Glee Care Ltd

Glee Care Ltd-Nuneaton

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

This inspection took place on 28 November 2016. The inspection was announced. We gave the provider 48 hours' notice of our inspection. This was to make sure we could meet with the provider of the service and talk with staff on the day of our inspection visit.

Glee Care Ltd - Nuneaton is registered to provide personal care and support to people living in their own homes. The service operates across Nuneaton in Warwickshire. There were 12 people using the service at the time of our inspection.

A requirement of the provider's registration is that they have a registered manager. A registered manager is a person who had registered with the Care Quality Commission to manage the service. Like registered provider's they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. At the time of our inspection there was a registered manager in post who was also the provider for the service. The registered manager was supported by the company director to run the service. We refer to the registered manager as the provider in the body of this report.

The service was last inspected on 4 February 2016 when we found the provider was not meeting the required standards. We identified two breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to establish appropriate systems to assess, monitor and improve the quality and safety of service provided. Also, implement systems to ensure staff had the skills and experience for the work they are required to perform.

The provider sent us an action plan which stated all the required improvements would be completed by 31 August 2016. During this inspection we found improvements had not been made and sufficient action had not been taken in response to the breaches in regulations.

The provider did not have sufficient systems and processes in place to assure themselves that people received a safe and good quality service that met their needs. We found risks associated with people's care were not always managed well to make sure people and care workers were protected from the risk of harm. We could not be sure the provider had sufficient knowledge of what constituted abuse because referrals were not always made to the local authority when safeguarding concerns were identified. Following our visit we spoke with the Local Authority about the concerns we had identified.

Care workers did not feel valued or supported by the provider to effectively carry out their role. The provider was not working in-line with their recruitment procedure to ensure suitable care workers were employed. This meant, we could not be sure people were kept as safe as possible. The induction process did not effectively support new care workers when they started work at the service. Care workers did not always receive the training they needed. We identified medication administration training was not effective. We could not be sure people received their medicines as prescribed because medication administration records

were not completed correctly.

People told us care workers did not always arrive to provide their care and often care workers did not arrive at the times they expected them. This had a negative impact on people's health and well-being. People's experiences of being supported by consistent care workers were mixed. People who required support with eating and drinking did not always receive adequate support to meet their nutritional needs.

Overall, people told us that individual care workers showed them kindness and maintained their privacy. Care workers demonstrated they knew some of the people they cared for, and they spoke affectionately about them. However, people told us they did not always feel their dignity was maintained by the service they received and we received mixed feedback as to whether care workers treated people with respect.

People's care records were not always detailed and personalised to give new staff guidance on how people preferred their care and support to be provided. We could not be sure the provider had taken action to ensure people's wishes and preferences were identified, listened to and considered when delivering care.

People told us they were encouraged by care workers to make made everyday decisions for themselves, which helped to maintain their independence. The provider and care workers understood the principles of the mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments had been completed for people who needed them. Care workers gained people's consent before they provided care. This ensured people were looked after in a way that did not inappropriately restrict their freedom.

Overall, people and their relatives told us the leadership of the service needed to be improved. People knew how to make a complaint. However, people and their relatives did not feel their requests and complaints were listened to and acted upon. The system in place to manage complaints about the service was not sufficient. This meant we could not be sure all complaints had been responded to and investigated thoroughly.

We found a number of 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. Following our inspection we notified the local authority commissioners about the serious concerns we had identified related to the safety and quality of care that people received. We spoke with, wrote formally and then met with the provider to give them the opportunity to provide assurances of actions taken to ensure the safety of people. We asked them to submit an urgent action plan to tell us how they were going to mitigate the risks.

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

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

still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The recruitment of new care workers did not ensure people who used the service were safe. The provider and care workers did not have the skills and knowledge to keep people safe. Risks associated with people's care were not always managed well. Care workers were not always deployed effectively to keep people safe. Individual accidents and incidents had not always been recorded. Medicine administration records were not correctly completed which meant we could not be sure people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us not all care workers had the skills and knowledge to meet their care and support needs. The induction process for new staff was not effective. Care workers did not receive adequate training to meet people's needs and some training was ineffective. Records of completed training were inaccurate. People did not always receive adequate support to meet their nutritional needs. The provider and care workers understood the principles of the Mental Capacity Act 2005. Care workers gained people's consent before providing their care.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us individual care workers showed them kindness and respected their right to privacy. People were encouraged to make their own decisions by care workers who recognised the importance of people remaining independent. We received mixed feedback as to whether care workers treated people with respect and whether the service people received maintained their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's experiences of receiving care from consistent workers were mixed. The service was not always responsive to people's needs. People's requests and complaints were not listened to and acted upon promptly. The system in place to manage complaints about the service was not effective. Information contained within people's care records was not always personalised and the level of information recorded was inconsistent.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received. Overall, people and their relatives told us the leadership of the service needed to be improved. Care workers did not feel supported by the provider to carry out their role.

Glee Care Ltd-Nuneaton

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 was 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.

Before the inspection, we reviewed all the information we held about the provider. This included information shared with us by people, the Local Authority and statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send to us by law.

We did not ask the provider to complete a Provider Information Return (PIR) prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not request this form because the inspection date was brought forward in response to concerns we had received about the service.

The inspection took place to follow up on two previously identified breaches in the regulations, and to make sure the required improvements had been undertaken. The office visit took place on 28 November 2016 and was announced. We gave the provider 48 hours' notice we would be coming so they could ensure they would be available to speak with us and arrange for us to speak with staff. Following our visit we spoke with four people who used the service, five relatives and two care workers via telephone. The inspection was conducted by one inspector.

During the visit we spoke with the provider. We looked at three people's care records to see how their care was planned and delivered. We looked at the recruitment records for three care workers to check whether they had been recruited safely and were trained to deliver the care and support people required. We looked at other records related to people's care and how the service operated including the services' quality assurance audits and complaints.

Inadequate

Is the service safe?

Our findings

During our last inspection on 4 February 2016, we identified the provider's recruitment procedures required improvement. We could not be sure consistent checks took place to make sure suitable care workers were employed. This was a breach of Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Following that inspection the provider sent us an action plan outlining how they would make the necessary improvements by 31 August 2016. They had planned to employ an office administrator and a care coordinator who would be responsible for obtaining references and completing checks before care workers commenced their employment. These checks would ensure care workers were suitable to work with people in their own homes.

Since our last inspection a care coordinator and a part time administrator had been employed. However, despite this, all of the necessary recruitment checks were still not taking place. This meant the provider's recruitment procedures did not minimise the risks to people safety. For example, we looked at the recruitment records for three care workers who were working at the service. Only one care worker's record contained an authenticated reference from their previous employer. The recruitment records for the other two care workers contained only one character reference. This showed us the provider was not working in-line with their recruitment procedure which we reviewed during our office visit. It stated written references would be sought from the potential care workers two previous employers before they started work. We discussed this with the provider and asked them for a response. They told us references had been requested, but had not been returned. They were unable to explain why they had not taken any action to obtain the information.

Recruitment records showed us disclosure barring service (DBS) checks were not always completed before care workers had worked unsupervised in people's homes. The DBS helps employers to make safer recruitment decisions and prevent unsuitable people from working with people using the service. For example, one care worker had started working at the service January 2016. The DBS check on their file was completed six months later in June 2016. This care worker explained this was their first job working in health and social care and they were not aware the check needed to take place. We discussed this with the provider who was unable to provide a clear explanation why the check had not been completed before this date. They acknowledged that this had potentially placed people at risk.

This was a continued breach of Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed .

The provider told us they understood their responsibility to protect people from harm and they knew to report potential safeguarding incidents to the local authority safeguarding team. However, they did not demonstrate sufficient knowledge of their responsibilities to keep people safe. For example, we identified two concerns of a safeguarding nature during our office visit. We discussed the concerns with the provider and they assured us they had informed the local authority so the incidents could be appropriately

investigated. However, they had not informed us and actions they had taken had not been recorded. They told us they would implement a system to record any future action they took.

A relative described to us how the service had failed to keep their family member safe on the day after our office visit. They told us their relative had been given too much medicine by care workers and this had made them unwell. Medical advice had not been sought by the provider to ensure the person was kept as safe as possible . The provider had not reported the medication error to the local authority safeguarding team. The provider had not sent us a notification to us inform us in-line with their responsibility under our regulations. We asked the provider why they had not reported this to us. They told us they had reported the incident to the person's relative. This further demonstrated the provider had insufficient knowledge of where to report concerns to in order to keep people safe.

From our discussions with the provider, staff and records available, we found that effective safeguarding training had not been provided in order to keep people safe. One care worker told us that they felt the content of the training was not sufficient for them to be effective in their role. Another told us they had not completed the training. They said, "I rely on the training from my last job as I haven't had any safeguarding training here."

The provider's safeguarding policy was not fit for purpose and contained incorrect contact details for adult social services in Leicestershire rather than Warwickshire . Therefore, we could not be sure care workers knew who to contact if they had any concerns.
During our last visit care workers were not aware of the provider's whistleblowing policy or when to take concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. During this visit a whistleblowing policy was in place. Care workers confirmed they were aware of the policy but they did not feel confident to raise their concerns. This was because previous concerns they had raised had not been listened to by the provider. For example, a care worker explained that one person who used the service required two care workers to move them safely but frequently only one care worker provided this care. They stated they had told the provider this was not safe but action had not been taken. This person's relative confirmed only one care worker had provided care on a recent occasion. They told us this had made them feel anxious because their relative had been at risk of harm. We discussed this with the provider and asked them for a response. They confirmed they were aware one care worker had provided care instead of two, but they had taken no action to mitigate the risk.

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

During our last inspection we found medicine administration records (MARs) were not correctly completed by staff to record when people had received their medicines. Records did not clearly list all the medicines people were prescribed, which meant we could not be sure people were receiving all of the medicines they needed.

During this inspection, records showed care staff had completed training to improve their knowledge and competency in handling medicines since our last inspection. We saw people's medicines were now clearly listed. However despite this action being taken we could not be sure people received their medicines as prescribed. For example, we looked at completed MARs for four people and identified unexplained gaps on two people's records which the provider was not aware of. For example, in October 2016 it was not recorded if one person had received their medicine on four separate occasions. In September 2016 it was not recorded if the same person had received their medicines on three occasions. The provider was unable to explain why the gaps had not been identified. Checks were not completed to ensure care workers gave

people their medicines correctly. The provider acknowledged if checks had taken place the gaps would have been identified.

People and their relatives told us enough care workers were employed by the service to meet their needs. However, all of the people we spoke with told us the deployment of care workers needed to be improved to keep them as safe as possible. They told us care workers frequently arrived late or occasionally did not arrive to provide their care. One person said, "Its' hit and miss if they arrive at all." This had a negative impact on the person's health as they had a health condition which meant they relied on care being provided at the agreed time. They confirmed at least once a week they had to wait for up to three hours before a care worker arrived.

A relative told us a care worker had recently arrived over two hours later than expected to provide care. They explained on occasions care workers arrived at 12.30pm for the morning call that was scheduled to take place at 7am, at 3.30pm for the lunch call scheduled for 2.30pm and at 5.30pm to put their relative to bed. The following day care workers might not arrive until 10am. They were reliant on care workers to provide their drinks. This placed them at risk of dehydration because they did not have access to a drink for up to 16 hours. We reviewed a selection of completed call records. Records did not reflect the accurate times care workers had arrived to provide people's care. For example, we saw care workers had written 'breakfast' 'lunch or tea' and not the times they arrived and left a person's home. This meant the provider was unable to provide further documentation to assure us people had received their care when they needed it.

Care workers told us calls were often missed. One said, "I arrived at (Person's) house last week at lunchtime. Their morning call had not taken place. (Person) had not had anything to eat or drink since the previous evening." Following our visit we discussed this missed call with the provider. They were unable to provide documentation to assure us the call had taken place. They told us they would make improvements to ensure missed calls did not happen again. However, from the information available to us were unsure of how they would achieve this.

During our last visit in February 2016 individual risk assessments were in place for people. However, they did not provide sufficient guidance for care staff to provide safe care to people. Following the inspection the provider told us they would further develop risk assessments to include guidance for care workers in order to keep people safe. During this visit we checked the risk assessments of four people. We saw improvements had not been made.

Identified risks associated with people's care were not always managed well. For example, one person displayed behaviours which put themselves and the staff providing their care at risk of harm. Earlier this year a member of staff had been harmed by this person and the person themselves had nearly been injured in a road traffic accident. The provider had failed to safely manage this risk because the risk assessment in place was generic and did not provide staff with sufficient guidance to keep themselves or the person safe. Records showed that five different care workers were scheduled to support this person during the week of our visit. Therefore, we could not be sure the person received consistent care and support. We discussed this with the provider and they told us they would implement a detailed risk assessment to instruct staff on how to manage this behaviour in the future .

Individual accidents and incidents had not been recorded. This meant the provider had not kept accurate records and had not undertaken an analysis in order to identify any patterns or trends to help prevent them from happening again. We were aware in May 2016 on four separate occasions one person had displayed behaviour which had the potential to cause harm to themselves. Following our inspection the provider informed us they had liaised with the local authority when the incidents had occurred. However, accurate

records of actions taken had not been not maintained.

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

Requires Improvement

Is the service effective?

Our findings

During our last inspection we identified records of the induction that new care workers had completed were not kept. Records of the training care workers had completed were not consistently kept. We received mixed feedback from care workers as to whether the training they had completed had been effective to support them to meet people's care needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following that inspection the provider sent us an action plan outlining how they would make the necessary improvements by the 31 August 2016. They told us records to evidence that care workers had completed a comprehensive induction would be kept. They also told us they would ensure care workers were competent to effectively carry out their role by providing more training. Our findings at this inspection showed that the planned improvements had not been made.

During this inspection people told us not all care workers had the skills and knowledge to meet their care and support needs. One person said, "The owners drop new people off and then leave them with me. I have to tell them what they need to do. It's a waste of time." People's relatives supported this view. Their comments included, "They (Care workers) don't seem to be trained very well. Many are young and in my opinion are not qualified to look after the elderly." And, "Whilst the carers are pleasant they seem a bit nervous when completing tasks. One did not know how to open a can of baked beans."

We reviewed the induction records for three care workers. We saw some improvements had been made however further improvement was required. For example, the files contained information to show that inductions had taken place. However, care workers told us the induction process had not supported them effectively when they had first started working at Glee Care. One said, "New workers are not supervised properly, they are dropped off at people's houses and are expected to get on with the job." Another said, "I shadowed the manager on a couple of calls. It wasn't enough really." They explained this was their first job in health and social care and visiting people they did not know made them feel uncomfortable.

The induction process was not in-line with the Care Certificate. The Care Certificate is an identified set of standards for health and social care workers. It sets the standard for the skills, knowledge, values and behaviours expected. Therefore, we could not be sure that the induction care workers had completed was in-line with current best practice.

The provider told us they delivered all of the training to care workers during either face to face discussions or via email. However, they were not a qualified trainer. Therefore we could not be sure they had the skills to deliver training they considered essential to meet people's care and support needs. We reviewed training records to ensure care workers had completed the training they required to meet people's needs. This information was not up to date. Following our office visit the provider sent us an updated version. However, this information was also incorrect. For example, thirteen care workers were employed but the training completed by nine was recorded. This meant we could not be sure training records were accurate.

Care workers told us the essential training they had completed such as, moving and handling training had not been effective to support them to provide care to people. One said, "I have only had four hours of training. It was not enough. They (Provider) just read out information to me and told me sign the form." Another told us they had not received any training. They said, "I was expected to get on with. I haven't had any training."

Care workers told us they had not completed training to gain the skills they needed to meet people's specific care needs. For example, one person had a urinary catheter. Whilst district nurses had overall responsibility for managing the catheter, care workers provided everyday assistance with this and needed to know if there was a problem which needed to be reported on. A care worker told us they checked each day to see if the person's catheter was blocked. They said, "I was sent some information via email to look at. Not really training. I don't really know what to look for ." Another care worker explained they had not received any training to manage one person's specific behaviours. This meant they did not feel confident to reduce the person's levels of anxiety when they became upset. Training records we looked at did not document this training had taken place.

We discussed this method of training with the provider as staff told us it was not effective. The provider confirmed they sent care workers training information via email so they could read the information when they had time. They said, "Often we send training out via email." We asked them how they knew if care workers had read and understood the content. They said, "We trust them to read it. They (Care workers) have never said they don't understand anything."

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

We asked the provider how they assessed the competence of the staff team to ensure they had the skills and knowledge to care for people safely and effectively. They explained since our last visit they had increased the frequency of 'spot checks' of care workers performance which included their approach to care, handling of medicines and time keeping. Staff and people confirmed that these observations took place. However, our discussions with people showed that these checks were not always effective because people often did not receive a good quality service at the agreed times. People's care and support needs were often not met.

Since our last inspection the frequency of meetings that took place between care workers and their line manager in order to discuss work performance had increased. The provider told us, "Meetings with staff have been increased and things are going well." We saw records of meetings that had taken place were kept. We asked care workers about these meetings. They confirmed meetings had taken place but despite this they did not feel supported by the provider to carry out their role. One care worker said, "I do have meetings but I don't say much because nothing will change as I am not listened to." Another explained the provider had told them they would have the opportunity to complete an accredited qualification in health and social care. However, the start date had been postponed several times by the provider. They told us this made them feel frustrated because they wanted to improve their skills to make sure they provided good care to people .

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. Where people lack mental capacity to make particular decisions, any decisions made must be in their best interests and in the least restrictive way 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. The application procedures for this are called the

Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within these principles and whether any authorisations to deprive a person of their liberty were being met. The provider told us that everyone using the service had capacity to make their own decisions. We saw people's capacity had been discussed and documented within the care plans.

One care worker told us they had not received training in MCA. However, our discussions with care workers confirmed they understood the principles of the MCA. One said, "I always ask how people want me to help them." Another said, "I know I can't do anything against a person's wishes. I have to ask them."
This showed us they understood they could only provide care and support to people who had given their consent.

We asked one care worker what they would do if a person refused assistance with their personal care. They told us, "I would encourage them and try to find out why they didn't want me to help them but I can't force them."

During this and our last inspection we saw records which showed that people had discussed their care and treatment needs and had given their consent to the support provided. For example, consent forms for support with medicines. However, care records were not always signed to show people had been involved in and consented to their care. We discussed this with the provider who told us they would ensure people signed their consent forms in the future.

People and their relatives told us they did not always receive adequate support to meet their nutritional needs. For example, one person told us a care worker had provided them with porridge on a plate instead of a bowl. This meant they not been able to eat it. A relative explained their relation needed to use a beaker with a lid on because they were unable to hold a cup. They told us a care worker had left a tea spoon in the beaker which meant the beaker did not close properly and the drink spilt. They commented, "It's not the end of the world but (Person) can't say if they haven't had a drink. Its poor care." However, some care workers we spoke with demonstrated a good knowledge of people's nutritional needs. For example, they knew who needed encouragement to eat and what foods people enjoyed to eat.

People we spoke with managed their own healthcare requirements or relatives supported them with this. The provider told us the service was flexible and care workers could support people to attend appointments if required. Care records we looked at did not instruct staff to report if people's health changed. However, our discussions with care workers assured us they would tell their manager or a person's relative if they were concerned about a person's health. Records we looked at confirmed the service involved health and social care professionals with people's care when required including and GPs and social workers.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that individual care workers showed them kindness. However their comments showed us that there were sometimes barriers to their caring approach. People told us, "(Care worker) treats (Person) very well, they really do care," "Carers are pleasant, but are often rushed." And, "Yes, they are kind but not all of them speak good English which means I can't always have a conversation with them." Care workers we spoke with did speak fluent English.
The provider and care workers showed concern for people's wellbeing. Care workers demonstrated they knew some of the people they cared well and they spoke affectionately about them. One explained they went to the library in their spare time to collect books for a person who enjoyed reading. The person confirmed this happened and said, "It is a very kind gesture." However, two care workers told us they would not recommend the service to other people because they did not feel they were cared for by the provider. One said, "I really like all of the clients and that is the reason I am still working here." Another said. "I don't really feel valued or cared for by (Provider)."

We received mixed feedback from people and their relatives about whether care workers and the service they received was respectful towards them. Comments included, "They (Care workers) are respectful. They are polite and do talk nicely to me." "I don't think it is very respectful to leave an elderly person waiting in bed for hours." And, "Some do talk to (Person) but others talk over them in a foreign language."

People told us they did not always feel their dignity was maintained by the service they received. One person was reliant on care workers to help them to use the toilet. They said, "I sometimes have to wait in bed for them to arrive. It's not very dignified as I need to use the toilet." They told us this made them feel embarrassed and upset.

People confirmed care workers maintained their privacy whilst they assisted them with personal care. For example, some people told us that care workers waited outside the bathroom door whilst they had a shower. Care workers described to us how they maintained people's privacy. For example, they closed the curtains and shut the bathroom door at this time.
People told us the care they received helped them to be as independent as possible. For example, one person explained how care workers gave them a flannel as they liked to wash their own hands and face. Care workers knew this and understood the importance of the person completing this task for themselves.

People told us care workers encouraged them to make their own decisions. For example, what clothing they wanted to wear. The provider told us people who received a service all had a relative or friend to advocate to help them make decisions. They were aware of the process to obtain an independent advocate if someone required one. An advocate is a person who supports people to express their wishes and weigh up the options available to them, to help them to make a decision.

The provider and care workers understood the importance of maintaining people's confidentiality. Care workers told us they would not speak with people about other clients and ensured any information they held about people was kept safe and secure. People's personal information and records were kept in locked

cabinets at the Glee Care office. Only authorised staff had access to this information.

Requires Improvement

Is the service responsive?

Our findings

Prior to our visit we received information of concern from people and their relatives regarding the provider's inability to respond to their needs. One person said, "Some (Care workers) are kids, far too young. I just don't feel confident in their abilities." They told us they had requested that a more mature care worker provided their care but this did not always happen. A relative explained to us how the provider did not respond in a timely way when they had wanted to discuss their relative's health. They said, "Response times are slow from (Provider). I phoned last week at lunchtime as I was a bit worried about (Person).It was 7pm before they finally returned my call."

As a result of the service not meeting their needs, two people told us they had already been in contact with their social workers to seek an alternative provider to care for them. A further two people told us they were dissatisfied with the service they received and they were considering changing their provider.

During our last inspection the provider's complaints policy did not include contact details for external agencies and did not signpost people as to where they could go if the complaint was about the registered manager or provider. During our office visit we reviewed the policy and the contact details for CQC and the local authority had been added. People confirmed they knew how to make a complaint and the policy was included within the information guide which was located within their homes.

Prior to our visit the local authority informed us they had received complaints from people about the service provided by Glee Care Ltd - Nuneaton. However, during our office visit the provider told us they had not received any complaints for more than six months prior to our visit. This contradicted what people and their relatives told us. Two people and three relatives felt their complaints had not been listened to and acted upon. For example, one person told us they had raised concerns about the service and they had not been satisfied with the provider's response. They said, "Poor response. My concerns were brushed under the carpet." Another said, "I have complained many times about carers not turning up. They (provider) say they will sort it out and after a few days it happens again, terrible customer service. I have given up complaining." This meant the provider had failed to record and act on the complaints received about the service.

People had mixed views about whether they were visited by regular care workers, in order to receive consistent care. One person and their relative spoke positively about the care worker who visited them nearly every day. However, two people were not supported by regular care workers who they knew well. They explained there was a high turnover of staff and often it was the provider who completed their care but not at the time they had expected them to arrive. One said, "Very frustrating for me, I don't know if I am coming or going." We discussed this with the provider who told us trying to recruit and retain staff was their biggest challenge. They said, "Some staff have been unreliable but I cover calls when needed. I admit calls can run a bit late."

We received mixed feedback from people about whether they had been involved in planning and reviewing their care. One person said, "When they first started my care they (provider) came out and met with me and asked how I liked things to be done." Another said, "I have never seen my care plan. Nope, never seen one of

those." Therefore, we could not be sure the provider had taken action to ensure people's wishes and preferences were identified, listened to and considered when delivering care.

During our last inspection we identified some care records were personalised, but others were task focussed and provided very little information about people or their preferences. During this visit we found people's care records had been reviewed within the last three months. We looked at three people's care records and saw some improvements had been made however further improvements were required. For example, one person's records contained detailed information for care workers to provide care in line with their wishes. It provided care workers with specific instructions such as to make sure they dried the skin in between the person's toes. However, records for the other two people were not as specific and information was focussed on the tasks care workers needed to complete. For example, 'provide personal care' and 'assist to eat' was written. This could be interpreted differently by care workers so people received inconsistent care when they were visited by staff who did not know them well. In response to this, the provider acknowledged this information was not sufficient for staff to carry out their role effectively. They said, "I am adding more information to care plans to make them more detailed."

Care workers told us they did have enough time to read peoples care records. However, they did not rely on the information because it was not always correct or detailed. Instead, they spoke with people and their families to find out the 'finer details' to provide personalised care. For example, people's preferred morning routines.

Care workers supported people to access the wider community which reduced the risk of people being socially isolated. One person told us a care worker regularly took them shopping which they really looked forward to. They told us this time was never rushed and they were able to choose where they wanted to go. They explained this helped to motivate them and had improved their health and well-being as a result. They said, "I really enjoy shopping, it brightens up my day and makes me feel happy."

Inadequate

Is the service well-led?

Our findings

Since our last inspection undertaken in February 2016 we have received a number of concerns from people, their relatives and other sources about the quality and safety of the service provided by Glee Care Ltd – Nuneaton.

During our last inspection the provider had failed to have systems and processes established to assess, monitor and improve the quality and safety of service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008.

Following that inspection the provider told us they would establish systems and processes by 31 August 2016 to ensure themselves people received a safe and good quality service. During this inspection we found effective systems were not in place to monitor and improve the quality and safety of services provided to people. This included that audits of medicine administration records had not taken place. Therefore, shortfalls had not been identified and we could not be sure people received their medicines as prescribed. The arrangements in place to check people received their calls at scheduled times was not sufficient. This meant that action had not been taken and improvements had not been made to ensure that people received care and support at agreed times.
Individual accidents and incidents had not been recorded correctly. This meant the provider had failed to maintain records and to analyse incidents so lessons could be learnt and action could be taken to help prevent them from happening again. The management of risks related to the safety and well-being of people was not sufficient. Risk assessments did not provide staff with clear guidance to keep themselves or people safe. This resulted in some people receiving unsafe care.

During our last inspection we identified improvements to recruitment procedures were required. During this inspection the improvements the provider told us they would make had not been made. Therefore, the provider had failed to minimise the risks to people's safety. This meant we could not be sure suitable care workers were employed to work with people in their own homes.

At our last inspection we identified records of the induction that new care workers had completed were not kept. During this inspection we identified the induction process was not in-line with the Care Certificate and did not effectively support care workers when they had first started working at the service. During our last inspection records of the training care workers had completed were not consistently kept. During this inspection records of the training care workers had completed were inaccurate. Care workers had not completed some training and the training they had completed was not effective to keep people safe and to meet people's needs.

The provider did not hold appropriate qualifications to deliver training to staff working within health and social care. Therefore, systems were not in place to ensure care workers had the correct skills, knowledge and experience for the work they are required to perform.

A number of care records did not contain sufficient detail to support staff in delivering person centred care

that was safe, appropriate and in accordance with people's preferences and wishes. We could not be sure people were involved in making decisions about their care.

The provider's safeguarding policy was not fit for purpose. Care workers had not received adequate training in relation to keeping people safe. Care workers told us they did not feel confident to raise their concerns because the provider had failed to take action when they had previously raised concerns about people's safety. The provider did not demonstrate sufficient knowledge of their responsibilities to keep people safe. They had failed to report safeguarding concerns to the local authority safeguarding team as required. Accurate records of the action taken to keep people safe were not kept. The provider had also failed to submit notifications to us in-line with their responsibility under our regulations. It is important that the CQC receives all necessary notifications so we can monitor the service provided and take action when required.

Prior to our visit we received information of concern from people and their relatives regarding the provider's ability to respond to their needs. People and their relatives told us their complaints had not been listened to and acted upon. The provider had failed to record the complaints received about the service and the system in place to manage complaints about the service was not sufficient.

Overall, people and their relatives told us the leadership of the service needed to be improved. Comments included, "(Provider) is abrupt." "The owner is the weakest link, they don't know what they are doing." And, "(Provider) is very charming, but they don't always action what they say they will."

Care workers told us the provider was unapproachable. They voiced their concerns about the leadership of the service. One said, "The managers just tell us what to do, they never listen." Another said, "It's unprofessional. I have worked in care before, this agency should be ashamed about how they treat their staff." They told us this made them feel they were not feel listened to, valued or supported to carry out their care worker role. They told us they would feel better supported if the provider took action in response to their concerns about people's safety.

We saw an 'on-call' telephone number was available for care workers to call if they needed support outside of office hours so the provider was available when care workers needed them. However, care workers told us the provider was not always available to provide advice because their telephone calls were not always answered.
This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager who was also the registered provider and they had day to day involvement in the running of the service, often covering calls at short notice. They were supported by the company director, a care coordinator and a team leader. The provider said, "We know we need to make improvements in some areas, in time we will." They told us they would make the improvements by, 'being more vigilant'.

The provider told us of their long terms plans to develop the service. They said, "We want to employ more staff and provide care to people who pay privately." This was because they had recently not been awarded a contract to provide care to people whose care was funded by the local authority.

The provider told us they welcomed feedback from people about the service they received. People confirmed this had happened. One said, "We did receive a questionnaire. It was tick box .I wrote not very good in all areas, I haven't had a response." We looked at analysis that had been completed from ten responses to satisfaction surveys sent out in 2016. This meant people had been given the opportunity to

complete surveys, so the provider could identify what they achieved well or areas which required improvement. People's responses were mixed. For example, eight people said they were satisfied with the care they received. However, six people said care workers were often rushed when they provided their care. This feedback had not been used to make improvements to the service.

Care workers confirmed they did have the opportunity to attend team meetings every couple of months. However, they told us they were not encouraged to share their ideas to make improvements to the service people received. One said, "They (provider) just give us a telling off." We looked at records of team meetings over the last 12 months and saw these were used to provide staff with information and inform them of future plans for the service.

Following our inspection we notified the local authority commissioners about the serious concerns we had identified related to the safety and quality of care that people received. We spoke with, wrote formally and then met with the provider to give them the opportunity to provide assurances of actions taken to ensure the safety of people. We asked them to submit an urgent action plan to tell us how they were going to mitigate the risks.