm. These issues occurred due to difficulties the registered manager had had recruiting sufficient numbers of staff.

Staffing levels had also had an impact on staff members ability to act in caring ways and to promote people's independence. Whilst this was not the case for everyone we spoke with, we received multiple reports of people feeling rushed, and care staff completing tasks for them as they did not have sufficient time to support people to do things themselves.

Record keeping was poor, including in relation to the administration of medicines. Staff were not always keeping a record when they were providing support to people to take their medicines. We also found evidence that indicated staff had not always supported people to take their medicines as prescribed. This could have a negative impact on their health and wellbeing. The registered manager was not able to provide evidence that all staff administering medicines had received suitable training and had their competence checked.

We found systems in place to help ensure only staff of suitable character were recruited were not robust. There was no evidence that any references had been sought for staff members employed or that other reasonable steps had been taken to provide reassurance that they were of suitable character. Not all staff

files contained required information such as proof of identity and a full employment history.

Whilst some risk assessments had been completed in relation to the care people were receiving, we found risk assessment processes were not always adequate. For example, staff told us one person had experienced multiple recent falls. However, there was no record of these incidents and the risk assessment did not reflect this. This would increase the risk that reasonable steps were not taken to help reduce this person's risk of falls.

There were gaps in the provision of training to existing staff. Some recently recruited staff were providing support to people without having received any training with CareBility. The registered manager showed us that some of these staff had received training in previous employment. However, they were not able to evidence that they had checked whether all staff members were competent to undertake the role, or that they had provided staff with sufficient supervision.

Assessments of people's needs were carried out when they started using the service. However, there was evidence that these were not always accurate or complete. For example, two people had type two diabetes and this was not known to the registered manager, nor reflected in their care plans. Issues in relation to staffing levels could also affect whether people were supported with meals at suitable times due to staff arriving for calls late.

People told us that a more long-standing group of care staff knew them or their relatives well. However, there was a high turnover of staff at the service, and people did not usually know who would be providing their care.

There was little reflection in people's care plans of any of their preferences, likes, dislikes or social histories. Some people reported that staff did not read the care plans and were not always aware of the support they or their family member needed.

People who had raised complaints were generally satisfied with the way these had been dealt with, and they felt comfortable raising concerns with the registered manager. However, not everyone felt the action taken had resolved the issues they had raised. Systems for recording and monitoring complaints were not adequate, and the registered manager was not able to locate relevant records for us to review.

At the time of our inspection, no person was receiving end of life care. We noted that staff had not received training in this area, and made a recommendation that the provider sources training in this area.

Arrangements for cover during the registered manager's absence were unclear and inconsistent.

The registered manager struggled to obtain information and records in relation to the running of the service and care provided. They told us this was due to the software they used crashing and a former employee having deleted records. Systems in place that would help the registered manager monitor the service, such as electronic call monitoring and an electronic care management system were not functioning correctly.

The registered manager was able to show us one example of an audit carried out. This was limited in scope and was not fit for purpose. This meant there was a risk that trends or patterns that would indicate a risk relating to the quality and safety of the service would not be identified and acted upon.

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.

The service had experienced difficulties recruiting staff. This had led to calls that were frequently significantly late or cut short.

Records relating to the administration of medicines were not clear. We found evidence that indicated one person had not received their medicines as prescribed.

Required recruitment checks had not been carried out for all staff. No references had been received for staff, and full employment histories were not always sought.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Not all staff had completed the required training to enable them to support people safely and effectively.

The registered manager told us they carried out checks on the competence of staff. However, they were unable to provide any evidence to support this.

Issues in relation to the timing of people's care visits had an impact on the support people were receiving in relation to their meals. There could be small gaps between the times staff attended breakfast and lunch calls.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Staffing levels had resulted in some people experiencing calls that were rushed. This also meant staff were not always supporting people to be as independent as they could be.

People's independence was not always promoted. This was as staff could rush people due to the way their calls had been allocated.

Most people told us they found care staff to be kind, friendly and respectful. However, there were exceptions to this.

Is the service responsive?

The service was not always responsive.

Care plans lacked details about people's preferences and social histories.

Staff were not always aware what the care and support needs of people were. People told us staff did not always read the care plans.

People who had raised complaints were in most, but not all cases, satisfied with the outcome. However, clear records of complaints and any actions taken in response to them were not maintained.

Requires Improvement 

Is the service well-led?

The service was not well-led.

The service used an electronic call monitoring and care management system. However, this system was not fully operational and could not be relied upon.

There were inconsistent arrangements for management cover during the registered manager's absence.

There were few systems in place to help the registered manager monitor the quality and safety of the service. Those that were in place were not fit for purpose.

Inadequate 

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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 inspection took place on 13, 15 and 20 June 2018 and was announced. We planned to contact the service the day before the inspection was due to commence. This was as CareBility is a small service, and we wanted to check someone would be available to facilitate the inspection and arrange access to the office and records. However, the registered manager told us they were attending training the day of the planned inspection, and said there was be no-one else available to meet us. We therefore agreed to start the inspection the following day. This meant the service had 40 hours' notice of the inspection.

Inspection site visit activity started on 13 June 2018 and ended on 20 June 2018. It included phone-calls to people using the service and their relatives, home visits that coincided with visits from people's care staff, phone-calls to care staff, and visits to the office. We visited the office location on 13 and 15 June 2018 to see the manager and office staff; and to review care records, policies and procedures.

The inspection team consisted of one adult social care inspector 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. The expert-by-experience had experience of caring for older adults who had used domiciliary care agencies.

Prior to the inspection, we reviewed information we held about the service. This included the reports produced by CQC's registration team when they assessed whether we should register the service. We also reviewed feedback we had received from people using the service or their relatives, and information received from local authorities in relation to safeguarding. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We sought feedback from Trafford and Manchester local authority commissioners and quality monitoring teams. Manchester local authority told us they did not commission any care with this service, and Trafford local authority provided us with feedback from monitoring visits they had undertaken. This information raised some concerns in relation to the timeliness of calls and consistency of care staff visiting people. We used this information to help plan our areas of focus during the inspection.

During the inspection we spoke with five people using the service and four people's relatives by telephone. We also visited two people (including one relative) at their homes during visits from their care staff. We spoke with eight staff members, including the registered manager, an administrative assistant and six care staff. We reviewed records relating to the care people were receiving, including contemporaneous notes (daily records), five care plans and two people's medication administration records (MARs). We reviewed records relating to the running of a domiciliary care service, including any available audits, training records, supervision records and seven staff personnel files/recruitment records.

Is the service safe?

Our findings

People we spoke with consistently told us that staff arrived significantly late for their calls. This had an impact on people's wellbeing and a potential impact on their safety. One person told us, "They [staff] are supposed to come at 9.30am and they are generally turning up at 10.30 or 11am. It has an impact on me because I'm late for my breakfast and I'm diabetic. I also like to attend a group on certain days, but because the carers turn up late I miss the transport and it's the only chance I have to get out... If they came at 9.30am as agreed then I'd get to my group." A second person said, "They [staff] are not always on time and they never let me know if they are running late. As they get me out of bed and I can't manage this myself, I just have to lie there and wait." A relative we spoke with told us, "The punctuality is very poor and its frequently up to an hour late for the morning visit and they are often early for the evening one. They say they get delayed by being caught in traffic but I think it's over capacity. It's problematic if I need to go out myself as the delays really affect my day. They very rarely let me know if they are late- I'd appreciate if they would."

The registered manager told us they had experienced difficulties recruiting and retaining care staff. They also told us they had been unaware of the geography of the local area when the service moved to Manchester/Trafford and the impact that traffic and travel considerations in the local area would have on staffing and transport requirements. These issues had resulted in there not being sufficient numbers of staff available to ensure people's calls were attended in a timely way. There was also evidence that staff did not always stay for the full commissioned call time.

The registered manager was not able to provide us with any overview as to the punctuality of call attendance or relating to whether staff stayed at calls as long as they were meant to. This was as the electronic call monitoring system that had been recently introduced was not yet functioning properly, and there was no alternative monitoring system in place. We spot checked the daily records for one person and found that over three quarters of the calls in a one month period were over half an hour late. Many calls were late by one hour or more. We also found that most of the calls were shorter in duration than they should have been. One call that should have lasted 45 minutes, was documented as being just 11 minutes in duration. The late calls caused visible upset to this person. They raised concerns with us about care staff being rushed, getting their meals late and late calls meaning they were not able to access a group they attended.

Records relating to staff allocations showed staff would not be able to attend calls in a timely way. For example, we saw examples of where staff had been scheduled to attend calls with two different people that were meant to be start and finish at the same time. We looked in detail at staff allocations on one day and found due to the way their calls where scheduled that they would be at least one and a half hours late for one of their calls if they stayed the full allocated time for each previous call.

The service had not ensured that there were sufficient numbers of staff to meet the needs of people using the service and to keep them safe. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have robust systems to ensure the staff they employed were of suitable character for the care assistant role. Records showed that staff had Disclosure and Barring Service (DBS) checks. DBS checks provide information on previous convictions, and dependent on the level of the check, can also provide information on whether the applicant is barred from working with vulnerable people. However, other information that is required in relation to staff recruitment had not been obtained. For example, we found application forms did not request a full employment history as required, there was no record of questions being asked about applicants physical/mental health, and there was no evidence of identification in one staff members personnel file.

Providers are required to obtain satisfactory evidence of staff member's conduct for any previous employment they had in health or social care settings. They also need to make reasonable efforts to verify the reason for staff members leaving that employment. None of the staff recruitment records we looked at, including those of three staff members who had previously worked in health/social care, contained any employment or character references. Neither was there evidence the provider had sought any references. The provider had not sought to reassure themselves as to staff members previous conduct or character in any other way, such as through review of previous appraisal documents. The registered manager told us staff received an interview prior to an offer of employment being made. However, they were unable to show us any records of interview held. Staff members we spoke we confirmed they had had an interview. However, one staff member told us, "I think the thing they need to improve there [in relation to interviews] is to ask more questions on people's character. It wasn't so much an interview. I was asked about my availability, and if I'd done care before."

The provider was not operating effective recruitment procedures to ensure staff were of good character and were suitable for the roles in which they were employed. Records that were required to be kept in relation to staff recruitment were not always available. This was a breach of Regulation 19(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not being managed safely. We found medication administration records (MARs) did not always provide sufficiently clear instructions for staff to follow, and did not contain other required details. For example, we saw MARs did not always record the person's full name, and did not detail the persons date of birth, GP or any allergies as is recommended by the National Institute for Health and Care Excellence (NICE). MARs did not detail what medicines staff had supported people to take, and they just recorded that the blister pack had been administered. We saw one person had been prescribed an additional medicine not contained in their blister pack to take for a short period. There were no clear instructions to tell staff how and when they should administer this medicine. Records also indicated that staff had only administered this medicine on one of the three occasions they should have given it. The registered manager told us they had been unaware of this error.

The level of support people required from staff to take their medicines was not always clearly recorded in people's care plans. Where people were receiving support from staff to take their medicines, records were not always in place to evidence what support had been provided. For example, we saw one person's care plan stated they were prompted by staff to take their medicines, and staff confirmed they did this. However, there was no MAR in place. Another person's relative told us, "[Relative] has cream for their legs. It's a prescription cream, but they [staff] don't sign for it." Not having records of administration in place would increase the risk of a medicines error, as staff or others involved in the person's care might not be aware of what medicines had or had not already been taken. NICE guidance defines medicines support as "Any support that enables a person to manage their medicines." People being prompted to take medicines should therefore have a MAR in place.

The registered manager was unable to provide evidence that all staff supporting people to take medicines had received training in medicines administration. They told us they had assessed the competence of staff to administer medicines, but were only able to provide records of this in relation to two staff members.

The issues outlined above in relation to the safe management of medicines were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the service was registered with CQC in May 2017, they had not notified us of any safeguarding incidents. However, we had received information from the local authority in relation to four safeguarding concerns. The registered manager told us they had not notified these concerns to us as social services had told them they would pass this information on, and because they had not raised the alerts. We had raised concerns with the registered manager in relation to their handling of a previous safeguarding concern. This was due to a delay in them responding to the concerns as they were on leave. We had also received conflicting information from them as to whether a staff member had or had not been suspended.

The service had a safeguarding policy in place, and staff understood what signs to look out for that might indicate someone was experiencing abuse or neglect. However, not all staff were clear on the reporting procedure they would follow to raise any concerns. For example, one staff member told us they would raise a safeguarding concern via a group chat using an internet based mobile messaging service, or the electronic care management system messaging service. However, such methods would not necessarily maintain confidentiality, nor ensure the registered manager was aware of the concerns in a timely way. This could prevent them taking action to keep people or informing the safeguarding authority.

We asked the registered manager if there had been any missed calls within the previous 12 months. They told us they knew there had been 'less than five' missed calls, but were unable to provide any overview in relation to missed calls, or records that could demonstrate how the service had learnt from any such incidents. We were aware from contact we had previously received from the local authority of at least two missed calls in the previous 12 months. Staff from the local authority had identified and raised these safeguarding alerts rather than the provider. This shows that systems to ensure people were kept safe from the risk of harm arising from missed calls were not sufficiently robust.

The provider did not have effective systems to ensure potential abuse was prevented, identified, and action taken to ensure people were safe from harm. This was a breach of Regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not effectively assessing and managing risks to people's health, safety and wellbeing. We received a mixed response when we asked people whether they felt safe when receiving support from staff working for CareBility. Whilst most people told us they did feel safe, one relative noted that staff did not always leave their family member's walking aid to hand. They also told us staff had not always closed the door securely when leaving the house. However, another person told us, "I do feel safe with them [staff]. They let themselves in and out and always leave my home secure and lock the key safe properly."

The registered manager had carried out some assessment of risks, for example in relation to risk of pressure sores, falls and the person's home environment. However, we found risk assessments were not always fit for purpose or had not been completed. For example, environmental risk assessments were not always fully completed. One person was supported by staff using a hoist, and there was no moving and handling risk assessment in place, nor documented safe system of working. This would increase the risk that staff would not use this equipment in a safe way, resulting in an increase likelihood of injury to this person. We saw another person's falls risk assessment indicated they had not sustained any falls in the previous 12 months.

However, we spoke with a member of care staff who told us they had two recent falls, one of which required attendance by an ambulance. The registered manager told us there had not been any accidents or incidents in the previous 12 months, and staff were not recording accidents such as falls if they had not witnessed them. This could result in a delay in the identification of hazards that might be contributing to falls, and in making sure the person had the support they needed to be kept safe. The registered manager told us one person required a soft diet. Whilst daily records showed staff were aware of this, and were providing a soft diet for this person, this requirement was not documented in any risk assessment or care plan. Given the high turnover of staff at the service, this would increase the likelihood of staff providing a diet of the incorrect consistency, which could present a risk of choking or aspiration.

These lapses in the assessment and management of risks were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff had personal protective equipment (PPE) such as disposable gloves available when they attended their calls. During our visits to people's homes we saw staff had PPE with them. However, one person we spoke with told us they had found staff did not always change their gloves when moving between different tasks, which could increase the risk of spread of infection. Staff we spoke with were able to demonstrate a good understanding of the reasonable steps they could take to reduce risks associated with the spread of infection. For example, one staff member told us it was important to make sure work surfaces were clean, to wash their hands regularly and to wear gloves and aprons.

Is the service effective?

Our findings

We received a mixed response when asking people if they thought staff were competent and had the skills required to meet their, or their family member's needs. For example, one person told us, "I get the impression they know what they are doing. The young girls always shadow the more experienced staff, and I feel that in an emergency they would know what to do", whilst a relative we spoke with told us, "Some more experienced ones [staff] get it but others don't... One of the experienced carers did spot that [relative] had an infection and suggested we get the doctor out. But most of the carers are very young and inexperienced."

We reviewed the service's training matrix, which showed not all staff had completed training in subjects that would have been important to help ensure they were able to care for people safely and effectively. For example, out of 15 staff, the training matrix showed seven had not completed moving and handling, safeguarding or medicines training. Eight staff had not completed first aid training or Mental Capacity Act training and six had not completed infection control training. There were also six staff who were indicated not to have completed any training. The registered manager told us some of these staff had received relevant training in previous employment, and we saw they had obtained training certificates from some staff to evidence this. However, the registered manager was not able to provide evidence that they had assessed any staff members competence to perform the role, including staff who had been recently recruited.

The provider had not ensured that staff had received appropriate training and supervision to enable them to competently carry out the duties they were employed to perform. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they completed regular supervision with staff. Staff also confirmed that as the registered manager also provided care to people directly, that they would have informal supervision if they were on the rota to work alongside them. Other than one supervision record for each of two staff members, the registered manager was unable to provide any further evidence that supervisions had taken place. In the two supervisions that had been completed, we saw that the registered manager had provided feedback to the staff members. However, there was no documented discussion of important topics such as health and safety, safeguarding or the individuals the staff member provided support to. Supervisions are an important tool to help monitor staff performance and to ensure they receive adequate support to undertake their role.

The provider was not maintaining necessary records relating to the management of the service. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 can only be deprived of their liberty so that they can receive care and treatment when this

is in their best interests and legally authorised under the MCA.

The registered manager demonstrated a good understanding of the principles of the MCA. We saw they had also challenged staff in relation to acting in accordance with the MCA. For example, we saw the registered manager had highlighted in a staff member's medicine competency assessment to seek verbal consent from people before administering their medicines. Care staff were able to tell us how they would act in accordance with the MCA, although not all staff were specifically aware what the MCA was. However, there was scope for improving how the service worked to meet the requirements of the MCA.

The registered manager told us two people using the service lacked capacity to make most decisions about their care. Staff told us they would consult with other people involved in the care of these people and would act in their best interests if taking any decisions of their behalf. However, it was not clear for one person how the service had determined that they lacked capacity. This was as staff had not clearly documented an assessment that followed the 'two-stage test' of capacity outlined in the MCA code of practice. The two-stage test involves determining if the person has an impairment, and whether that means they are unable to make a particular decision at a particular time. We saw in one person's care file that it stated their relative would make all major decisions for them. This person's relative did not hold a lasting power of attorney or other legal authority to act as a decision maker on their behalf. We discussed with the registered manager that it is important to be clear about the legal role other people, such as relatives, had in relation to decision making for their family member. Some people had forms to consent to their planned care in their files, although we saw some people with capacity had not signed these. The registered manager told us signed copies would be kept at people's homes, although we were not able to verify this.

We recommend the service reviews good practice guidance in relation to the implementation of the MCA to improve their approach in this area.

We asked the registered manager about the process followed when receiving new referrals to the service. They told us they received assessments carried out by social workers, and then carried out their own assessment of people's care needs and preferences. This was then used as the first draft of people's care plans. However, we found assessments were limited in scope and accuracy. One relative told us they had contacted the registered manager with corrections following receipt of the first draft of the care plan. During our inspection we also spoke with two people who told us they had type 2 diabetes (non-insulin dependent). Care staff we spoke with were aware of this, and what this meant in relation to dietary requirements. However, the registered manager was unaware that either individual had diabetes, and this information was not reflected in their care plans or risk assessments. This would increase the risk that staff would be unaware of this health condition and may not provide an appropriate diet, or be aware to look out for potential complications arising from their diabetes. One person told us staff had bought them a higher sugar version of the breakfast cereal they usually had, despite believing they knew about their diabetes, which could have had a negative impact on their health.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with who were supported by staff to prepare or eat meals told us staff offered them a choice of what they wanted. One person said, "They [staff] do my meals and always ask 'What are you having?'" Although we saw some people's care records prompted staff to give people a choice of what they ate at meals, there was very little information on dietary preferences, requirements or the level of support people needed to eat and drink. This information would be particularly important if people's presentation changed and they were no longer able to communicate their preferences, particularly given the high staff

turnover. One person also made us aware that the issues the service had in relation to attending calls on time also had an impact in relation to provision of their meals. This person told us, "I often don't get my breakfast until late morning, and it has been nearer 12 mid-day before they come. I have then said, please don't come at 1pm for my lunch visit, and they may come a bit later, around 2pm as I've only just eaten."

Is the service caring?

Our findings

Most people told us they found care staff to be kind and caring, although there were exceptions to this. For example, one person told us, "Some of them [staff] chat a little to me, but some don't say much at all." A second person told us, "The majority of the carers are pleasant, for example yesterday the girl was lovely and chatty. There are a couple who aren't so nice and one is a bit surly." A relative we spoke with said, "They [staff] are generally very pleasant. They can take a joke too. We asked for female carers and they have only ever sent females."

During our visits to people's homes, we found interactions between staff and people using the service to be positive and respectful. We heard laughing and light-hearted conversation taking place, which showed that people felt comfortable with the staff providing their support. One relative we spoke with told us they found there was a small group of longer-standing staff members. They said this group of staff knew their family member well. However, they were not supported exclusively by this group of staff, and other staff attending the calls did not know or understand their family member's support needs and preferences as well. They told us that their family member was happy with this arrangement, but this meant they would have to spend time telling staff how to carry out their care.

The issues in relation to having sufficient numbers of staff to provide people's care and support outlined in the safe section of this report, had also had an impact on the ability of staff to act in caring ways and support people's independence. Care staff were on zero hours contracts, and not all staff worked regular hours. The registered manager also told us some of the care staff were employed primarily as drivers. They told us that this meant there were approximately five regular and consistent members of care staff.

Whilst this meant there was a smaller staff team, we still received mixed feedback in relation to the consistency of care staff attending people's calls. Some people experienced a good level of consistency, whilst others told us they did not know which staff would be attending their calls, and told us they saw a larger group of staff than they would wish. The consistency of care staff was also an issue identified during spot-checks by Trafford local authority. Staff confirmed that they did not support a set group of people. Whilst people's preferences in relation to the gender of care staff that supported them were respected, staff told us there did not appear to be any other consideration of people's preferences for certain members of care staff. For example, one staff member told us staff were not allocated based on who they had got to know and develop good relationships with.

The staffing issues also had an impact on the time care staff spent with people, and people reported that staff could rush them. We saw people's care plans identified ways in which staff could support their independence, and staff also demonstrated an understanding of how they could support people to maintain skills. However, staffing pressures had affected their ability to do this in practice. One person told us, "They [staff] do check that I'm ok and ready to be helped, and they always say I must go at my own pace." However, comments from other people using the service were less positive, and included: "When washing me they don't really give me time to do what I can myself. They just take over and do it" and "They always seem rushed and on the back foot. This can mean that they [staff] can be abrupt rather than patient,

especially when they are running late. The Driver can be hooting for them outside or even comes and rings the doorbell to hurry them along." Three out of the four care staff we asked told us they would be happy for a friend, relative or loved one to use the service. However, one staff member commented, "Honestly, no [I wouldn't be happy for a friend/family member to use the service]. It's the impact of the timeliness of calls, and staff having the patience with clients. People can be lonely and I like to sit and talk to clients, but time is rushed."

The service was not consistently supporting people to remain independent. This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff maintained their privacy when providing personal care. Most people also felt they were treated respectfully by staff. One person told us, "We have normal conversations. They [staff] speak to me as I speak to them." However, we also identified lapses in respectful treatment of people using the service. For example, one relative told us staff had washed their family member's hair when they had been fully clothed and then left them with a wet top.

The service had an equality and diversity policy that included information for staff to consider particular requirements and preferences based on people's religion or culture for example. The registered manager was able to provide examples of how staff supported people in line with any preferences arising from their cultural background. The format of the care plans prompted staff to consider if people had any particular needs arising from their race, gender, sexuality or religion for example. However, this information was not always completed, or had been completed in only limited detail. The registered manager told us, "We have to respect and implement human rights, and ensure people have equal access to services."

People told us that staff did not inappropriately share confidential information. One person told us, "I have never heard them [staff] talk about other people in a way that would identify them." We saw paper based records kept in the office were kept in lockable storage. The registered manager was aware of recent changes in data protection legislation and had asked staff to read information in relation to the changes. This would help ensure staff were aware of the steps they should be taking to protect people's personal information.

Is the service responsive?

Our findings

Four people who told us they had raised complaints with the registered manager. These related to staff arriving late for calls, and staff not informing them when they were running late. People told us the registered manager had listened to their concerns, and most people felt there had been an improvement following them raising a complaint. One person told us, "I phoned the manager. They are lovely, and if I complain they tend to sort it out." A relative we spoke with said of a complaint they had raised in relation to the timeliness of calls, "They [registered manager/staff] were receptive and apologetic that things had got to that stage..." However, they told us that the actions taken had not resolved the issues relating to timeliness.

The registered manager told us the service had received complaints in relation to the 'lateness' of calls. In the provider information return (PIR) they had completed in March 2018, they had stated that the service had received five formal complaints within the previous year. However, the registered manager was only able to locate details of one complaint. They were not able to find records of any complaint acknowledgements or responses. This was despite the service's complaints policy stated that a written acknowledgement should be provided to the person raising the complaint within five days, with a full outcome provided whenever possible within 28 days. The registered manager told us they believed complaints were recorded on their electronic care management system, but that as they had been incorrectly recorded as correspondence, they were not able to locate them.

This demonstrated that the provider did not have effective systems for recording, handling and monitoring complaints. This was a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans contained variable levels of detail about the care and support they needed. Much of the content of care plans consisted of tick-box answers. Further detail that would guide staff as to how to provide person-centred care that would meet that person's needs was not always recorded. We also found issues in relation to the accuracy of care plans, as they did not always reflect all people's health care support needs or cultural support needs. The registered manager told us that staff supported one person to access the community, although there was no information in relation to this in their care plan.

We found no care plans contained information on people's social histories, interests, likes or dislikes. Such information would help staff understand people's needs and support them to provide person-centred care. There was very limited information in relation to people's preferences, which in most cases was limited to the gender of care staff they would prefer, and statements directing staff to offer people a choice in relation to the clothes they wore or food they ate.

Care staff told us they found care plans provided them with enough information to understand what support people required during their calls. However, two people we spoke with told us they had never seen staff read the care plans, and we also received comments that new staff were not always aware of people's care needs or preferences. One relative told us, "I get annoyed as new staff don't know what to do. They never read the care plan and I'm not sure it's as detailed as it should be."

The provider was not carrying out adequate assessment of people's needs and preferences. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the registered manager had involved them in the initial assessment of their needs, which including the first draft of the care plan. Most people had been using the service for less than one year, and there had therefore not been any formal reviews of people's planned care at the time of the inspection. However, people told us they did provide feedback to the manager in relation to any changes that were needed, and said the registered manager had passed this information on to care staff.

We saw there were check-lists in people's care plans that helped staff identify and record if the people they were supporting had any support needs in relation to communication. The registered manager talked about ways in which staff facilitated communication with people who had additional support needs due to a sensory impairment or disability. For example, they told us staff used cue cards with one person. Another person's relative told us staff were good at reading and understanding the non-verbal communication their family member used.

The registered manager told us that no-one using the service was receiving end of life care. We saw care plans had space to record information about end of life wishes should they wish to discuss this with the service. This section was either blank or stated that this aspect of care had not been discussed with the person in the care plans we looked at. The training matrix showed that none of the care staff had received training in end of life care. As the service provides support to older adults who may be approaching the end of their life, such training would be beneficial.

We recommend the service provides training to staff in end of life care.

Is the service well-led?

Our findings

This was the first inspection we have undertaken of CareBility since the service was registered in May 2017. At that time, the service was registered in Houghton Regis, Bedfordshire. However, the service had shortly after moved to Manchester due to being awarded a contract with Trafford Local Authority. The registered manager had not informed CQC of the change in location as required, which was discovered by chance when we visited the registered address in Bedfordshire. Following contact from CQC, the registered manager submitted applications to amend the registered address of the service.

There was a registered manager in post, who was also the sole director of the company. When we contacted the registered manager to announce the inspection, they told us all their administrative support staff had left. They also told us a former care co-ordinator had left the employment of the service. When we commenced the inspection two days later, there was a new office administrator in post. The registered manager told us it was intended this member of staff would deputise for them in their absence.

We asked staff if they were always able to get hold of the manager or any deputy to receive advice or assistance if they required it. Most staff we spoke with told us they had not needed to contact a manager. However, one member of staff told us different people provided cover during any absence of the registered manager. They told us this could create difficulties as these people did not know the services systems, processes or the people they provided support to.

The week of 09 July 2018 we tried to contact the service on their land-line number and the call was diverted to the registered manager who was out of the country on leave. There was a poor connection and they struggled to hear us. We subsequently sent them an email, and queried the management arrangements in place during their absence. When we called the service later in the week, the phone was answered by another person who was not present during the inspection who informed us they were acting as the manager during the registered managers absence. They told us they had started work at CareBility two weeks previously.

The registered manager was an experienced registered nurse. However, they had not had experience of working in a domiciliary care agency prior to setting up CareBility, and they acknowledged that running a care agency had presented challenges they had not expected. During our process of registering the registered manager in April 2017, they were asked to submit a declaration to state they would undertake a level five leadership and management qualification. We asked the registered manager what progress had been made in relation to this. They informed us they had not made any progress in relation to this due to other commitments they had.

The service used an electronic care management system, which was also an 'electronic call monitoring' system. However, the registered manager and member of administrative staff found it hard locate information we requested about the running of the service and the care people were receiving. The registered manager told us this was either because the system had 'crashed' on the first day of our visit, or they suggested that a former employee had deleted the relevant records.

The service was relatively small, and the registered manager was able to answer the majority of our questions about its' running. However, they were not able to evidence what they told us was correct though the provision of records for example. Sometimes responses about important issues such as missed calls were also vague and this did not provide assurances that oversight of the service was adequate. For example, the registered manager was not able to readily provide records that would demonstrate which staff member had worked with which person on given days. When we did receive this information, and cross-referenced it to other information we had been given, we found it was not always accurate. For example, after the inspection the registered manager sent us two different versions of staff allocations. Neither of these versions matched a record the registered manager had previously given us to demonstrate which staff members were working on given days. This meant we could not have confidence in the accuracy of such records.

We found the electronic care management and call monitoring system was not fully operational. The staff allocations produced by the system showed gaps where it appeared no staff were allocated to calls. The registered manager described a back-up system they used, but this had meant that no clear records in relation to allocations had been maintained. The electronic call monitoring system was not working at the time of our inspection, and this meant the registered manager was unable to provide us with an overview in relation to the timeliness of calls, call duration or missed calls. No alternative method of capturing or monitoring this information was in place.

There were few systems or checks in place to help the registered manager monitor, manage and improve the quality and safety of the service. The registered manager told us they carried out audits of medicines and care plans. However, they were only able to provide the record of one such check, which was comprised of a one-page check list with yes/no answers. This audit also related specifically to the completion of contemporaneous care notes, and made no reference to the quality of care plans, nor any aspect of medicines management. This was despite the registered manager informing us the same form was used to monitor these aspects of care delivery. We saw there were gaps on people's medicine administration records and there was no explanation as to the reason for these gaps. Furthermore, there was no evidence that anyone had checked whether these people had received their medicines as prescribed. The registered manager told us they thought the gaps were just clerical errors, but they were unable to provide further reassurances that this was the case.

There were no records of accidents or incidents, and there was no monitoring of accidents such as falls, as staff were not recording these incidents unless they witnessed the actual event. There was also no monitoring of themes or trends in complaints as these events were not recorded in a way that allowed complaints to be easily identified amongst other records.

The provider had struggled to recruit sufficient numbers of staff, which had resulted in issues in relation to the timeliness of calls, and staff rushing calls. Whilst they had made attempts to recruit additional staff, these attempts had not been successful. The local authority had made the provider aware of the need to have audits of medicines and daily records in place. Six months later, the provider had not acted upon this advice and such audits were still not in place. Daily records and MARs were also not returned to the office on a consistent basis, which meant some of the records we asked to review were several months old. The service did not hold any daily records of care at the office for one person they were supporting.

The provider was not operating effective systems to ensure compliance with the regulations and to monitor and improve the safety and quality of the service. Records relating to the management of the regulated activity were not always maintained. The issues outlined above were breaches of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been no formal feedback gathered in relation to the quality of the service. However, the registered manager also worked 'on-rota' providing direct care to people using the service. People told us this helped make them visible, and they confirmed that the registered manager asked them how things were going when they visited to provide their care.

We saw the registered manager had held staff team meetings, and they provided us with minutes from two team meetings carried out within the previous year. During these meetings they had updated staff in relation to operational procedures, and topics such as record keeping, use of mobile phones when visiting people using the service and a reminder to staff to encourage people to drink more during the hot weather. This would help ensure staff acted in consistent ways and were aware of the manager's expectations.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not carrying out adequate assessment of people's needs and preferences. Regulation 9(1)

The enforcement action we took:

We took enforcement action to cancel the registration of the provider and registered manager. This was completed on 29 October 2018

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service was not consistently supporting people's independence and ensuring people were treated in a respectful manner. Regulation 10(1)

The enforcement action we took:

We took enforcement action to cancel the registration of the provider and registered manager. This was completed on 29 October 2018

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not managing medicines safely. There were lapses in the effective assessment and management of risks to people's health and safety. Regulation 12(1)

The enforcement action we took:

We took enforcement action to cancel the registration of the provider and registered manager. This was completed on 29 October 2018

Regulated activity	Regulation
Personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The provider did not have effective systems to ensure potential abuse was prevented, identified, and action taken to ensure people were safe from harm.</p> <p>Regulation 13(1)(2)(3)</p>

The enforcement action we took:

We took enforcement action to cancel the registration of the provider and registered manager. This was completed on 29 October 2018

Regulated activity	Regulation
Personal care	<p>Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints</p> <p>The provided did not have effective systems for recording, handling and monitoring complaints.</p> <p>Regulation 16(2)</p>

The enforcement action we took:

We took enforcement action to cancel the registration of the provider and registered manager. This was completed on 29 October 2018

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider was not operating effective systems to ensure compliance with the regulations and to monitoring and improve the safety and quality of the service.</p> <p>Records relating to the management of the regulated activity were not always maintained.</p> <p>Regulation 17(1)</p>

The enforcement action we took:

We took enforcement action to cancel the registration of the provider and registered manager. This was completed on 29 October 2018

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider was not operating effective recruitment procedures to ensure staff were of good character and were suitable for the roles in which they were employed. Records that were required to be kept in relation to staff recruitment were not always available.

Regulation 19(1)(2)(3)

The enforcement action we took:

We took enforcement action to cancel the registration of the provider and registered manager. This was completed on 29 October 2018

Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The service had not ensured that there were sufficient numbers of staff to meet the needs of people using the service and to keep them safe.</p> <p>Regulation 18(1)</p> <p>The provider had not ensured that staff had received appropriate training and supervision to enable them to competently carry out the duties they were employed to perform.</p> <p>Regulation 18(2)</p>

The enforcement action we took:

We took enforcement action to cancel the registration of the provider and registered manager. This was completed on 29 October 2018