Roch 2 Limited

Bluebird Care (East Hertfordshire)

Inspection report

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Date of inspection visit:
25 June 2021
29 June 2021
07 July 2021

Date of publication:
16 September 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bluebird Care (East Hertfordshire) is a domiciliary care agency providing personal to older people and young adults some of whom may live with dementia, physical disability and sensory impairments.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection 115 people used the service, 105 receiving the regulated activity of personal care.

People's experience of using this service and what we found
People and staff told us there was ineffective leadership at the service since the registered manager left. The quality of the service people received deteriorated and their needs were not met.

People told us the level of care they received was inadequate because staff only stayed the minimum amount of time and they were rushed, at times not even turning up for the visits. Visits to people were not carried out at the agreed time often people waited hours for their support to arrive which meant they received personal care, food and drink and their medicines late.

The provider's governance systems were not used effectively to ensure the service provided to people was safe and effective. The manager and the provider did not check if staff stayed the contracted length of time when visiting people, if support was provided by two staff to people where this was a requirement or that the invoices people paid reflected the care and support they received.

Safeguarding systems and processes were not robust and staff failed to report concerns appropriately. The manager and the provider failed to identify where people were exposed to the risk of financial abuse and neglect by the service they operated.

People and staff told us there were not enough staff to provide a good service. Often one staff member was allocated to provide care for people who needed two staff to maintain safety. Travel time was not effectively factored into staff's schedule which meant they were late arriving to people's homes from the beginning of their shift. The training staff received did not prepare them for their roles and their competencies to carry out tasks, such as manual handling, medicine administration, were not assessed.

Inexperienced staff members were sent to support people with complex needs often on their own which led on one occasion to staff sustaining injuries as well as putting people at risk of harm.

We observed staff not following government guidance in wearing Personal Protective Equipment (PPE) and people confirmed this. Staff in the office did not wear masks when they left their desks and people told us that staff often turned up at their home without wearing masks, aprons or gloves when they provided

personal care.

Relatives were not happy with the care and support their family members received. They told us they had raised issues with the management, however no improvements were made. They told us their life had been negatively impacted by the poor service provision.

The manager and the provider failed to take immediate actions following our first day of inspection to keep people safe. When we returned to the service we found that the management team were still allocating one care staff to support people where two staff were required and there were numerous visits where staff did not stay for the length of the agreed time.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 24 October 2018).

Why we inspected
We received concerns in relation to staff training, one staff allocated to support people who required two staff, poor leadership. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bluebird Care (East Hertfordshire) on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Bluebird Care (East Hertfordshire)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission, however they have left the service in August 2020. This means that the registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had been employed who was in the process of registering with CQC.

Notice of inspection
We gave the service 48 hours' notice of the inspection. Inspection activity started on 25 June 2021 and ended on 07 July 2021. We visited the office location on 25 and 29 June 2021. We had a meeting with the provider and manager on 07 July 2021 to give feedback about the inspection and discuss what immediate actions they had taken to ensure the service was safe.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and eight relatives about their experience of the care provided. We spoke with seven members of care staff. In addition, we also spoke with the manager and the nominated individual who was also the provider. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included nine people's care records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risks of financial harm or abuse by the provider. Staff told us that prior of our inspection management instructed them to, "Rush the visits as much as possible." Staff said they were told to not log out when they left people's homes in order to make the figures look good".
- Staff were required to inform the office when they arrived and left a person's house. This process logged them in and out of the care visits and ensured the provider was able to both ensure staff attended and also stayed for the duration. They used this to develop the invoice. Where staff had not logged out people were invoiced for the contracted time not for the actual duration of the visit, meaning a significant number of people, and the local authority were charged for care that had not been provided. One person said, "They do charge me even if I don't get my full time." A relative told us, "I did raise with the [registered?] manager the fact I am still being charged for the full time relating to my [family member] care but [person] doesn't get their full time always. The manager's response was: Have they left [person] clean and comfortable in an appropriate way?' I answered yes to this, but they then said, 'Well some carers are quicker than others and whilst some finish early there will be times when other take longer, so invoices not changed."
- We showed examples of the invoices to the manager who agreed that people had been charged for time they had not received. This included people living with dementia who may not be able to recall at a later time the actual time staff spent with them.
- Staff confirmed on the second day of the inspection that the management team had taken action to ensure that as a result of our inspection findings, staff stayed for the agreed time with people.
- Staff were not knowledgeable about safeguarding procedures. Staff told us they received some information about safeguarding as part of their induction. However, they confirmed they did not report safeguarding concerns to local safeguarding authorities when the management did not act on the concerns they raised. For example, a staff member told us several staff members had raised concerns with the management about visits not being done or being very late. However, nothing was done about this although it meant people were not receiving the support they needed. Staff or management had not made any referrals to the local authority safeguarding team about this.

The lack of processes and systems in place as well as lack of staff's understanding about safeguarding procedures was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's systems did not ensure people were protected from financial harm or mismanagement that may cause them harm.

Staffing and recruitment

- The system in place for allocating care visits was ineffective. People's call times were not consistent, varying day to day when staff would arrive. There was not enough staff availability to ensure people

consistently received their visits at the agreed times. The routes that staff followed were not planned to ensure they had time to travel between visits. This meant that staff were not able to meet people's care needs effectively and safely.

● We found numerous examples where one staff member was allocated to a visit where two staff were required. This placed people and staff at risk of injury. We were informed of one staff member who had injured their back as they carried out moving and handling procedures alone.

● Staff told us the registered manager had allocated them to carry our single calls where two were required. This placed staff and people they supported at risk of injury. We asked the manager if they had knowingly sent one staff member and they confirmed they had on numerous occasions. They said to us, "Yes, we have, this was the case up until yesterday."

● We looked at a ten-day period in June 2021 and reviewed the 30 minutes planned visits for this period. Out of 3706 thirty minutes planned visits 240 visits were completed in under 10 minutes and 20 of these visits were done by one staff member instead of two.

● People and relatives told us staff rarely stayed for the agreed length of the care visits. One person said to us, "Half an hour? No way! It's barely fifteen minutes. Some of them can't get out of here fast enough. It is not a wash; it is a cat lick!" We confirmed numerous short calls for this person.

● We looked at the period between our first visit to the service on 25 June 2021 and our second visit on 29 June 2021. We found 85 visits completed in under 10 minutes, and three occasions when one staff member was sent as opposed to two to support people. We asked the manager what action they had taken since our first visit. They said, "Nothing yet, I have been out in the field training the field care supervisor. There have been no other actions by me, but we have plans about what we are going to do."

● Visits agreed to be provided at a specific time of day are known as time critical. Time Critical care visits are required in order to meet specific assessed needs including administering medicines. All four people who Bluebird Care (East Hertfordshire) had agreed to provide care at a specific time suffered delays. Sometimes in excess of three hours. This meant their critical health need may not have been met, leaving them at risk. The manager also had not system to flag when a critical visit was late and relied upon the filed care supervisor's knowledge to alert them.

●Staff told us there were not enough staff to ensure people were supported safely. One staff member said, "[Visits] are often late, and [visits] were missed due to staff not being available." Another staff member told us that they were always running late and expected to travel from one part of the county to another to carry out visits but only given 5 minutes travel time in between calls. They told us that there were often missed visits and the manager was aware of this. They told us they felt pressured into doing extra visits by office staff who were calling them numerous times in one day asking to do more visits.

This meant there were not enough staff to ensure people's needs were met safely and at the agreed time. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People and relatives, we spoke with told us they felt staff were aware of the risks to their health and wellbeing. One person said, "My [family member] has had a couple of falls not when carers are here, and they know about this risk as well as being aware they can only stand for a short while." However, we found that some staff practices were not safe. For example, staff carried out manual handling like changing people's position in bed, operating hoists for people who required two staff on their own. One staff member told us, "Often double up calls are attended by only one carer as simply cannot get cover and the manager is fully aware of this practice."

● The provider and the manager had not ensured staff were sufficiently skilled and competent to support people safely. Staff told us they completed their induction in one day and the provider's training matrix

evidenced this. Staff told us, they were supporting people with mobility equipment although they were never shown how to use this.
● Relatives told us often staff had no knowledge about how to support people and meet their needs. One relative said, "Lots of new care staff 'just arrive' to support [family member]. No shadow shifts. Recently, [family member] was taken ill and is now in hospital." The relative told us they felt that if the regular staff had attended, they would have recognised that the person was not herself had not eaten and would have contacted emergency services or the relatives. However, the relative found the person unresponsive on arrival home from work and called emergency services. This meant staff were not sufficiently skilled to support people safely.
● Areas of possible risk in relation to people's care were not always identified or assessed, for example, in relation to people's specific support needs such as dementia, diabetes or mitigating the risks of choking.

We found people were at risk of harm as staff were not sufficiently skilled or provided with the most up to date information regarding people's care needs and how to support them safely and effectively. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People told us staff did not always wear appropriate Personal Protective Equipment (PPE) to reduce the risk of infection. One person said, "I have had problems when one carer came to wash my hair, they told me they had not been Covid-19 tested and their mask kept falling down. I felt they were too close to me for this to happen. The other night a carer came in to [carry out a task] and wasn't wearing a mask at all. Another carer pulled their mask down to speak to me, but I asked them to replace it."
● Minutes of a staff meeting also identified this as a concern in May 2021. Management did not develop a plan to improve this. When we visited the office, we saw on both occasions staff in the office did not use PPE when staff or visitors entered the office.
● Staff had not received training in relation to COVID-19, putting on and removing PPE, infection control or monitoring people for signs of illness. Some staff when asked about COVID-19 training did not know what this was for. In the minutes of the meeting in May 2021 management noted that staff knowledge around the use of PPE was not robust. However, no plans were in place to address this; therefore, people were not protected from the risk of infections.

Staff were not provided with sufficient support to safely use PPE to keep them and others protected. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely; Learning lessons when things go wrong
● Relatives told us people's medicines were not always managed safely. One relative told us they administered their family member's medicines in the morning and, as the care plan detailed, the lunch time medicine was to be administered by staff. However, they told us on numerous occasions staff administered the lunch time medicine in the morning. This meant the person had not received their medicines as intended by the prescriber.
● One staff member told us it was required for them to support people to take their medicines. They told us they had only completed an on-line training without having their competency to administer medicines safely checked.
● The provider's incident/accident log had no record of the medicine administration issues relatives and people told us about.
● There were no competency or practical assessments undertaken by the manager or provider to assure

themselves staff were skilled and followed safe medicine administration techniques when supporting people to take their medicines.

● People requiring time specific medicines for health conditions they lived with such as Parkinson's did not receive these consistently at the time required. This was due to staff being late on most days arriving for the visits.

● There were no lessons learnt processes or actions taken by the manager or the provider following complaints they had received or incidents and accidents. People and relatives told us they had raised the same concerns several times with the office staff and the manager, however things had not changed. For example, when a person's needs changed the relative requested the care plan to be changed and information to be cascaded down to staff. They told us that for a period of two months nothing had been changed and staff were not aware of the person's current needs when they supported them.

Staff were not appropriately trained and skilled to administer people's medicines safely. There were no processes in place to learn from incidents and accidents or when things went wrong to help improve the care and support people received. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff told us the training and support they received were not enough for them to learn their role. Staff told us their competency to support people safely and effectively was not assessed.
- Staff told us the induction training was done in one day and it was on-line. They told us they had completed safeguarding, manual handling and other subjects in one day. However, when we asked specific questions about their training, they could not remember what they had learnt. For example, we asked a staff member what their safeguarding training was about and what they understood their responsibilities were when supporting vulnerable people. They did not know.
- The provider's training matrix supported staff's feedback about completing their induction training of more than 10 subjects in one day. These included safeguarding, infection control awareness, manual handling and other subjects.
- The provider told us the induction training and certificates were issued in one day, however staff were given workbooks and supporting information for them to read. The provider and the manager had not assured themselves that staff were knowledgeable and prepared for their role before supporting people on their own.
- Relatives told us newly employed staff were not confident and knowledgeable when they started working at the service. One relative said, "[Staff] really do care, they are gentle and want to be as helpful as possible, but they are leaning on the job."

Staff had not received appropriate training and support to enable them to carry out the duties they were employed to do. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had an assessment before they received care and support. A care plan was developed based on this assessment. However, the care plans did not give staff enough information and guidance to support people in line with current best practice guidelines.
- There was no best practice guidance for staff to know how to support people with diabetes, to know about signs and symptoms of low and high blood sugars (hypo and hyper glycemia). Relatives of people living with this condition told us staff were not knowledgeable and did not understand the importance of certain care needs their family member had because of their health condition. For example, giving breakfast at a certain time to people who received their insulin.
- People who lived with Parkinson's had not received their medicines consistently at the same times during

the day. Guidance was not in place for staff to understand why people living with Parkinson needed their medicines consistently at equal intervals during the day.
● When people joined the service, the initial assessment detailed the time people required their visits from staff. For example, a person needed their visit at 9:30 am every morning due to their health needs. Their relative told us staff often visited as late as 11am. The provider's visit planner evidenced that the visits for this person were not scheduled at 9:30 am daily for staff to aim to arrive in time and often visit times planned varied between 9:30 and 11am.

People's assessed needs were not met safely and effectively. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People's care plan detailed if they needed support with food and drink. However, people experienced delays in having their nutritional needs met. For example, a person told us staff needed to prepare breakfast for them and lunch. Because staff were often very late to visit, they had late breakfast and were not hungry when staff visited at lunch time.
● One person said, "My morning visit should be 9.30am but on these missed call days they have arrived at 1.20pm. I am able to get up but cannot wash or dress myself. They are supposed to do my breakfast as well, but I do manage to get myself something." One relative told us, "They were supposed to come at 8.30 am but it can be 9.30 before they come. [Family member] is an early riser and wants breakfast around 8.30 which the carers were supposed to do. I have to get up and do breakfast." This relative told us that whilst they could do breakfast for their family member at present they could not continue on long term.
● Although staff completed an on-line food, nutrition and hydration training part of their induction, they had not demonstrated a good understanding of safe food hygiene. One relative told us, "One day recently [family member's] dinner was put in front of them stone cold. They couldn't eat it. It is a worry if they [staff] are not heating food to a safe temperature for [family member]." Another relative told us, "Lunch call should be 1pm. Often care staff will turn up at 12 noon, [family member] declines because it is too early, and they are not hungry. There are big signs in the house, and it is in the care plan, that care staff must call me if [family member] declines food. They don't."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Relatives told us staff contacted people's GP if they were concerned about people's health, However, some relatives raised concerns about newly employed staff who were not experienced enough to recognise when people's needs changed.
● One relative said, "They don't keep me fully up to date with things. GP told me carers had phoned to say that they felt the district nurse should visit [family member]. It is fine with them using their initiative but not telling me is not appropriate."
● People were not always supported by staff when they could not make arrangements to attend hospital appointments. One person told us they did not know how to book transport for them to attend hospital appointments and staff had no time to help them do this. The person had to spend their own finances to book private transport.

Ensuring consent to care and treatment in line with law and guidance
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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● People told us staff asked for their consent before they carried out tasks. One person said, "Currently my condition is having no impact on my ability to make choices and take control, but this might change in the next few weeks."
● People who had a diagnosis of dementia and they may have lacked capacity to take some decisions had no MCA assessments carried out by staff or manager. Best interest decisions were not in place to evidence that the support people received was in their best interest.
● Relatives of people who lived with dementia told us that not all the staff supporting their family member understood how to effectively support people to accept the care they needed. One relative told us, "My [family member] has Dementia and never comments on the carers. A couple of times they refused to have a shower and become very agitated. Some carers will try to persuade them to let them wash [family member] but not all."

We recommend that the provider and the manager ensures that the principles of the MCA are applied when necessary and assessment and best interest decisions are put in place when people lack capacity to ensure staff has guidance in how to support people in their best interest.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- People did not receiving safe and effective support. The lack of strong leadership in the service led to a chaotic, task led, rushed and impersonal service. People told us the service was not consistent. They had several staff members visiting them daily and there was no continuity.
- One person said, "We are getting far too many new carers calling since the start of the pandemic." A relative told us, "My [family member] does not get regular carers and sometimes they can have eight different carers in a day. [Family member] can't verbally communicate … at times they show they are unhappy with not having regular carers by holding onto their blanket and not letting staff move them. I have to go in and reassure them so they can make them comfortable. I wonder how [family member] will be when I will no longer be able to do this."
- People and their relatives told us the service was not well-led. They told us management were not visible, did not respond when concerns were raised. One person said, "[Management] really needs to improve recruitment systems and whilst they try to communicate with me when things go wrong, they are merely firefighting and scurrying around along with office staff to find carers to cover the visits." Another person said, "I don't know who the manager is."
- People and relatives told us there were no changes to the quality and safety of the support they received following concerns they raised. One relative told us, "My [sibling] did ring and raise issues that staff were not doing all they were asked to do but this has not been resolved. The timing of the breakfast call and the length of calls are an issue. The office claimed the carers were coming at 8.30 am but they aren't, and it needs sorting which it hasn't been."
- We found that not all the complaints and concerns people and relatives told us they raised with office staff were recorded. This meant that not all concerns and complaints were investigated and resolved, and the service had not improved.
- Staff felt management were not approachable or caring to staff and people using the service. Staff said the management team did not demonstrate good leadership and did not listen to their views or opinions. One staff member told us, "I don't feel supported. Calls [visits to people] are often late and calls were missed due to staff not being available. This was passed onto the manager, but nothing was done about it. We are given five minutes to get from one person to another. We are always late."
- Staff told us that the service had changed considerably since the new manager had been in post. Staff felt the new manager and the provider lacked management skills to lead the staff team and put staff under pressure to cover shifts.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There were ineffective quality assurance systems in place to assess, monitor and improve the quality of the service. In October 2020 the local authority contacted people for feedback about the service and concerns of late visits, staff cutting visits short and one staff member was visiting when two were required were raised. The provider had been notified about these issues.

● In May 2021 CQC received concerns from people about missed and short visits as well as a lack of training for staff. We asked the provider to review the length of time staff stayed when providing care and staff training and make the required improvements. They responded and told us they were aware of short care visits, however had plans to address this. They told us staff received all the required training and there were no other issues.

● At this inspection we found that people regularly and systemically had visits that were shortened, late or attended by one carer when two were required. The provider was asked to demonstrate to us how they had addressed these issues since it had been identified. They showed us an audit and action plan that noted they had to monitor late visits. However, staff told us they were asked by management and office staff to complete visits as soon as possible for people so they could carry on with visits.

● Some quality audits were carried out but failed to fully identify areas for improvement. For example, although quarterly audits of visits length were completed, where issues were identified these were not investigated to understand why. The manager or provider did not monitor regularly, shortened visits or where one staff attended where two were required.

● On our first visit to the service we showed the provider and manager from their own data where visits were significantly less than the planned time. Neither were aware of the significant number reported. The provider said, "After your demonstration it is clear that late and short calls are not being monitored."

● On our second visit we once again reviewed this data for the period 25 June 2021 to 28 June 2021. We found the same concerns with timeliness. Neither the provider or manager had put in place measures to improve this. When asked, the manager said, "No, we have not monitored the call logs with staff since your previous visit. To be honest we have taken our eye of the ball."

● Audits of care records did not identify where risk assessments for areas such as dementia, diabetes or choking were required.

● Training development plans did not ensure staff had the required training in place, such as infection control, choking, diabetes, Covid-19 or donning and doffing. Quality audits completed by the provider had not identified that staff completed all the induction training in one day and had not identified these as areas for development.

● The provider's systems did not identify where staff not logging out from a visit meant that people were subsequently invoiced for the entire length of that call. People told us they had raised this with the office but had been ignored.

● The management team did not promote a culture of continuous learning and improving care. Numerous opportunities were available to the management team to enable shared learning and development across the organisation that were not utilised.

● We found breaches of regulation relating to staffing, infection prevention and control, safeguarding, training and support for staff and management. These widespread failings demonstrated the provider did not fully understand regulatory requirements.

There was an absence of effective management and leadership to ensure the provider had oversight of the quality and safety of the service. The provider and registered manager could not demonstrate how they evaluated and reviewed the service in order to make improvements or continually learn and improve the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider did not engage with people using the service to enable them to identify areas for improvement. A survey had been started in August 2020 but stopped due to low uptake. The provider did not then seek other ways to understand people's experience of the service and was therefore unaware of the issues identified at this inspection.

● People and relatives told us they had not been asked for feedback about the service.

● The provider did not engage with the staff team. Although they worked closely with the senior team, they were unable to demonstrate to us where they had sought feedback from care staff.

● Team meetings were held, however these were held for senior staff and management and not attended by care staff. The meetings did not follow a structured agenda and were not effective at identifying areas for development. For example, a meeting in April 2021 noted for visits to be monitored. It did not establish what staff were to monitor, what the current issues were, how to improve, and did not review the effectiveness of actions taken.

There was a failure by the provider to engage with people and staff to fully understand the quality of care provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager and the provider had not been responsive to issues and concerns. They had failed to be open, honest, and apologise to people when things went wrong.

● Duty of candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. There was no evidence in people's care records, discussions with staff or management to demonstrate where this had occurred.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The lack of processes and systems in place as well as lack of staff's understanding about safeguarding procedures meant people were protected from financial harm or mismanagement that may cause them harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was an absence of effective management and leadership to ensure the provider had oversight of the quality and safety of the service. The provider and registered manager could not demonstrate how they evaluated and reviewed the service in order to make improvements or continually learn and improve the service. There was a failure by the provider to engage with people and staff to fully understand the quality of care provided.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate training and support to enable them to carry out the duties they were employed to do. There were not enough staff to ensure people's needs were met safely and at the agreed time.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm as staff were not sufficiently skilled or provided with the most up to date information regarding people's care needs and how to support them safely and effectively. Staff were not provided with sufficient support to safely use PPE to keep them and others protected. Staff administering people's medicines were not appropriately trained and skilled to administer these safely. There were no processes in place to learn from incidents and accidents or when things went wrong to improve the care and support people received. People's assessed needs were not met safely and effectively.

The enforcement action we took:

We issued a warning notice for failure to comply with Regulation 12, (1) (2), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.