

Fortress Supported Living Services Ltd

Fortress Care Services

Inspection report

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Ratings

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

Summary of findings

Overall summary

The inspection visit to the office to look at records and speak with the provider took place on 8 February 2018 and was announced. We contacted the provider on 5 February to give them advanced notice of our intention to inspect the following day. We did this to make sure someone would be available to show us the records we needed to see. The provider asked for us to delay our inspection visit as they had an important appointment and we agreed to move our inspection to 8 February. We also carried out visits to people who used the service, and their relatives, on 8 and 9 February 2018 and spoke to a relative by phone on 2 March 2018.

We last inspected the service on 8, 9, 23 and 25 August 2017. We rated the service Inadequate overall and identified multiple breaches of regulation relating to safeguarding, the recruitment, skills and availability of staff, leadership, consent, person centred care and the management of complaints and of risk. The provider had also failed to notify the Care Quality Commission (CQC) about the absence of the registered manager from the service.

Following the inspection we placed the service into special measures. When a service is placed in special measures the expectation is that providers found to have been providing inadequate care should have made significant improvements by the time we carry out our next inspection. At this inspection we found that the service had not made sufficient progress in the intervening months. We were still not assured that people would always receive a consistently safe and high quality service which met their individual needs.

Fortress Care Services is a domiciliary care agency. It provides personal care to people living in their own homes. It provides people with both daily care visits and also live-in care. At the time of our inspection six people were using the service.

The service had a registered manager in post but leadership of the service was provided by the nominated individual of the business. 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.

Staff received training in safeguarding people from the risk of abuse. The provider had raised no safeguarding concerns since our last inspection but had not acted promptly to refer someone, who may have posed a risk to people who used the service, to the Disclosure and Barring Service (DBS). This demonstrated a failure to take all possible actions to protect people from the risk of harm.

Risks to people's health and safety were poorly assessed and managed, especially related to people's risk of falls. Information about risk was confusing and new staff would not have all the information they needed to protect people.

Staff who supported people regularly demonstrated a good understanding of people's needs but there was a lack of a clear strategy for covering staff absence, especially that at short notice.

No new staff had been recruited since our last inspection but those already in post and those who had transferred from the provider's recruitment agency had not all been safely recruited. Records did not clearly demonstrate that all staff had the required DBS checks in place before they took up their post and two references had not always been sourced. This meant the provider was not acting in accordance with their own recruitment policy.

Medicines were administered by trained staff but a lack of stocktaking measures meant we could not be assured that people always received their medicines correctly. The provider did not carry out a robust audit of medication records or staff competence to administer medicines. The provider did not have sufficient oversight of the safety of medicines at the service.

The provider carried out an assessment of people's needs and encouraged people to be involved in decisions about their care and support. Assessments were not always accurate and contained contradictory information, or had important information missing, which could place people at risk.

Staff received training to carry out their roles and training provision had improved since our last inspection. However we remained concerned about the quality of the training and induction for new staff and the provider's oversight in this area.

Staff supported people to manage their healthcare needs and access the care they needed. Some staff demonstrated a lack of understanding of people's specific healthcare needs. Care plans did not clearly record the involvement of other healthcare professionals and some key information had been archived.

People received good support related to their eating and drinking.

People or, where appropriate, their relatives, consented to their care and their choices were respected. Staff had received training in the Mental Capacity Act 2005 (MCA). The MCA ensures that people's capacity to consent to their care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process.

Staff mostly treated people with patience and kindness and relationships were good. Action was not always taken to reduce one person's distress. Staff respected people's privacy and mostly maintained their dignity but some people were observed to appear unkempt which did not ensure their dignity.

Care plans were comprehensive and were designed to be person centred. However, some information was not accurate and some plans were not complete. This meant there was a risk that people would not receive care and support which met their individual needs, especially if staff were new or had not worked with them before.

A complaints procedure was in place, but a formal complaint from a healthcare professional had not been investigated. People who used the service did not all know how to make a complaint although people felt comfortable raising any informal issues with the provider.

There was no structured system of audits in place to monitor the safety and quality of the service. Spot checks were not thorough and supervision of staff, especially live-in staff, was very infrequent.

The provider did not fully understand all their responsibilities with regard to the regulation of the service. They had not notified CQC of important incidents affecting the health and welfare of people who used the service. They also failed to display their previous Inadequate rating on their website. This had the potential to mislead people.

The provider was not always open, honest and transparent. Sometimes we identified concerns and key information by chance when looking at other matters. This did not demonstrate a proactive approach on the part of the provider to work with CQC to bring about the all the required improvements at this service.

We recognize that the provider had made some improvements since the last inspection and we welcome these. We are encouraged that some individual carers are providing a good service to some people. However this inspection has found that many concerns remain and some new concerns have been identified. We do not feel that the service has made the improvements expected in the months since our last inspection. This service will remain in special measures and CQC intends to take further action to ensure people always receive consistently safe and high quality care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Risks to people's safety were not accurately assessed and managed.

Recruitment procedures did not fully protect people who used the service.

The provider did not have a contingency plan for the unforeseen absence of regular staff. There were not sufficient numbers of suitably trained and experienced staff to provide appropriate cover arrangements.

Most records showed that medicines were administered according to the prescriber's instructions. However, a lack of stocktaking measures meant this could not be confirmed.

Staff were trained in infection control and understood their responsibilities to protect people from infection.

The provider had not learned from previously identified concerns relating to people's safety and people remained at risk of harm.

Inadequate ●

Is the service effective?

The service was not always effective.

The provider involved people, and their relatives if appropriate, in assessing their needs. Assessments were not always accurate and information was sometimes incomplete and contradictory.

Staff received training but did not receive a robust induction or all the specific training they needed.

Staff worked with other professionals to support people with their healthcare needs but records did not always provide a clear picture of this partnership working. Staff handovers between shifts were not robust.

Staff supported people well with their eating and drinking.

Requires Improvement ●

People consented to their care and staff had received training with regard to the Mental Capacity Act 2005.

Is the service caring?

The service was not always caring.

People who used the service praised the caring nature of some of the staff who regularly supported them. Some staff interacted with people warmly and with kindness.

Staff had always not taken effective action to minimise one person's distress or raised the issue with the provider.

Staff maintained people's privacy but some people appeared unkempt which did not ensure their dignity.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

People's care plans contained contradictory and inaccurate information. Plans did not clearly identify how new staff should meet people's individual needs. Staff working regularly demonstrated a good understanding of people's needs and preferences.

Complaints were not robustly investigated.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

The provider failed to send CQC the required notifications for serious injuries and failed to display their last inspection rating. The provider did not fully understand all of their responsibilities with regard to the regulation of the service.

The provider was not always open, honest and transparent during the inspection process. They had failed to take robust and proactive steps to address the serious concerns identified at the last inspection.

The provider supported their staff informally but formal audit systems were not in place. The provider did not effectively monitor the quality and safety of the service.

Inadequate ●

Fortress Care Services

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.

The inspection took place on 8 and 9 February 2018 and was unannounced. We also carried out visits to people's homes and spoke with one relative by phone.

The provider was given an initial 24 hours' notice of our initial visit because the location provides a domiciliary care service and we needed to be sure that someone would be in. The provider asked us to delay our inspection visit due to an appointment and we agreed to do this.

One inspector and one inspection manager carried out this inspection.

Before the inspection we reviewed the information we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We had received no notifications since our last inspection.

We visited three people who used the service. We also received feedback from two relatives. We spoke with the nominated individual of the business, two members of staff and a visiting healthcare professional. We looked at four care plans, seven staff files and records relating to the quality and safety of the service.

Is the service safe?

Our findings

When we last inspected the service in August 2017 we found that people were not kept safe and were not protected from risk. We rated this key question Inadequate and identified breaches of regulation relating to safeguarding, the recruitment, skills and availability of staff and the management of risk. At this inspection we found that many issues identified at the previous inspection remained a concern.

Risks continued to be poorly managed in some cases. A new care planning system had been introduced since our last inspection and a section was dedicated to assessing risk. We found that information about risk was not always accurate. One person's falls risk assessment dated 1 February 2018 stated that the person had had no falls in the previous year and had no report of any problems with balance. We found that this person had a significant fall on 10 January 2018. The fall had resulted in the paramedics being called and the person attended the local A and E department. There was no record of this fall in the person's care plan in their home and we only found out about it when we asked about another matter.

We asked the live-in carer about this person's risk of falls and the recent fall. They were not sure about the details of the fall in January saying, "I think it was last month. [The person] had bruises on [their] hand and down the side and went to hospital. [The record] should be with the office as I wasn't here when it happened'. Whilst this carer had a good understanding of this person's risk of falling we found that information in records was not accurate. This meant other staff would not have a comprehensive picture of risks for this person. The carer also told us that the person occasionally needed medicine to calm them and this increased their risk of falling but this was also not recorded in the falls risk assessment. Since the inspection the provider told us that they have introduced a new risk assessment form but this was not seen on inspection

A live-in carer also told us that the person had had another fall. They said, "[It was] about nine months ago. [They did not go] to hospital". There was no mention of this fall in the person's records at their home. The carer told us that most records had been sent to the office.

A second person used a wheeled walker to help them with their mobility but their moving and handling risk assessment said they used a 'zimmer' frame which was not accurate. The plan also stated 'No moving and handling is involved in supporting [person]'. The carer, who demonstrated a good knowledge of this person's needs, told us that the person did not like to be touched or helped when moving around. They told us, "[Person] doesn't like to be touched as [they] think they will fall". This significant piece of information was not recorded in the person's risk assessment and new staff might increase the risk of falling by attempting to offer the person some physical guidance or support.

A third person's moving and handling plan was confusing and meant there was a risk of the person not being safely supported, especially by staff unfamiliar with the person's needs. Again we found that this person had recently had a fall resulting in a serious injury and admission to hospital for several weeks. Following their discharge from hospital their moving and handling needs had changed but the records relating to this person were contradictory.

A copy of the person's care plan was available for us to look at in the office. It was dated 27 January 2018 and stated that care staff should use a standaid to assist the person with their mobility following a fall on 30 November 2017. It also stated that two carers should assist the person. There was no further information about the type of support staff should give or the involvement of any other professionals. An undated moving and handling risk assessment did not mention the standaid. The provider told us that further and more up to date information would be at the person's home.

However records in the person's home stated that the person 'walks with a ' zimmer' and a stick' and can 'walk outside'. The care plan contained both out of date and current information about the person's mobility and the inaccurate information was located at the front of the care plan with the most current information behind. This presented a risk of any new staff being unfamiliar with the person's needs and placing them at risk.

A fourth person had had a fall requiring admission to hospital. The CQC had not been notified about this fall. The person's falls risk assessment had not been updated in the light of this fall and contained only information about the number of falls the person had had.

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

At our last inspection we found that the provider did not have a robust procedure for staffing care visits and live-in care packages when staff were unexpectedly on leave. We found that in these circumstances the provider had arranged cover with staff who had not undergone appropriate training or had suitable checks in place. This placed people at risk. At this inspection we were again not fully assured that a robust system was in place to provide cover.

The very positive feedback we received about one live-in carer, and whose practice we observed, led us to ask what happened when this staff member was not at work. The provider had told us that live-in care staff work two or three weeks in a person's home and then have a similar time off. They supplied rotas which confirmed this was the case for some people but rotas showed one live-in carer being on duty for eight weeks without a break. This live-in carer had been working since before 30 November 2017 and was not due for a break until mid March. We understood that this was their choice and both the person who used the service and their relative were also happy with this.

We asked about the last time the carer had had a break. They told us another staff member acted as a live-in carer but they did not know their name. Both they and the person's relative told us that this staff member had not been fully aware of the person's needs. During a week supporting and caring for the person the new staff member had not realised that the person who used the service was able to speak. They were surprised when the regular carer had a conversation with the person on her return to work. The relative we spoke with told us that they were very anxious when other carers had to come. We found a complete reliance on one member of staff in this case and a lack of a strategy to cover the person's care package in the event of a sudden absence of this excellent live-in carer.

The provider had seven members of staff. One was not currently available for work. Three carried staffed regular live-in care packages between them, two were bank staff and one did regular shifts in one geographical area. Only two bank staff members did live-in care and we saw that they had not worked in several months and so would not be familiar with people's needs.

One bank member of staff had done no training in the last nine months and had no record of any contact

with the provider. One of the regular live-in carer's last annual leave period in April 2017 had been covered by this member of staff. The provider was not able to show us evidence of a robust induction for this person and oversight and supervision of their work was very limited.

We were not assured that this level of staffing ensured enough flexibility to cope with a sudden absence of a key member or members of staff. We had identified similar issues at our previous inspection and the provider did not demonstrate that they had considered this potential risk and learned from it.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014

We established that the bank member of staff who covered the regular carer's annual leave period had applied to work at the service on 8 March 2017 and begun their employment that month. They worked as a live-in carer in April and May 2017. The provider was not able to show us a Disclosure and Barring Service (DBS) check for this person, which covered from April 2017. We saw a check dated 17 August 2017 and a written record confirming that a different check had taken place 3 March 2017 but no supporting documentation was available. The date of this check preceded the staff member's application date. We were not fully assured that all appropriate checks had been in place for this staff member when they started work. There was only one reference on file for this staff member, as well as for other staff. This was not in accordance with the service's recruitment policy where it states that two references would be sought. In addition this staff member's reference was not from their previous employment but was a personal reference.

We found that DBS checks for other staff were also confusing and often people had multiple DBS certificates, some of them imported from other organisations. This meant we could not be fully assured that all appropriate checks were in place to make sure people were safe to work. However we were encouraged that the provider had signed up for the DBS update service. The provider intended that this would ensure a more transparent record in future.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our previous inspection we had found that measures had not been taken to protect people from the risk of abuse. Staff had not been safely recruited and the provider had not taken appropriate action to protect people from potential risks. They had also failed to fully co-operate with adult social care professionals who were investigating following a safeguarding concern being raised. At this inspection we found that staff who posed a potential risk were no longer employed and one person had been referred to the Disclosure and Barring Service (DBS). This referral was for them to assess if the staff member required placing on the list of people barred from carrying out this kind of employment. We found that the provider had only recently made this referral in January 2018 when the issue was identified during our August 2017 inspection. This did not demonstrate a proactive approach to safeguarding people from potential harm and abuse.

We found that measures designed to safeguard people from the risk of abuse required some further improvement. Staff had received training in keeping people safe from abuse and those we spoke with demonstrated a basic understanding of how to raise a concern if they suspected someone was at risk of harm. However, one of the two staff we spoke with were not clear about how to raise concerns outside of the organisation, directly to CQC or the local authority for example. The lack of oversight of the live-in carers meant that we could not be fully assured that the provider was doing all they could to make sure people were fully protected.

We looked at how staff supported people to take their medicines. Each person had a medication administration record (MAR) chart in place and staff signed it when they administered medicines. Charts were returned to the office on a regular basis for the provider to audit. We found some gaps in charts but the provider had not made any enquiries about why this was and so we could not be certain people had received their medicines correctly on those days. However, most charts we viewed were fully completed and staff demonstrated a good knowledge of the medicines they were administering.

Staff had received training in administering medicines but we saw no evidence that their competence to do this was checked to make sure they were working safely. We found no accurate stocktaking which meant we could not check to see if people had received the correct amounts of medication. The provider had not identified this as an issue which needed addressing.

Staff received training in infection control and some staff had recently had this refreshed. We noted that staff working as live-in carers kept the kitchens clean where they were preparing food. They told us they used equipment such as aprons and gloves to minimise the risk and spread of infection.

Is the service effective?

Our findings

At our last inspection in August 2017 we rated this key question Requires Improvement. We identified a breach of regulation relating to how people consented to their care and a further breach relating to the skills and experience of staff. At this inspection we found some improvements in how the service ensures people consent to their care but we continued to have concerns about the skills, training and experience of some staff, and about the provision of person centred care.

People who used the service told us they were happy with the way staff supported them. One person said, "I have heart pain. The carers help me with that". We asked if care staff treated them well and they said, "Yes they do". Another relative was extremely complimentary about the skills of the live-in carer saying, "[Carer] can get my [relative] to do things for herself. She is excellent". However they expressed concerns about the skills of staff who only occasionally supported and cared for their relative saying, "Thank goodness it's only one week at a time – another new face would set [my relative] back".

Each person had received an assessment of their needs and we saw that new care plans had been put in place in January and February which meant people's needs had been recently reviewed. However, assessments were not always accurate. For example, one person told us that they were hard of hearing and blind. We saw that the care assessment in the person's home stated that they had no problems with either their vision or their hearing. Another person's assessment stated that they had no problems with their balance. We found that they had recently had a serious fall and staff told us they were known to be at risk of falling. Their care plan also stated that they were continent while the live-in carer told us they were not. This meant that although the new assessment forms were detailed, information was not always accurate. This could place people at risk of not receiving the care and support they needed.

A third person's care assessment and care plan made no mention of the fact that their distress and confusion could sometimes make them behave in ways that staff might need particular skills to manage. The person was often unwilling to get up in the morning. A relative told us, "[My relative] has punched, slapped and thumped. ...some days it can take three hours to get [them] up". The care plan and assessment did not include this information or any guidance for staff to help them encourage and support the person successfully. The live-in carer for this person was very familiar with their needs and demonstrated excellent skills in providing care. However other staff who only occasionally provided care or who were new to the person would not have all the information they needed to provide safe and effective care.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Staff we spoke with demonstrated that they understood people's needs and had received the training they needed. Staff told us that they felt supported by the provider and could ring them for advice and guidance. At our last inspection we noted that staff had not received all the training they required and the provider was not able to tell us exactly what training people had received and when as they carried out most training themselves and issued one certificate covering all topics. They did not tell us what training and experience

they themselves had which qualified them to provide this training. We saw that most training involved staff watching DVDs at the provider's home.

At this inspection we found some improvements with regard to the organisation of training but we were still not fully assured that staff had received all the training they needed. The provider showed us a training matrix which documented training to be provided throughout the year. We saw that four staff members had undertaken moving and handling training in January 2018. A fifth staff member was due for this training in March 2018. This staff member's multi topic certificate documented that they had last received this training on 4 May 2016. There was no record of any practical session for any staff member.

In addition we noted that, following a fall, one person who used the service was discharged from hospital and needed a hoist to assist them to move. The live-in carer told us that they had themselves sourced some training directly from the physiotherapy department at the hospital on how to use this piece of equipment. Other staff involved in this person's care had not done this and so we were not fully assured that all staff involved in this person's care would be clear about the support the person needed.

Since our last inspection in August 2017 we found that some staff had undertaken additional online training in infection control, continence management, the Mental Capacity Act 2005 (MCA), safeguarding and medication. Some staff had received recent training relating to dementia and told us this was helpful. However some staff, who the provider told us were in the current staff team, had no record of recent training. For example one person had last had moving and handling training 11 November 2015. One member of staff only had a multi topic certificate issued by the provider on 23 March 2017. There were no other records relating to their induction, training or on-going supervision and support, other than one spot check undertaken on 28 April 2017. This documented limited information about the staff member doing laundry. We saw very few records of staff supervision and no recorded sessions for some staff.

Although we saw evidence of good practice on the part of some staff we also had some concerns. Staff were not always proactive and effective systems were not in place to share and hand over important information. For example one live-in carer told us that the person they were caring for often became distressed about something. We asked if the other live-in carer had found the same issue and they said, "I don't know. I haven't asked her". There was no information about this issue in the person's care plan and the live-in carer had not considered it worth sharing and exploring with other colleagues and the provider

We considered whether the service was operating in line with the Mental Capacity Act 2005 (MCA). The MCA ensures that people's capacity to consent to their care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved. This aims to ensure that any decisions are taken in people's best interests according to a structured process.

At our last inspection we found that people's capacity to consent to their care had not been assessed and understanding of the MCA was poor. At this inspection we noted some improvements. Staff had all received training related to MCA and those we spoke with had an understanding of its principles. We found that people's capacity to consent to their care had been assessed and recorded in their care plan. Some records had been signed by the person they concerned or by the person who had lasting power of attorney for them.

A series of reviews of people's care had taken place and as part of this the provider had asked if people consented to having their information shared. People's response was recorded but they had not always signed to confirm this. One person's plan was contradictory stating that the person had capacity to consent

but also had an advocate and a relative with lasting power of attorney. This person was living with dementia and we could not be clear about their needs with regard to consent. Their live-in carer and relative told us the person was very confused and we observed this confusion.

Staff supported people with their eating and drinking and we observed staff preparing meals and drinks for people. Food was nicely presented and kitchens were clean where food was being prepared. Staff received training in food hygiene. We looked at records related to one person's food intake and found that the person enjoyed a healthy and varied diet. Their relative told us, "[The live-in carer and my relative] sit and eat together. They used to go out and eat together when [my relative] was well".

Care plans contained basic information about people's needs in this area. There was no detailed information about people's likes and dislikes relating to food. This is important information when supporting someone living with dementia who may no longer be able to tell you what they do and do not like to eat. This is particularly concerning if the person is also losing weight.

We found a mixed picture regarding how the provider supported the healthcare needs of people receiving a live-in care service. We observed excellent care for one person who had suffered a recent fall. The live-in carer had supported them in hospital with their eating and drinking as well as ensuring they did their exercises. The person's relative was sure that this care and attention was the reason the person was doing so well. Staff from the occupational therapy service were very impressed with the progress the person was making with their mobility.

We saw that this live-in carer made meticulous notes and was clear about all the healthcare needs for this person. They managed the person's health appointments and made sure medicines were promptly available. We could not be assured that such good care was delivered when this particular live-in carer was off duty. This situation happened rarely but was a concern to the person's relative.

Another person received some support from the dementia intensive support team but the team's involvement and advice was not documented in the care plan to guide staff. We asked when the team had last reviewed the person and what advice they had given. The live-in carer was not able to tell us about the nature of the team's involvement saying, "I think[they came] last year. I think the file is in the office because [the providers] take it".

A third person told us they had a very significant health condition which made their breathing difficult. We asked the live-in carer about their condition but they did not know what it was and could not tell us if anything made the condition better or worse. This demonstrated a poor understanding of this person's healthcare needs.

Is the service caring?

Our findings

The majority of the daily care calls were carried out by one member of staff who we met on our last inspection in August 2017. All the people we spoke with gave us extremely high praise for this carer and we found them to be caring, patient and kind. At this inspection we concentrated on the care for people who had live-in carers. We received very positive feedback about some of the staff and some less positive feedback about staff who occasionally cover shifts. Whilst the consistency of the staffing meant it was possible for relationships to form it also meant that it was more of a problem when these staff were not at work.

One live-in carer was viewed almost as a member of the family and a relative gave exceptionally good feedback about them saying, "[Carer] is so patient with [my relative]...She is great". We found that this staff member was very familiar with the person's needs and took great care to provide high quality care and support. The person confirmed that they were very happy with this carer saying, "She's lovely". A relative echoed this stating, "She is calm and nothing fazes her".

People who used the service also gave positive feedback about other regular staff and we received no negative comments. One relative said, "[Carer] is very good. [They] help my [relative] when the dementia is very bad".

However we also had some concerns. For example, we asked one live-in carer what kinds of support they gave to people. They told us they gave people their medicines, carried out personal care and cooked meals. They then added, "If [person using the service] lets me, I sit in there but [they] don't like me. It distresses [them]". The fact that this carer felt they might be causing distress to the person had not been recorded or shared with the provider and so no action had been taken to see if the person's distress could be reduced. The person was living with dementia and was very confused on the day we visited them.

Care records included a section called 'A little about me....' Information recorded here stated things like the person's preferred name and where they used to work. It also recorded what was important to the person and key relationships. This helped staff gain a more comprehensive knowledge of the person and what was important in their life.

It was clear that the person, and sometimes their relative, had been involved in drawing up their care plan. The provider gave people the chance to feedback about their care and recent review meetings had been held with them and their relatives to review their needs together.

We observed staff working respectfully albeit in a task led manner sometimes. There was little in the way of encouraging people's independence or being proactive about people's care. However, several of the people who used the service were not in good health and told us they wanted the staff and their relatives simply to look after them. We noted that one person had very long and dirty nails. It was clear they would not be able to cut their own nails and staff had not done this for them. We would expect live-in care staff to be aware of people's appearance and their cleanliness as an important way of maintaining their dignity and keeping them well.

Is the service responsive?

Our findings

At our previous inspection in August 2017 we rated this key question as Requires Improvement and found breaches of regulation relating to person centred care and the management of complaints. At this inspection we found some improvements but further were still required, particularly the investigation and management of complaints.

A complaints procedure was in place but people we spoke with were not all clear about how to make a complaint and to whom. People mostly told us they would talk to the carer or live-in carer. We asked one person who they would tell if staff did not treat them well or they had some other complaint and they said, "I don't really know". However relatives also told us that they would contact the provider if they had a concern. One relative told us, "[The provider] is always helpful and receptive to anything".

We asked the provider if they had received any formal complaints since our last inspection. They told us there had been one formal complaint made by a paramedic when they had attended a person's home where Fortress Care Service had a live-in carer. The complaint related to a member of staff and concerned an incident on 10 January 2018 which had come to the provider's attention on 1 February 2018. There was no record of the exact nature of the complaint and the provider had not tried to contact the paramedic for further information. The provider said that a conversation had taken place with the member of staff on 2 February but they had made no record of this. On 5 February, which was the day we had told the provider we were going to carry out an inspection that week, the provider contacted the member of staff by e mail to ask for an explanation of why the complaint had come about. A further e mail was sent to the member of staff on 7 February as they had failed to respond.

The provider failed to carry out a timely investigation into a complaint made by a healthcare professional. We could not be assured that the provider would always take prompt and effective action to investigate and act on any future complaints.

This was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People's needs had been recently reassessed as part of a review process and a new more person centred care plan format put in place. Plans contained some specific details about how people liked to receive their care and their individual likes and dislikes. For example one care plan stated 'I would like to have my breakfast in bed and be supported with my personal care before going into the lounge'. The live-in carer confirmed that this choice was respected. The plan also documented the importance of a particular friend and the live-in carer told us that the friend had visited the previous day. Another person's plan noted that staff should 'engage in good discussion', although we observed staff communicating in a task led manner during our inspection.

We found that although the new format was comprehensive, information was not always accurate and could be confusing for staff. The format was person centred but we could not be assured that people were

receiving personalised care as some sections of the care plans were blank, some were inaccurate and some only contained very basic information. For example, in a section covering the person's aspirations about what they wanted to continue with or achieve stated, 'Nothing, really'.

We also found contradictions in the information. One person's medication plan stated that they both required assistance with their medicines and were fully independent. Another person's plan had similar contradictions and the provider wrote to us after the inspection saying that they had reviewed the plan and made sure that it was now accurate.

We found no information relating to people's religious or cultural needs or those relating to any sensory needs. One person's plan did not mention that the person considered themselves both deaf and blind. People's communication needs were not clearly documented which meant staff unfamiliar to the person might struggle to connect with the person and ensure they had the care and support they needed. We also found no management plans relating to people's behaviour which might be related to a health condition such as dementia. Any new member of staff would be left to rely on a handover from other staff and their own skills.

The provider's website stated that the service was able to provide end of life care, however they were not actively providing end of life care at the time of our inspection. Staff records showed that no care staff had received any specific end of life training and this was not planned. People's end of life wishes were not recorded in their care plan, although it was clearly recorded where people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place and staff knew if people had this in place.

Is the service well-led?

Our findings

At our previous inspection we rated this key question as Inadequate. We had multiple concerns about the leadership of the service and during that inspection we identified nine breaches of regulation. Breaches included one which specifically related to the overall management of the service. At this inspection we identified some improvements had been made but continued to have multiple concerns which led us to question the competence and ability of this provider to deliver consistently safe and effective care. We identified continued breaches of some regulations as well as additional breaches relating to the provider's failure to comply with CQC requirements.

It is a requirement for services which have previously been rated to display this rating prominently on any website. Fortress Care Services had not ensured that their website displayed the current Inadequate rating from the August 2017 inspection. This meant that there was a risk of people being misled about the quality and safety of the service. The provider arranged to have the website updated whilst we were still on inspection.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Registration) 2009.

It is a further requirement for services to inform CQC about a number of matters including any serious injury to a person using the service. During this inspection we found that three people had had falls in the last year that needed attendance at A & E for treatment and two required admission to hospital. One person sustained a broken hip and was in hospital for several weeks. The provider had failed to notify us of these serious injuries and told us they did not realise they should have done so.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) 2009.

There was a registered manager in post but they were not present during this inspection. At our previous inspection the registered manager had been off sick for several weeks but we had not been informed of this lengthy absence, as is required by the regulations. We were not clear what part the registered manager was currently playing at the service as the provider and nominated individual told us, "[Registered manager] is not doing much at the moment". We saw that the nominated individual was overseeing the management of the service and people told us that this was their perception also. One staff member said, "Most of the time [nominated individual] is the one who does all the running around".

Although the provider had made some improvements to the care plans and had reviewed people's care needs, we found that assessments were not always detailed or accurate. Current information was sometimes stored alongside out of date information. In addition we also found that information, such as that about recent falls or involvement of healthcare professionals had been archived. This meant there was risk that staff did not have a complete picture of people's needs. Archived information was not easily accessible and the provider told us files were stored in the garage which meant we could not be assured of the security of people's personal information.

We also found that there had been some considerable delay in attempting to make the improvements to the care plans. Most plans had been reviewed in January and written and delivered to people in February, with one being delivered to a person at 11pm the night before our inspection. We found the provider had not been proactive in reviewing people's needs and ensuring all records were fit for purpose.

In addition, systems were not in place to ensure that important information was effectively communicated to key staff. The staff filled in comprehensive daily notes which other staff had to read through in their entirety during handover. This could involve reading many week's worth of notes. The provider had recently introduced an electronic system but this had only added to the recorded information as daily notes were replicated there word for word.

Management of risk remained poor and the provider relied on a few skilled staff to ensure people received safe care. There was still no clear strategy with regard to covering these staff member's absence with skilled and experienced staff who knew people well. We saw that sometimes shifts had been covered by staff who did not have all the skills and training needed. It was not clear how the provider would ensure safe staffing levels if a live-in member of staff was absent at short notice. Support for staff, through supervision and appraisal, was not well organised. Oversight of the competence of live-in staff, who were quite isolated in their role, often remaining with one service user for months at a time, was infrequent.

At our last inspection we found that the provider was not open, honest and transparent during the inspection process. For example they failed to tell us how many people used the service, firstly saying four and finally confirming a figure of nine. We asked how many staff were employed and they originally told us one was employed and this increased to a final figure of fifteen. This lack of co-operation and transparency made it difficult to reach our judgments and led us to question the culture of this service.

At this inspection we identified some similar issues. Before our inspection we asked the provider how many staff were employed and they told us they had six permanent members of staff. They confirmed this number at the start of our inspection visit. However, whilst looking at training records we identified a seventh member of staff was named. We asked the provider who this was and asked if they were bank staff. The provider told us they were "In the pipeline" and told us they had not done any shifts yet. They then contradicted this stating that the person had done some live-in care shifts but could not remember when and the records were not available.

We asked the provider to check the payroll which confirmed that the staff member had done a week's live-in care shift in April 2017. We saw no induction for this person although they did have a record of the multi topic training certificate which the provider had himself devised. Recruitment of this staff member and others was not in accordance with the provider's own recruitment procedure. No new staff had been recruited since our last inspection but one staff member had been transferred from the provider's recruitment agency.

The provider regularly sought feedback from people who used the service and relatives. We saw that this feedback was very brief but positive. People told us they found the provider approachable and staff described both the nominated individual and the registered manager in positive terms. One staff member told us the provider visited them twice a month but this was not recorded anywhere.

Apart from the occasional brief spot check of staff other audits of the quality and safety of the service were not in operation. Medicines were not effectively audited and staff competence to administer medicines was not checked.

There was no evidence that the provider fully investigated incidents and learned from them to drive improvement as we found concerns at this inspection mirrored those we had found previously. The provider had not linked with peer organisations or joined forums which might be the source of help and guidance. A service placed in special measures is given a period of time to reflect on our findings, take action and begin to address the issues. We found that the provider had not made sufficient progress in the intervening months and we could not be assured that people could rely on a safe and effective service.

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