Kendrick Haylings & Jones Limited

Bluebird Care Hurley Office

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Bluebird Care Hurley Office is registered to provide personal care and support to people living in their own homes. The service operates across Warwickshire and Staffordshire. There were 63 people using the service at the time of our inspection visit.

The inspection took place on 6 and 20 September 2017 and was announced on the first day. We called the service an hour before our arrival to ensure the manager and provider were available to speak with us when we arrived. The inspection was prompted in part by information of concern received from members of the public, about the standard of care being provided.

There was no registered manager at the service. The previous registered manager had left their post in June 2017. The service was being managed by a care manager [referred to as the manager throughout this report] and an operations manager, who both began their role in June 2017. The manager left the service following this inspection visit and the service continues to be managed by the operations manager.

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

The service was previously inspected on 20 March 2017 where we found the service was not meeting the Health and Social Care Act 2008 and associated Regulations and there was a breach in Regulation 17 Good Governance. The service was rated as 'Requires Improvement'. This was because insufficient improvements had been made since our previous inspection and there were continuing concerns. Processes had not been established to consistently assess, monitor and mitigate the risks relating to the health and safety of people who used the service. One referral about an important event which called into question one person's safety had not been made to the CQC. We found some identified risks relating to people's needs had not been assessed in full on their care plans and there were some gaps in guidance for staff. Some people experienced late calls and had not been contacted by the service to warn them in advance. We found best practice was not always followed when recording why medicines were not administered to people.

At this inspection we looked to see if the provider had responded to make the required improvements as set out in their action plan dated June 2017. During this inspection we found the same issues continued to require improvement and we found additional concerns.

There were insufficient numbers of suitably skilled staff to meet people's individual needs. Missed and late calls and medicine errors were not monitored or recorded effectively to manage and reduce risks of them occurring in future. We found events that might mean a person was at risk of harm were not consistently identified and managed effectively in accordance with the provider's different processes. Medicines were not always administered safely and best practice was not always followed when recording why medicines

were not administered. Care plans were not all accurate and there were gaps in guidance given to staff about how to support people safely. Some identified risks had been recorded but not assessed in full on people's care plans.

Staff had not been provided with consistent training or support from the provider to enable them to carry out their role effectively. The provider did not always work within the principles of the Mental Capacity Act 2005. Where people lacked the capacity to make certain decisions, mental capacity assessments had not always been conducted thoroughly to establish which decisions they could make themselves. People's nutritional needs were not always met. Care plans were not accurate and it was difficult to see what action had been taken to ensure people received on going healthcare support.

People were positive about how caring the staff were. They told us staff respected their privacy and dignity. However, carer workers had not been treated in a caring way by senior staff, which meant they were not always able to provide person centred care for people.

People were involved in planning their care, however care reviews had not been completed in a timely way. People did not always receive the personalised care they needed, because care plans were not always up to date. People knew how to complain, however not all complaints were identified or managed in accordance with the provider's complaints process.

There was a continued lack of oversight by the provider which meant people were placed at risk of harm and actions identified as requiring improvement at our last visit had not been addressed. Management systems continued to be ineffective because they did not identify concerns we found during our inspection visit.

We found a continued breach, and additional breaches of the Health and social care Act 2008 (Regulated activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means the service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded."

The 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.

Events that might mean a person was at risk of harm were not consistently identified and managed effectively in accordance with the provider's different processes. Missed and late calls and medicine errors were not monitored or recorded effectively to manage and reduce risks of them occurring in future. Medicines were not always administered safely and there were gaps in recording. There were insufficient staff to fulfil care calls and meet people's needs safely. Care plans were not all accurate and there were gaps in guidance given to staff about how to support people safely. Some identified risks had been recorded but not assessed in full on people's care plans.

Is the service effective?

Inadequate

The service was not effective.

Staff had not been provided with consistent training or support from the provider to enable them to carry out their role effectively. The provider was not always working within the principles of the Mental Capacity Act 2005. Where people lacked the capacity to make certain decisions, mental capacity assessments had not always been conducted thoroughly to establish which decisions they could make themselves, and which decisions they required support to make. People told us staff gained their consent before they provided personal care. People's nutritional needs were not always met. Records were not accurate and it was difficult to see what action had been taken to ensure people received on going healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were positive about how caring the staff were. They told us staff respected their privacy and dignity. Carers had not always been treated in a caring way by senior staff, which meant they were not always able to provide person centred care for people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were involved in planning their care, however care reviews had not been completely in a timely way. People knew how to complain, however not all complaints were identified or managed in accordance with the provider's complaints process.

Is the service well-led?

Inadequate

The service was not well led.

There was a continued lack of oversight by the provider which meant people were placed at risk of harm and actions identified as requiring improvement at our last visit had not been addressed. Management systems continued to be ineffective because they did not identify concerns we found during our inspection visit.

Bluebird Care Hurley Office

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 was prompted in part by information of concern received from members of the public, about the standard of care being provided.

The comprehensive inspection took place on 6 and 20 September 2017. The first day was announced, this was to ensure the managers, the provider and the staff were available to talk with us about the service when we visited. The second day was not announced. The first day of the inspection was conducted by two inspectors and the second day was conducted by one inspector.

Before the inspection visit we reviewed the information we held about the service. We looked at information received from relatives, members of the public, healthcare professionals, local authority commissioners and reviewed the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The local authority provided us with information regarding recommendations it had recently made to improve the quality of the service. We considered this information when planning our inspection of the service.

This inspection was a follow up visit to check improvements had been made in the management of the service. During this inspection, we asked the provider to supply us with information that showed how they managed the service, and the improvements they had made. We considered this information along with the action plan they had submitted to us following their inspection in June 2017.

During our visits we spoke with the manager, the operations manager, the provider, the director and the senior carer. We reviewed seven people's care plans to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated, including medicine records, staff recruitment records, the provider's quality assurance audits and records of events and complaints. Following our first visit we contacted people who used the service by telephone. We spoke

with 5 people who used the service and six representatives, including relatives. We also spoke with five care staff.

Inadequate

Is the service safe?

Our findings

At our last inspection 'Safe' was rated as 'Requires Improvement.' We found insufficient improvements had been made since our previous inspection in March 2016 and similar concerns continued. Processes had not been established to consistently assess, monitor and mitigate the risks relating to the health and safety of people who used the service. One referral about an important event which called into question one person's safety, had not been made to the CQC. We found some identified risks relating to people's needs had not been assessed in full on their care plans and there were some gaps in guidance for staff. Some people experienced late calls and had not been contacted by the service to warn them in advance. We found best practice was not always followed when recording why medicines were not administered to people. At this inspection we looked again at all the issues where we had continued concerns.

We looked at how events that might mean a person was at risk of harm were reported and analysed. At our previous inspection we found events had been recorded and shared with senior staff for analysis. However, it was difficult to see how the events had been managed due to the lack of detail in recording. At this inspection we found an increase in the number of events recorded by carer workers and shared with senior staff. Thirty three incidents had been recorded in the previous 12 months. All events were recorded using the same form. However, different types of events had not been identified and managed effectively in accordance with the provider's different processes. So we could not always see if appropriate action had been taken by the provider to manage the risks to people and keep them safe. For example, staff told us one person had recently experienced two falls in their home. We asked the manager to show us the record of these events. These events had not been recorded, however the manager was aware of the falls. There was no evidence that any learning had taken place following the events and the manager had not reviewed the person's needs in order to prevent future incidents.

Staff told us they were asked to report any type of issue on an incident form. Some incident forms were not completed in full and it was difficult to see what action had been taken to protect people and reduce risks to their safety. For example, we looked at one recorded incident but because of the lack of information on the form it was not clear what type of incident it was. There was evidence a senior member of staff had reviewed the incident form. The issue appeared to be an allegation of verbal abuse by a staff member against someone using the service. We discussed this with the provider and they told us the incident should have been, "Investigated further with clearer recording, perhaps under the complaints process." This demonstrated there were gaps in the staff's understanding about how different types of events should be identified, for example if it was a safeguarding issue that would require further escalation to an external authority or a complaint.

Some events such as late or missed calls or medicine errors had not been recorded at all. There was limited evidence of any overview or management of events by the provider and there were gaps in the provider's understanding about how different types of events should be managed to reduce the risks to people. These were continued concerns we had found at our previous inspection and the provider had not acted in accordance with their action plan dated June 2017, to make improvements.

There was a procedure to identify and manage risks associated with people's care. When people started using the service, an initial assessment of their care needs was completed that identified potential risks to providing their care and support. The manager told us when people's care was reviewed, these risks were assessed again. However, we found some identified risks had been recorded but not assessed in full on people's care plans. For example, we looked at one person's care record who used Oxygen in their home. There was no risk assessment or care plan in place for the use of the Oxygen to ensure staff used this safely. Another person had bed rails attached to their bed, there was no risk assessment or care plan in place to ensure staff used this equipment safely and consistently. We looked at another person's care plan who used a catheter. We found there was no assessment of risk relating to catheter care and there were gaps in the guidance given to staff about how to support the person safely. The information did not advise staff what to do if there was a concern. Staff told us information in care plans was not always complete. One care worker said, "Some are detailed, for example, they will tell us what colour straps to use for which hoist. But they are not consistent and some plans don't tell us." This was a continued concern we had found at our previous inspection, where the registered manager had given us their assurance that all care records would be reviewed and updated to assess risks to people's wellbeing and provide more detailed guidance for staff to enable them to support people safely. Therefore the provider had not acted in accordance with their action plan dated June 2017, to make improvements.

On the days of our inspection there was no information available to confirm what medicine training carer workers had received, so it was difficult to see what competency levels staff had. Staff told us it was part of their induction but it was very basic and they had gaps in their knowledge. Some were not confident supporting people to use specialist equipment, for example, a convene. A convene is a continence aid worn on the penis. A care worker told us, "Convenes are difficult, I haven't had training." Following our inspection visits, the provider forwarded information which showed some staff had not had medicine training since 2012. The provider assured us all staff would receive medicine refresher training before the end of October 2017.

Staff used an electronic medicine administration record (MAR), to record when medicines had been administered. At our previous inspection we found records did not consistently show whether people had received their medicines, and if not, why medicines had not been administered. The previous registered manager told us medicine records were audited each month and carer workers were contacted if there were any errors. They told us in their action plan following our previous inspection visit that improvements had been made to electronic care records, which ensured medicine administration could be accurately recorded. However, at this inspection we continued to find a number of concerns in the administration of medicines, which included gaps in recording on MARs. For example, we found one person had been prescribed a laxative drug which was listed in their medicines care plan. However, the medicine was not listed on the person's MAR to show when staff had given the person their medicine. This meant we could not be sure the person was receiving the medicine in accordance with their prescription. This had not been identified by the manager's checks of medicines records.

On the first day of our inspection visit we found there was no central or consistent method of recording medicine errors. The manager told us there had been no medicine errors reported. Therefore, there was no evidence of how events were managed to reduce risks to people's safety. The manager assured us going forward any errors would be recorded on an incident form. On the second day of our visit we saw an error had been reported by staff, however it was unclear what actions had been taken to reduce risks to the person.

Some people were prescribed medicines on a when required/as needed basis. We did not see any plans or protocols in place with MAR charts to guide carer workers on when to administer 'as necessary' medicines.

The manager confirmed that there were none in place. This put people at risk of receiving their medicines inconsistently, or when they were not required.

One person had been prescribed eye drops for an eye infection. Instructions on the MAR showed the person should have one drop in each eye, 4 times per day. Carer workers visited the person 4 times a day to support them with taking their medicine. However, in another part of the person's MAR it stated the medicine was needed only when it was required. There were no instructions on the person's MAR to instruct when to give the medicine 'as required'. We asked the operations manager and the manager to clarify when the person should receive their medicine. They told us they could not be sure, it was probable that the eye drops should be administered as per the instructions, one drop in each eye, 4 times daily and this was an error in the recording. Records showed when the medicine had been administered during September 2017. Twelve doses were marked as not being given. There was no explanation provided on the MAR to explain why the doses had been missed. We were concerned this put the person at risk of a more severe eye infection developing. The operations manager agreed to check the person's prescription to ensure their medicines were administered safely and as prescribed in future.

We found staff did not always follow recognised guidance on the safe administration of pain relief. For example, one person's MAR showed they had received their pain relief medicine on the 1 September 2017 at 8.41am and their next dose was administered at 12.00pm. The medicine required a gap to be left between doses of 4-6 hours, to ensure the person did not take too much. We asked the manager about this, who stated they did not check records to ensure an appropriate gap between doses was followed. This had not been identified by the manager's checks of medicines records.

One person's relative told us their family member was supposed to be supported to use specialist equipment to aid their breathing. However, they told us some carer workers said they could not support their family member to use the equipment because they had not received the correct training. This had a negative effect on the person's well-being because they were not receiving their medicine as prescribed. We asked the manager and the operations manager how staff supported this person and they were not clear. We looked at the person's care plan and found it gave staff instructions to support the person with their medicines, however this medicine was not recorded on their MAR. This meant their care plan was not accurate and some staff did not have the knowledge to support this person safely. The manager assured us that they would review the person's care needs, update their care plan and arrange training for staff on how to use the specialist equipment as soon as possible so they can deliver care safely. Staff told us this person was in hospital receiving treatment. This was a continued concern we had found at our previous inspection and meant the provider had not acted in accordance with their action plan dated June 2017, to make improvements.

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

At our previous inspection we found some people experienced late calls and had not been contacted by the service to warn them in advance. At this inspection we found this issue had continued. We found people did not always receive their scheduled calls when they should and they were not warned in advance. One person told us their morning call to help them get up, could be as late as 11.15am. Another person explained the weekend before, the care worker had not arrived by 1.30pm for their morning call, so they rang the care office and cancelled it. The next day the care worker was late again and told the person, 'I can only give you 20 minutes', which was not the full length of their call. People told us they did not know what time their calls were going to be or who was going to do them because they had not been provided with this information. A relative told us, "We have one call a day, we've never been given a designated time, it is usually early

morning. It varies from day to day. They don't ring if they're going to be late." Some people told us they did not receive calls at regular times and sometimes they were not introduced to new carers. For example, one person told us about their morning call, "Today they came at 11.15am. I called the office at 10.30am to find out where they were. It was a new person, I'd never seen them before. They had got lost and were running late. My relative explained to them what to do." A care worker told us, "It's chaotic at the moment. I am sent to people I've never worked with before. The only information I have is on the electronic system which is sometimes a bit out of date."

The manager explained calls were scheduled for people using an electronic system, which also acted as a call monitoring system. A second system was also used to schedule calls in a different geographical area and this was used to electronically record people's care plans. Outside office hours, late calls were identified by the senior member of staff who was 'on call'. The two systems worked alongside each other, but did not provide comprehensive reports to show when staff arrived and left scheduled calls, to provide the manager with an overview. We looked at the two monitoring systems and found inconsistencies in call time recording. For example, in one person's care plan we saw one of their scheduled calls on the 29 August 2017, should have lasted 15 minutes. The call log records stated a member of staff had only been with them for 3 minutes. There was no explanation on the care records to explain why the call had been cut short. This had not been identified by the manager. This was a continued concern we had found at our previous inspection and meant the provider had not acted in accordance with their action plan dated June 2017, to make improvements.

Some people did not feel there were sufficient staff to meet their needs. People told us, "A couple of months ago we had a lot of late calls and the reason was they were short staffed"; "No (they don't have enough staff), because otherwise they would all know what they're doing and would be trained. There is a great turn-over of staff" and "I think girls are run ragged, it's a disgrace." Two members of staff told us, "Staff are forever changing" and "There are definitely not enough staff, I've heard of missed calls." Staffing had been restructured since our last inspection visit and there was now one senior carer who was responsible for supervising all the care staff. The operations manager explained they were in the process of recruiting and were looking to recruit up to seven more carers. They told us they managed the gaps on the call rota by asking existing staff to work additional shifts. A senior member of staff told us, "I understand that staff do get tired, but we are all tired. I always push my needs to one side." One carer we spoke with told us they felt, "Pressurised," to do additional shifts.

We found missed and late calls were not monitored or recorded effectively to manage and reduce risks of them occurring in future. Two people told us, "They missed a call, once, a while back, they didn't ring" and "Last time was a couple of months ago. Therefore I now phone on the day to make sure someone is coming." We asked the manager if there had been any missed calls, where staff had not provided support to people as scheduled. They told us they were not aware of any. The manager explained they were responsible for checking the electronic systems to ensure people received their care calls as scheduled. We asked the operations manager if there had been any late or missed calls and they told us there had been. We checked the electronic system and found an example of a missed call. One person had missed their scheduled call in August 2017. The records stated this was because carers had arrived 2 hours late for the call, and the person was on their way out of their house. This demonstrated there was no overview of late or missed calls and people's safety was at risk if they did not receive their scheduled care calls.

People we spoke with and information of concern we received told us some calls which required two carer workers to support people safely, had been attended by one carer only. A care worker told us, "I have done calls which needed two carers. I recorded on PASS [the electronic recording system] that I could not do the call because I could not get them out of bed. I reported this to the office." A relative told us, "[Name] has

double up calls and occasionally we had one carer a while ago approximately 6-8 months ago. I had a word with them about it and was told it was because they did not have enough staff." We discussed this with the manager and they told us, "It would have been because of staff sickness. We would have informed the family who would help the carer to do the call." The manager told us they did not know if the family member had training to use specialist equipment. Therefore people were at risk of harm. Some people told us these incidents occurred around August 2017. This period was when the previous registered manager had left and the new manager and operations manager were managing the service. The manager, operations manager and provider agreed this had been a challenging time because there had been high numbers of staff on annual leave. They had been aware of this period of reduced staff since June, however nothing had been put in place to ensure there were sufficient staff to meet people's needs. The operations manager told us they asked existing staff to work additional shifts, "We tried ringing around but didn't have much luck." We asked the provider if they had considered obtaining temporary staff to ensure there were sufficient staff, they said, "I never thought about it." They told us instead, "We started the recruitment process at that point." This demonstrated a lack of insight by the provider. There was no evidence these events were monitored or recorded to effectively manage and reduce risks of them occurring in future. On the second day of our visit the manager told us they had begun recording late and missed calls in a consistent way.

We found this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment records contained gaps and it was not clear if recruitment checks had been carried out for all staff to make sure they were suitable and of good character to support people safely before they began working for the service. Records showed the provider's recruitment procedures included obtaining references from previous employers and checking staff's identities with the Disclosure and Barring Service (DBS) prior to their employment. The DBS is a national agency that holds information about criminal records. However, records did not show clearly if DBS checks had been obtained and checked by the provider before staff started working with vulnerable people. We discussed this with the operations manager and since our inspection visit they have provided their assurance all staff have undergone appropriate checks and these have been recorded on their files.

We spoke with staff to gauge their understanding of their responsibilities to safeguard vulnerable people. Staff knew to report any concerns about people's health or wellbeing to their line manager, however they did not know they could contact the local authority to report a concern if their manager was not available. A senior member of staff told us, "I don't know what to do if a carer reported an issue of abuse to me on call [this is the system staff use when they contact a senior member of staff outside of office hours for advice]." We found local authority contact details were not accessible to staff. This demonstrated significant gaps in staffs' understanding of the safeguarding process and a lack of oversight by the provider in ensuring staff were trained effectively to deal with serious events. Following our inspection visit the provider has assured us all staff will receive refresher training before the end of October 2017.

Inadequate

Is the service effective?

Our findings

People had mixed opinions about whether staff had the skills they needed to support them effectively. A relative told us, "New staff don't know what they are doing." People told us staff received inadequate training before they supported people. Carer workers told us, "New staff don't get training at the moment. We don't know who's trained to do what"; "Some staff have moving and handling training before they start and some have not. Same for medicines training" and "Training needs improving…. I had ten minutes moving and handling training in my induction. It did not include all the equipment I use now. I am not confident with moving and handling, for instance if I come across a new hoist. Sometimes I get help from other staff on a double up call."

Staff had not been provided with consistent training to enable them to carry out their role effectively. On the days of our inspection there was limited information available to confirm what training carers had received, so it was difficult to see what competency levels staff had. We discussed this with the operations manager and the provider. They told us the previous registered manager had carried out training with staff. However records of staff training were not clear and from the information provided by the operations manager, we saw some staff had significant gaps in their training. For example, some staff had not received sufficient moving and handling training to enable them to support people safely. Newer members of staff had not received any training on how to support people with their specific needs, such as catheter care or nebulizer use. A nebulizer is a device which administers medicine to treat asthma. Some senior staff had gaps in their training, such as infection control and training on people's specific needs. This meant that they could not effectively support carer workers to carry out their role.

We found some staff, who had started work after the previous registered manager left, had not received training in accordance with the provider's policies and were working alone supporting people. Not all staff were suitably skilled to carry out their role effectively. For example, we asked one care worker how they recognised if people were at risk of developing pressure areas. They told us, "I googled what to look for, because I've had no training." This meant there was a lack of oversight by the provider who was not aware of staff competencies. The operations manager explained they would continue in the role as trainer and were in the process of updating the induction, moving and handling and medicine training. Following our inspection visits the provider gave us their assurance all staff would receive moving and handling and medicine training before the end of October 2017. They told us they were in the process of trying to obtain further training for staff from health professionals, in order to ensure all staff had the skills to meet people's individual needs.

The operations manager told us new staff studied for the Care Certificate, which includes training in the fundamental standards of care, when they started work. However, only one existing member of staff had been supported to obtain the Care Certificate. Following our inspection, the provider told us all new staff were undertaking the Care Certificate.

We found staff had not received sufficient support from the provider to carry out their role effectively. The provider had not acted in accordance with their supervision policy. Staff told us supervision meetings and

unannounced 'observation checks' of their practice were not up to date. Supervision is a meeting between the manager and member of staff to discuss the individual's work performance and areas for development. One care worker told us they had never had a supervision meeting with their manager since beginning work at the service. Others said, "Supervision is not regular, I would like more" and "I have had no supervisions and no feedback unless something is wrong or a client tells you you're good. I don't really feel supported." The operations manager explained staff supervision was currently in the process of being brought up to date.

We found this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff gained their consent before supporting them and relatives confirmed this. Staff told us they knew they could only provide care and support to people who had given their consent. One carer told us staff, "I ask people what they would like to do. If they say no, we'll do something else."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the provider was working within the principles of the MCA. We found some people lacked the capacity to make certain complex decisions, for example how they managed their finances. We found where people lacked the capacity to make certain decisions, mental capacity assessments had not always been conducted thoroughly to establish which decisions they could make themselves, and which decisions they required support to make. It was not clear if people who did not have capacity to make certain decisions had an appropriate person, either a relative or representative, who could support them to make these decisions in their best interest. The manager and the operations manager explained that mental capacity assessments and best interests' decisions needed to be reviewed as part of the care records audit that was being planned.

We spoke with the operations manager who had a good understanding of the MCA and they explained they had been supporting the manager to understand their responsibilities to comply with the requirements of the Act. The manager told us people were reviewed to identify if they had potential restrictions on their liberty and told us there were none currently identified. The manager told us most people who used the service had capacity to make decisions about how they lived their daily lives.

The manager and the operations manager agreed there were inaccuracies on people's care plans and it was not clear what level of support they required to make decisions, or if they had capacity to consent to their care and treatment.

We found this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they prepared food and drinks for some people and other people were supported to prepare their own meals to help maintain their independence. We found information about how staff should support people to eat and drink to maintain a balanced diet was not always accurate on people's care plans, which may put them at risk. For example, we looked at the care records of one person who staff told us had

difficulty eating and drinking and used a catheter. One carer told us, "We usually wait until [Name] is finished in case [Name] chokes. This is not on their care plan, it's just common sense." Another carer said, "I noticed a concern with [Name]'s fluids. I noticed the amount of urine being output. I recorded this and let the manager know, about a month ago. I suggested to [Name] in the office that it was a good idea to monitor [Name] and put it on their care plans and be careful about their swallowing. I suggested a referral to the speech and language therapist to [Name] in the office." Staff told us the person was taken to hospital for treatment. We found the information on the person's care plan relating to nutrition and hydration was out of date and recorded they did not need assistance to eat and drink. The manager told us, "[Name] was struggling a day or so before they went into hospital, which we would have acted on." However, there was no record of any referral made to an external health professional following concerns raised by the carer. There was no assessment of risk relating to the person's nutrition and hydration or their catheter use. This meant there were gaps in the guidance given to staff about how to support the person effectively and help them to maintain a balanced diet. The care plan was not accurate and senior staff had not acted on information provided by staff and there had been a negative impact on the person's well-being.

Some people told us if there was a need, they made their own healthcare appointments with health professionals. Other people told us staff supported them to access healthcare services. Staff we spoke with understood the importance of monitoring people's health, however they had mixed opinions of whether concerns they raised with senior staff at the care office were dealt with effectively. For example, a carer told us, "I reported a concern to the office and was advised to ring 111, who said a referral to the district nurse was required. The office hadn't done it, so the next day I referred it to the district nurse." The operations manager told us they had not been consistently recording referrals made to health professionals on peoples records and would do so in future. This meant people's records were not accurate and it was difficult to see what action had been taken to ensure people received on going healthcare support.

Requires Improvement

Is the service caring?

Our findings

People were positive about how caring the staff were. Two people told us, "The carers are fantastic as a whole" and "Staff are caring and treat me with respect." Staff respected people's privacy and dignity and encouraged people to maintain their independence in accordance with their abilities. One carer told us, "I love my job" and "Everyone deserves their independence."

We found carer workers had not always been treated in a caring way by senior staff. For example, they had not been provided with consistent training or support to enable them to carry out their role effectively. Some staff did not feel confident to meet people's needs. Staff had been asked to work additional shifts and to work shifts alone, where two carer workers were required, which meant some care calls were late or missed. This demonstrated carer workers were not always able to provide person centred care for people, which had a negative effect on some people's well-being.

Staff told us they read people's care plans to find out about people's preferences so they could support people in the way they preferred. Care plans had a section called 'What is important to me', which included important information about people, such as their relationships with others. However, staff told us care plans could be improved to make them more personalised. One carer said, "It would be better to get an overview of the person when I first log on [to the electronic record system]." They explained this would help them communicate better with the person they were supporting, because it would be easier to understand their preferences. The manager told us staff were required to read people's electronic records to understand any changes to people's needs.

Staff told us they were given opportunities for personal development within the service. Some staff were supported by the provider to study for nationally recognised care qualifications. For example, the manager was being supported to undertake level five diploma in social health care and leadership to support them in their managerial role in the service. Five other staff were being supported to undertake other nationally recognised care qualifications.

Staff understood that some people found it difficult to communicate verbally, but they understood people through their body language and facial expressions. The manager told us, "One person cannot talk and they have regular carers that they know well. They understand them and use thumbs up and down. They have a spelling board so they can give their preferences."

Staff understood the importance of treating people with dignity and respect. One relative told us, "They treat [Name] with respect." A carer explained how they supported people to maintain their independence and their dignity. They said, "I ask people what they'd like to do. If they say no to something, we'll go onto something else…We can't force people to do something."

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the care staff provided when they received their calls. One person told us, "I am perfectly happy with the girls and understand the reasons they are late."

Some staff we spoke with explained how they tried to provide care to meet people's needs, to ensure they had the best quality of life. However, some staff told us they found it difficult to do this because they received inadequate training and support. For example, a care worker told us they would not support people with catheter care, because they had not received the relevant training. This meant people did not always receive the personalised care they needed.

People told us their views about their care had been taken into consideration and included in care plans during the initial assessment of their needs. However people had mixed views about the frequency of meetings to review their care. People told us, "[Name of manager] came to my house and updated the care plan because it had not been done for four years. I was happy to get the care plan up to date" and "We have suggested some changes and they have changed the care plan." This showed the service had been responsive to changes in this person's care needs, however we found not all reviews had been carried out in a timely way and this meant some people's care plans were inaccurate. The manager and the operations manager they were in the process of arranging meetings with people in order to ensure the accuracy of their records. This was a continued concern we found at our previous inspection and meant the provider had not acted in accordance with their action plan dated June 2017, to make improvements.

The manager told us people could share their experiences of the service during their care reviews and by telephone. They said, "I ring customers regularly to ask how their care calls went. If we have negative feedback I will log this as a complaint going forward. Everything has been okay so far. If we have compliments I ring carers straight away." The operations manager told us, "This is the right thing to do, so people feel valued in their jobs." They told us there had been no customer of staff questionnaire completed since our previous inspection visit.

People and their relatives told us they felt comfortable to raise any concerns with staff. One person told us, "I would make a complaint if it was genuine. I would make myself known to the office." There was information about how to make a complaint and provide feedback on the quality of the service in people's service user packs in their homes. The policy informed people how to make a complaint and the timescale for investigating a complaint once it had been received.

We found there was no centralised place to record complaints and comments made by people. Information was kept separately by two senior members of staff and was not managed in a consistent way because they did not know they were each holding different records. Therefore it was difficult to see how the issues people had raised about the quality of the service, were being managed and if any learning had taken place as a result. We found evidence of one formal complaint recorded since our previous inspection visit. This had been dealt with in accordance with the provider's policy. There was evidence of one compliment from a relative about the standard of care provided by the service. They had written, 'Thank you for the compassion

and patience you and your girls showed [Name].' Following our inspection visit the manager told us they planned to regularly review all complaints and feedback information to look for trends and patterns.

We found some issues people had raised, had been recorded as incidents by staff and had not been identified as complaints. Therefore the issues had not been actioned in accordance with the provider's complaints process. For example, one person had complained that their care worker was rude to them and this had been recorded on an incident form and reviewed by the operations manager. The matter had not been investigated in accordance with the provider's complaints or safeguarding procedures and the person had received no contact from anyone at the service to establish their views on the matter. We spoke with a care worker and asked them how they would support someone to make a complaint. They said, "I've been told to write an incident form for someone at the office to look at." On the day of our inspection, a senior member of staff told us a member of staff had raised a concern to them about another member of staff's practice. They had asked the member of staff to record this as an incident. We found the concern was not dealt with in accordance with the provider's grievance or whistle blowing procedures. This demonstrated there were gaps in the staff's understanding about how different types of events should be identified. This meant not all complaints were identified or managed by senior staff and there was limited evidence of any overview by the provider.

We found this was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection 'Well led' was rated as 'Requires Improvement.' This was because some serious events had been recorded but not managed properly to reduce the risks to people. We found one referral had not been made to the CQC. Some identified risks had not been assessed in full on people's care plans and there were some gaps in guidance for staff. Some people experienced late calls and had not been contacted by the service in advance. Best practice was not always followed when recording why medicines were not administered. These issues had continued since our previous inspection of the service in 2016; we therefore found the provider was in breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider set out what improvements they intended to make to the service in their action plan dated June 2017. At this inspection we checked the progress of the improvements and found they had not been made and the issues continued. We also found evidence of new concerns. In addition, we had received information from members of the public about the standard of care being provided and found evidence to validate some of these concerns.

At this inspection we found evidence that the issues we had previously identified continued at the service. We have rated the service as 'Inadequate' and the service is therefore in 'special measures', which means it will be kept under close review.

There was no registered manager at the service. The previous registered manager left their post in June 2017. The service was being managed by a care manager [manager] and an operations manager, who both began their role in June 2017. The manager left the service following our inspection visit and the service has continued to be managed by the operations manager.

Following our inspection visit, the provider has given us their assurances they will take steps to make improvements. They have provided us with detailed action plans and made a voluntary agreement to cease taking further clients until the required improvements have been made. They agreed they had lacked oversight and had relied on staff to take appropriate actions to maintain the service effectively and safely. They said, 'Over the past 24 months our governance has not been totally effective. We have trusted and overly relied on the then admin team in post (lead by the Registered Care Manager) to follow our business procedures, gather information, train effectively, and report factually back to the directors. All the tools for monitoring and analysing our performance were available, but records have not been accurately maintained, and as directors we believe that we were not stringent in overseeing the business.'

The manager was aware of their responsibilities to provide us with notifications about important events and incidents that occurred at the service. They were aware it was their responsibility to notify other relevant professionals about issues, such as the local authority. However, we found although there had been an increase in the number of incidents reported to senior staff, some incidents had not been managed appropriately, because they had not been identified and dealt with accordingly under the provider's policies. There was little evidence of oversight by the provider to ensure events were being managed

appropriately to keep people safe. This demonstrated there were gaps in all staff's understanding about how different types of events should be identified and managed to reduce the risks to people.

Events that might mean a person was at risk of harm continued not to be consistently identified and managed effectively in accordance with the provider's different processes. Some important events such as missed and late calls and medicine errors were not monitored or recorded effectively to manage and reduce risks of them occurring in future. Carer workers told us senior staff had sometimes not acted on concerns they had raised about people and this had made a negative impact on some people's well-being.

We found continued inaccuracies in care plans and gaps in guidance given to staff about how to support people safely. Some identified risks had been recorded but not assessed in full on people's care plans, including nutritional needs not being met. Due to gaps in recording, it was difficult to see what action had been taken to ensure people received on going healthcare support. In addition, staff recruitment records contained gaps and it was not clear if recruitment checks had been carried out for all staff to make sure they were suitable and of good character to support people safely before they began working for the service.

There was an action plan in place following a recent audit of the service undertaken by the provider's franchise company. We asked the operations manager and the manager which actions on the plan had been completed, and whether they had agreed timescales for completion of the remaining actions. The operations manager and the manager told us the action plan had not been shared with them by the provider, and subsequently actions had not been completed. The provider told us they had asked the previous registered manager to address the issues within the audit and had not checked actions had been carried out. This demonstrated a lack of oversight by the provider.

There was little evidence of any evaluation or improvement of the service. Records showed checks made on the service were not effective because they did not identify concerns we found during our inspection visit. Such as, missed and late calls, medicine administration errors and inaccuracies in people's care plans. For example, we looked at the records for one person who was cared for in bed due to their limited mobility. However, the person's records were inaccurate because they stated they were able to stand independently, support their own weight and walk unaided. We brought this to the attention of the operations manager who said, "I can confirm the person is cared for in bed, the care records and risk assessments are not correct. They need to be updated." The manager explained they had started making checks of people's electronic care plans to check the standard of staff recording, including medicine administration. It was difficult to see what improvements had been made because there was no central record of required actions and the manager told us they had not checked to see if required actions had been completed by staff.

We found this was a continued breach from our inspections in March 2016 and March 2017, of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people what they thought about the quality of the service. One person told us, "I am happy with the service apart from calls being late." We saw the manager, the operations manager and the provider were accessible to people who used the service. We asked staff about the leadership of the service. They told us, "It's good, there are things that could be improved, for example communication and planning in advance"; "It is very unorganised at the moment, calls keep changing" and "It's chaotic at the moment."

Some staff told us they did not feel supported in their role. One care worker gave an example and said, "We need more notice of rota changes, sometimes we are advised at midnight of changes when we start at 6am the next day." Most staff we spoke with told us communication within the service was poor. Carer workers told us there had not been a staff meeting for many months and they received irregular supervision

meetings with their manager. One care worker told us, "We rely on office gossip to find out what is going on." The operations manager had recognised communication was an issue when they joined the service and told us they were in the process of making improvements to the way staff were supported. The Director told us, "We are open and people can come and talk to us. We can give them information that clarifies things… We are trying to organise a staff meeting and a staff letter at the moment, to share information with staff."

The operations manager told us they had access to services offered by the provider's franchise company to support them in their role, such as leadership and management training with other franchise managers.

Local authority commissioners had last visited the service in June 2017, to check on the quality of care people received. They had visited the service on four separate occasions in the previous 12 months to monitor required actions were being carried out. The provider explained they had been working alongside the local authority commissioners to make improvements to the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act 2005 to ensure they had obtained consent for care and treatment from those people who lacked the capacity to make decisions themselves.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensure care and treatment was provided in a safe way for people. They had not ensured that effective systems or processes were established and operated effectively to assess, monitor and mitigate the risks relating to the health and safety of people who used the service. The provider had not ensured staff had the competence and skills to care for people safely. They had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not ensured that any complaints received were investigated or proportionate action taken in response to any failures. They had not established and effectively operated a system for identifying, recording, handling and responding to people's complaints.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems or processes were established and operated effectively to assess, monitor and improve the safety of the service provided or to assess, monitor and mitigate the risks relating to the health and safety of people who used the service. They had not maintained accurate and complete records for people or staff. Their governance system did not ensure their practice was evaluated or improved.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff. They did not ensure staff received appropriate support, training, supervision and appraisal, to enable them to carry out duties effectively.