Bloomsbury Home Care Limited

Bloomsbury Home Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

We inspected Bloomsbury homecare over two days. On the 11 December 2017 we carried out an announced inspection and we gave the provider 48 hours' notice to ensure that they would be present. On the 15 December, we arranged to visit five people receiving a service from Bloomsbury home care within their own homes.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults who require a variety of care and support with personal care and everyday living across a number of locations. This included, Southend, Colchester, Clacton and Tendering areas and Ipswich.

During the last inspection in 2015, we rated the service good in all domains. However, during this inspection we found breaches in regulation under the Health and Social Care Act, 2008, and have rated the service as Requires Improvement overall.

A registered manager was in place at the time of inspection. However, following inspection the registered manager resigned and a the provider is recruiting to fill this post.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
People receiving care who had complex needs did not always have robust risk assessments and care plans in place for staff to have a full understanding of how to meet their needs safely.

Medicines were poorly managed and systems in place to ensure that staff were administrating medicines safely were significantly lacking. This was a breach in regulation 12 of the Health and Social Care Act.

Care staff had a good understanding of safeguarding vulnerable adults and knew who to contact if they had any concerns over people's wellbeing and safety. However, the local authority had received a large number of safeguarding concerns over the previous 12 month period. These related to the care and treatment at the service.

Staff had access to PPE (personal protective equipment) such as gloves and aprons worked in a way that promoted good infection control, but equipment was not kept in a sterile or clean environment.

A computerised monitoring system was in place to monitor missed calls. Previously late calls had been safeguarding concern, but this had improved.

We made recommendations about how the provider assess risks to people in their home environment.

Training had been highlighted as a concern by the local authority, but this was improving and a the service now monitored this.

People at risk of neglect, malnutrition and dehydration did not have robust person centred care plans for staff to follow. This was a breach in regulation 14 of the Health and social care act.

Staff adhered to principles of the Mental capacity act, seeking consent and not limiting freedom, but assessments were not robust. We made recommendation's for the provider to review these processes to keep abreast of current legislation and guidance.

Supervisions were not robust and we made additional recommendations for this to be improved.

People told us that staff were caring but felt undervalued by the service and this resulted in staff leaving. This disrupted good continuity of care.

Care plans were not person centred and did not give staff the information that would support them to provide person centred care. This was a breach in regulation 9 of the Health and Social Care Act 2008; Person centred care.

Written complaints were responded too, but verbal complaints were not always followed up. When investigations took place, the registered manager did not explore all available facts to reach a decision. This is a breach of regulation 16, of the Health and Social Care Act, 2008; Complaints.

Staff felt undervalued due to the pay and conditions. Systems were not in place to improve retention of staff.

The provider had not acted swiftly to mitigate concerns about the safe running of the service as they did not agree with external findings of processes. Governance systems in place to monitor the quality of the service were poor resulting in a breach of regulation 17 of the Health and Social Care Act, 2008; Good Governance.

You can see what action we told the provider to take at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Medicines were not safely managed.

Staff sterile equipment was not stored in a clean environment.

Staff had a good understanding of safeguarding procedure's.

Is the service effective?

Requires Improvement

The service was not always effective

Care plans to support people with identified risk of malnutrition and dehydration were poor.

Supervisions of staff did not record actions to take to support development.

Staff followed the principles of Mental Capacity Act in practice, but assessments were poor.

Is the service caring?

Requires Improvement

The service was not always caring

People told us that staff were caring and respectful.

Staff went above and beyond their role to support people.

Staff did not always feel cared for by the organisation.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans and risk assessments were not person centred.

Complaints were not thoroughly investigated and used to

improve the quality of the service.

Where end of life care was needed, the service worked cohesively with other professionals and loved ones.

The registered manager supported people with flexibility over care visits when possible.

Is the service well-led?

Inadequate

The service was not well led

Retention of staff was poor and systems to improve this had not been considered, leaving staff feeling undervalued.

Systems in place to monitor the quality of the service were poor.

Where concerns and actions had been found by external stakeholders, these were not acted on within allocated timescales.

Bloomsbury Home Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.'

The inspection started on 12 December 2017 we visited the office location to see the manager and office staff; and to review care records, and policies and procedures. We ended the inspection on the 15 of December 2017 following visits to people receiving care from the service.

The inspection team consisted of two inspectors for the Care Quality Commission.

Prior to the inspection we reviewed all statutory notifications received from the service since the last inspection. These are notifications that the provider has to submit to the commission to comply with the Health and Social Care Act, 2008; 2015. This including a provider information request form, about the service they are providing.

This also included safeguarding alerts relating to missed calls, and poor medicine management.

We spoke with and reviewed information from the local Council Quality Improvement team (QAT) and safeguarding team, who had been working closely with the service following their own quality visits, where a number of areas of concern had been found.

We spoke to seven people using the service, which included visits to five people's homes, the registered manager, the provider, the office manager and five members of staff working for the service. We also reviewed seven peoples care plans, five staff recruitment files and a variety of policy and procedures for the service.

To ensure that the service was monitoring the quality and safety of the service provided we also reviewed all the auditing and quality reporting actions carried out by the manager and provider for the location.

Requires Improvement

Is the service safe?

Our findings

The registered manager and provider did not affectively monitor the proper and safe use of medicines. The QAT had found significantly failings in this area in September 2017 and had worked with the provider to try and rectify these concerns. Concerns included lack of staff training and poor recording of medicines given. The provider did not agree there was an issue with administrating medications and, whilst they revisited medicines training for staff, they had done little to rectify the other concerns.

When we visited the location on the 11 December 2017, we found that the recording and monitoring of medicines given remained poor. Medicines were not recorded on a separate MAR sheet (Medicine administration record), instead they were included in people's daily records. Doses and instructions were not recorded properly and we found care entries that did not accurately record what people had been given. For example, one person had been given risperidone medication for "irritability," but the entry stated they had been given an extra one because they were in a "bad mood." Risperdal medication is a is an antipsychotic medication mainly used to treat schizophrenia, bipolar disorder, and irritability. Previous entries stated that the person had received one tablet. As no MAR was kept, we could not check against it. Information on the daily notes stated "one per day." This medication was not kept in the blister pack, so staff administered from the box.

We asked the provider to investigate and they informed the commission that the person received 1-2 tablets per day. There was no care plan about how staff should decide what dose to give, whether they had the skills and training to make that decision, how the person had been consulted and permission gained and whether their "bad mood" had been explored and monitored to ensure that the person was not deteriorating. Audits did not pick up on this information. This meant that the service was not making sure that the person's behaviour was not controlled by excessive or inappropriate use of medicines.

A policy for as required medicine (PRN) had been fully implemented. This policy supports staff to know when they can give a person additional information and how to monitor it. When people required staff to apply creams to them, there was no body map to state where creams would be applied.

In one person's note's we found that eye drops had been administered but we could not find this medication documented. The registered manager audits of notes had not highlighted this and the provider agreed the medicine should have been updated on the person's records. Lack of this recording resulted in the person's condition not being monitored affectively.

If people required antibiotic's clear instructions about when they would need them, for example following or before food, specific times were not recorded. Staff would need this information to demonstrate that they giving medication safely in line with instructions supplied by medical professionals.

Staff we spoke to had a good understanding of how to safeguard people from the risk of abuse. They were able to give good examples of when they would need to contact managers and external agencies. However the service had, had a considerable amount of safeguarding alerts made in a twelve month period leading

to inspection, compared to similar sized organisation's providing similar care. Some safeguarding alerts had been made around neglect through missed medications. In spite of safeguarding concerns around missed medication, and concerns highlighted by the local council, the provider had not changed how medicines were monitored and had not used the information to swiftly introduce a more robust system. This put people at continued risk of not receiving their medicines appropriately.
The lack of oversight and monitoring of medicines management placed people at risk of not receiving the appropriate medications. This could result in potential physical harm. This is a breach in Regulation 12, of the Health and Social care Act 2008; Safe care and treatment.

The service provided staff with the appropriate infection control PPE (Personal Protection Equipment) such as gloves and aprons. We saw staff using these appropriately when visiting people in their homes, and saw that supplies in homes were topped up by staff. Staff collected these from the office. However, stores of these were kept in the staff toilet at the office. Boxes of sterile equipment kept in such close proximity of the toilet risked coming into contact with urine when the toilet was flushed.

Environmental risk assessments of people's homes were carried out during the initial assessment period. However, for those people who smoked in their homes, the service interventions to protect staff were not robust. Risk assessments included the need for staff opening the windows if caring for a person who was smoking. At the time of inspection, the weather was cold and this may not be appropriate when providing a person with personal care as they would be exposed to cold. It is also important that the assessor review whether people who smoke also use creams applied by staff for skin conditions that could be flammable. This was not in place.

We recommend that the provider review risk assessments for people who smoke. This information should include all risks, and any action that staff and the person should take to avoid risks.

Where staff needed to use specialist equipment, such as hoists, we saw that care plans included information of when equipment had been or needed to be serviced, and contact details if equipment went wrong. For those who had key safes, (a secure place for a house key to be kept) only staff involved with their care, and the office would have the access codes to obtain the key. This information was handled safely and securely, minimising risk of unknown people accessing vulnerable people's homes.

Recruitment at the service was on-going and the registered manager was able to inform the provider when they were able to take on additional peoples care packages, dependant of the staffing available and the acuity of people's needs.

Team leaders carried out initial assessments of potential staff and then interviewed them at the office. Interviews included scenarios for potential staff and the registered manager then had oversight of the final assessment paperwork to authorise whether a post was offered.

The service had carried out the necessary safety checks on staff prior to them beginning their care duties. This included collection of references, criminal back ground checks (DBS), evidence of previous work experience, address and photographic evidence of who people were. This was in line with safe recruitment practices.

The service had in place a computerised monitoring system to monitor missed calls via a secure work phone. Previously late calls had been safeguarding concern, but this had significantly improved. Staff told us these were easy to use and they would swipe a barcode in people's addresses to demonstrate the start and end of the visit. If they were late the registered manager or team leader on call would be alerted. Staff told us

the phones used also give them adequate information to safely support people, including any relevant updates. One said, "Our phone system has all the information so we can brief quickly and easily too."

The staff rota was completed by team leaders and monitored by a location in Lincolnshire. The registered manager received alerts when staff had not attended to people or when staff were late to people's homes. People we spoke to told us they had received the odd missed visit and sometimes late visit, but staff always phoned them. One person said, "I have had missed visits, but they phone and check I am okay first. If I needed someone they would send someone. It doesn't happen often. Sometimes the manager will come when there are not enough staff." Another said, "Yes there has been the odd day when they are running behind but they always make sure I am okay and let me know how long they will be."

People told us that staff made sure they were safe. "The staff will call me if they are running late and that makes me feel safe, knowing where they are and when they will come." One person said, "They leave me safe, leave everything ready and assessable for me."

Requires Improvement

Is the service effective?

Our findings

Care plans around fluids and nutrition did not give staff the information required to support people with their food and nutrition. The registered manager told us within the PIR that they did not support anyone with complex behaviours or dementia. We confirmed this during discussion. However, on review of care notes we found that the service did care for people with dementia. Care notes for one person reviewed stated they had not eaten properly over a period of a week, and that they were at risk of not eating. . There was no evidence of what staff had done to monitor this and feed the information back to the team leaders and managers. For example, one person had dementia and there was no information about how their diet should be monitored, even though staff had the role of preparing food. The person had also been recorded as having behaviour's that challenged.

Another person had been refusing to eat meals and drink fluids on a regular basis and this had been recorded as linked to their low mood. This was not explored in the risk assessment and care plan. It just stated, "High risk of malnutrition due to health and should be encouraged to persist in a full balance diet." There was no person centred information about what people enjoyed to eat and drink, what staff could to do to encourage them, how and where they should continue to monitor and report risks. This type of information can give staff the tools needed to mitigate the risk of malnutrition.

On one occasion staff documented they had phoned to report a person's refusal to eat, or explored any reasons why they did not want to eat. The registered manager told staff to respect the person's wishes. There was no evidence that the service had taken action to address the refusal to eat which put the person at risk of malnutrition. However, risk assessments, and care plans did not inform how staff should manage pain and neglect,

People told us that in general their diets were supported. Although one person said, "I have microwave meals which they heat up for me, but sometimes they are cold." This could make a person unwell if their food is not correctly heated. We did observe that in one case where a person was unable to access fluids independently between visits from care staff, that they had left a drink during the day so that they would not become dehydrated.

The lack of guidance and support for people with risk of malnutrition and dehydration could leave people at risk. This is a breach of Regulation 14, of the Health and Social care Act, 2008; 2014.

Team leaders carried out peoples' needs assessments at the beginning of their service and at six to eight monthly intervals throughout people's care, or earlier as the need presented. Where people had additional health problems that needed support from other professionals, we saw that these details were logged, and that staff would communicate with these professionals when needed. For example, if a person had poor skin integrity that needed oversight from district nurses.

A person told us, "They are very nice and asked me what I wanted." Another said, "the team leaders are really good, I have (name) number and I can phone them if things have changed. They phone and check if I

am happy with the care and they visit me to update things." When asked whether staff supported them to remain independent and respected their choices and decisions people told us, "Yes, they always respect my decisions,"; "They wouldn't do anything I was unhappy with,"; "They try and help me do things for myself when I can." Promoting independence is good practice as it supports people to stay in their own homes for as long as they feel able. However, staff were not always equipped with the knowledge to support people to remain independent, as this information was not always recorded in care plans and care records. This had previously been a concern highlighted by the local council.

People were able to choose whether they had male of female staff supporting them. One person said, "I only like females and that's what I feel comfortable with." The registered manager told us, "Its people's choice. We did have a complaint where a person needed two carers and we sent a man and a woman. They didn't like that and we made sure it didn't happen again."

Team leaders had train the trainer certificates and carried out all training for new staff. They received regular yearly train the trainer update sessions and had recently completed a train the trainer moving and handling course.

The initial induction was three days long and carried out in groups. Where possible the registered manager organised groups of new starters from across other locations to come together for training so that group exercises could take place following training sessions. Staff had to complete their induction without pay. The registered manager told us that this was because they had previously paid for induction and sometimes new staff would attend and then leave. In recompense, staff were given an additional £100 in their wages on completion of three months. But one member of staff told us, "It doesn't really cover the time we spent on induction."
Following the inspection the provider told us that staff now received £150 a month in the first month of employment to cover training time.

The registered manager informed us that additional training was in the process of being sourced, including accessing training for staff supporting people living with Huntington's disease. Training provided to staff also linked to the Social Care Institute for clinical Excellence for dementia care and skills of health resources.

Staff had to undertake one shadow shift, with a peer colleague who observed them providing care. We reviewed staff files we could not see any evidence of these, of how a decision had been made after one shadow shift that a carer had the skills needed to work safely and independently. The registered manager informed us they had just introduced a new observation form for the observe to complete, but these were not active at the time of inspection.

Team leaders carried out care staff supervisions and the registered manager supervised the team leaders. Staff could expect two spot check observed practices, one, one to one supervision and one appraisal a year. We reviewed staff files and found that where supervision records were there, when staff had asked for further training, no actions had been decided for further exploration or discussion. The registered manager told us that one to one supervisions only happened twice a year there was no evidence of how these that been followed through. As many staff had not remained at the service for long periods, some would not have achieved more than one supervision. Staff we spoke to had mixed comments about frequency of supervision. One said, "I think we get supervision once a month," another told us, "I never get supervision."

We recommend that the registered manager improve oversight of actions developed from staff supervisions to ensure that staff have the support and skills to practice safely.

Due to concerns from external agencies the service had made improvements to induction, and monitoring of training and all staff had received mandatory training. The registered manager had introduced a thorough staff induction guide / handbook with important information, and training had been updated on a spread sheet and monitored by the office manager so that refresher training could be organised in a more timely way. However, there was no system in place to support recognising when staff were due for future training updates. For example, the use of a traffic light system to identify those who were out of date and those approaching being out of date. Following inspection the office manager implemented this process.

Staff had to complete a workbook over a three month period which was kept in the office so it wouldn't get lost. Staff could complete this during supervision or drop in to the office if they had a gap in between visits. Whilst the induction did not result in a care certificate, which is a national recommended induction for care staff, it did cover the 15 fundamental care standards highlighted within the care certificate.

Care staff supporting people had access to all relevant contact details contained in peoples care plans. For example, next of kin and doctors surgery. Staff told us that when they needed to call a GP or support someone to make an appointment, this made it easier to help people access the support they needed.

All staff had to complete Mental Capacity Act training. This was e-learning based. 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 told us that staff always sought their consent before supporting them with various aspects of care. An example given was, "They always ask permission before they wash me and dress me. If I don't want too then they won't do it." We saw evidence in care records where staff had recorded that consent had been sought. Staff told us, "I always presume someone has capacity. If I think something has changed I would let the team leader know so they could carry out an assessment."

We observed that consent forms were also included in care plans which were signed by people receiving care. However, capacity assessments themselves did not adequately document what decision was to be made, and how a decision was decided. Capacity assessments are decision specific and staff completing them, when there is a concern that a person lacks capacity, must record the question to be asked and detail how they assessed the persons capacity.

We recommend that the registered manager review how capacity assessments are carried out in line with current legislation and guidance, and assure themselves that they have proper oversight of staffs ability to complete these appropriately.

Requires Improvement

Is the service caring?

Our findings

Whilst people we spoke to felt cared for and reported that most care staff were very caring, some had also experienced times when staff had been uncaring. We had received some complaints from people via our website, and feedback to people following complaints was not always given, and complaints not always thoroughly investigated. This is further explored in the responsive domain.

Staff did not always feel cared for by the provider and people receiving a service told us that staff had told of them of their difficulties.
For example, people we spoke to told us that they were unhappy with the quick turnaround of staff. One said, "You get to know people and then they go because they don't get paid enough money." Another said, "I had a brilliant regular carer but [name] couldn't afford the petrol, they don't get paid travel either you know. Well they couldn't stay working like that." They felt that the provider had not done enough to ensure that the service could remain consistently caring. This is further discussed within the well led domain.

People we spoke to told us that all staff at the service were kind and considerate. This included the registered manager. Comments included, "The staff are really lovely, I don't see many people so it makes my day when they come and we always have a little laugh"; "I am not always an easy person to get along with, but staff are respectful no matter what mood I am in"; "They are very nice, even the manager and provider. I have spoken to (provider name) and (manager name) a lot and they always take my calls. "Sometimes (the manager name) comes to see me and checks I am getting on okay. He is very kind." One person told us, "I get down sometimes because of (reason), they sit here and let me talk. They are really gentle and kind. I don't know what I would do without them."

People told us they were provided with care from small groups of staff and they felt this was really good. One person said, "I like them because I am a private person and I have small number of staff who come to me and know me well. This makes me feel safe." Another said, "I only have a few staff that come to me which means we have developed really good relationships. They know me, I know them, they know when I am having a bad day and how to help me through. They are really very kind. Although it seems once you get to know someone they leave, as the conditions aren't good."

Staff we spoke to knew people well. For example, we spoke with one member of staff who was carrying out a care call. In spite of not having all the relevant information recorded in the care plan for the person, for example, how they liked care provided staff were able to inform us of what the person liked and disliked and how exactly they liked things carried out. The person was able to later confirm how well staff knew them.

Some people told us that they had had carers that were not kind to them and spoke to them in a uncaring way. But in each case they had spoken to the registered manager and the member of staff didn't return. One person informed us that, "The carer wasn't horrible; just we didn't seem to get on well together. I don't think they liked me and I didn't like them. But after I told the manager they didn't come back."

Team leaders spoke to people regularly to find out how they were. This included phone contact and being

rotated on shift to complete care needs. People told us that this made them feel cared for.

People told us that staff respected their privacy and dignity and where they were able to do things for themselves, staff encouraged this. "They cover me up when they help me wash," one person said. Another told us, "They always make sure I look presentable, I like to look my best."

The registered manager gave an example of when a member of staff had gone above and beyond and remained at a person's address after they were taken to hospital to clean the house so it was presentable when they returned home. They did this in their own time and this was a relief to the person. Other examples were given by people about when staff had brought them the odd bit of shopping after noticing they were running low on things.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not always person centred and did not contain the information about people that staff would need to ensure that care was provided in a person centred way. For example, statements around personal care support included statements like, "30 minutes to assist the adult out of bed and all other grooming needs." This gave staff no information about how to support the person, whether they have any preferences about how they like care tasks completed, and how they can be supported to be as independent as possible.

New care plans had been introduced but they were task orientated and did not considered the persons preferences and wishes, how they would like the task performed. For example, one person liked their hair styled in a certain way. This had been documented in an old version of the care plan, but the new version just informed staff to provide hair care.

Whilst care plans were not always person centred, people we spoke with who retained capacity told us that they felt they were receiving person centred care. However, for people living with dementia, it is essential that care plans can give staff the information they need to support that person in a person centred way, how they like things done. The registered manager had informed us that the service did not care for anyone with dementia. However, a review of care records demonstrated that this was not the case.

For one person living with dementia, care plan and care notes evidenced that staff knew what daily tasks needed to be completed, but not what emotional support should be given. Advice from health professionals was documented for staff to keep persons mind active, however none of the daily records demonstrated that this was happening. Statements included, "Person watched tele." "Creamed legs, left safe." This did not demonstrate that the person was receiving the support recommended by the healthcare professional.

Care records did not demonstrate how staff had monitored and communicated increased risks to others. For example, care records for one person who had multiple risks, including pain, malnutrition, and neglect recorded, "expressed great pain while moving," refused personal care, verbally aggressive recorded on a number of occasions. No information was included of whether these risks had been discussed with the person and relevant capacity assessments and potential referrals to other health professionals had been made.

Whilst people told us they received person centred care and they had visits from small teams of staff who knew them well, care plans and care records did not provide staff with sufficient detail to manage identified risks in a person centred way. This could have a significant impact on those people who were less able to make their needs known, and who may also on occasion have staff attending who did not know them well.

This was a breach in Regulation 9 of the Health and Social care Act, 2008; Person centred care.

Where possible people's additional requests were accommodated. For example, a person wanted to change their visit time on one morning a week, and wanted some support to access the local community. Regular

staff were able to offer this.

The registered manager and provider did not always review peoples' complaints thoroughly and did not take learning from the complaints made to improve the quality of care.

Where verbal complaints were made, they were not recorded. We saw that a person had complained about a senior member of staffs attitude towards them. We had also received whistle blowing complaints about a senior member of staff and how they spoke to people. When the complaint was received, the registered manager told us they had spoken to the staff member and asked them not to go visit the person whilst the concern was investigated. But they had not documented this conversation, what actions they were taking, or a deadline for the investigation. They told us they had held a supervision and explored the concerns with the member of staff or documented in the staff file, but did not inform people what action they had taken. One person told us, "I complained about the member of staff because they were rude to me, and the registered manager made sure they didn't come back to me. I do not know what happened to the member of staff. Whether they were dealt with at the time." This demonstrated a lack of openness and transparency by the service.

Another complaint documented that a member of staff had to carry out care for a person who required two members of staff to move them and that staff were verbally aggressive. The registered manager had submitted a safeguarding referral recognising potential abuse concerns. They carried out an internal investigation which did not uphold the complaint. However, they had not looked at staff rota's to see who had been due to visit the person, or interviewed all members of staff involved. They had not effectively investigated the complaint. The registered manager did follow procedure to inform the person of the outcome and how to complain further if they wished.

As the provider and registered manager had not investigated complaints in a through and transparent way this is a breach in Regulation 16, of the health and Social care Act, 2008; 2014.

In spite of the lack of thorough investigation, we did note that people were provided with various information of how to complain, including how to notify the care quality commission if they had concerns over the care provided.

At the time of inspection, the service was not providing care for anyone who required end of life care. They had experienced this care need on one occasion and worked well with the hospice end of life team to ensure that the person had a comfortable and dignified death at home. This had included increasing the additional visits to support the next of kin to provide the care needed. The registered manager was able to provide staff who were off duty but knew the person well to support them and their loved ones. Staff were given access e-learning to help them understand their role in supporting someone at the end of their life.

Inadequate

Is the service well-led?

Our findings

Some staff told us that whilst the registered manager was supportive, they did not feel valued by the organisation. There was a high turnover of staff, but the provider had not explored the cause. The registered manager told us it was difficult because staff got paid minimum wage, they did not get paid travel time in between home visits. They also told us that staff would receive a small amount of petrol allowance which would be removed if they were off work with sickness.

Staff gave us examples of how they did not feel listened to, respected, valued, or supported. One member of staff who had left the service told us, "I couldn't stay as we didn't get paid enough. I am sure after the petrol and the time spent driving I got paid less that the minimum wage. How can I stay when we are treated like that and other companies offer paid travel time and petrol allowance."

Another member of staff in a complaint to CQC told us, "We used to get paid petrol money but they took that away without even asking us. You don't feel valued. I can't afford to work for them," another informed us, "I can't afford heating this month;" and one member of staff said, "I've known staff to put petrol for work on credit cards as they couldn't afford to get petrol to work."

The provider told us staff used to get mileage payments only in "exceptional circumstances," but that staff did get a contribution towards petrol for the month. However, if they were off sick or had not booked holiday through the system and had time off they would lose that contribution. The provider had not reviewed the contribution against the actual cost of petrol. All but one member of staff spoken to did not seem aware of this contribution.

Two members of staff informed us that they did feel supported. One said, but I am thanked on a regular basis for my hard work and encouraged how well we all work as a team." Another told us, "Yes, I do feel valued. I feel listened to and my team leaders and manager show me this by listening to any problems. However others told us, "I feel valued by my clients and families, but not by my employer no."; another said, "I absolutely do not feel supported."

The providers driving policy was that it was staff's responsibility to ensure they were insured to drive on business insurance. Without this insurance, any accidents on the road during care time would not be covered by normal insurance. The provider and registered manager had not taken measures to insure that staff provided evidence that they were insured to drive for work, such as insurance documents, and MOT certificate's. One member of staff told us. "We were told on induction we didn't need business insurance as we would be using public transport to take service users out and about."
This is incorrect and placed staff at risk of not being covered should they be involved in an accident.

One person highlighted the poor pay and conditions as being directly responsible for a deficit in their care provision. Whilst complementary about care staff, they said that their freedom had been limited since the care commenced and they were no longer able to venture to larger supermarkets to get their shopping as they had done with previous care companies. Part of the care package included support to get shopping.

Instead, the person who previously benefited from the activity and choice at a supermarket, had to rely on staff with shopping lists, or walking with staff to local convenience stores. The person told us, "It does make me feel isolated sometimes. But they can't help it, they only get paid minimum wage and they don't even get petrol money. They can't afford business insurance on their cars or the petrol, so they either walk with me to the shop over or get my shopping for me. I miss the outing to the big shop, it's cheaper there, and I enjoy the trip out as I'm stuck in here a lot. There is not enough time to use public transport." This is not supporting person centred care or empowering people to achieve best outcomes and independence.

Whilst issues remained about pay and conditions, staff told us that the registered manager was visible and approachable, and the provider did make efforts to know people. Because of this staff told us, "I feel that there is an open and inclusive service for people receiving the care. I would be comfortable reporting concerns to my registered manager."

The registered manager held weekly conference call meetings with team leaders on a Monday morning to ascertain if there were any on-going concerns and actions that needed to be taken in regards to staffing and care for people. Registered managers from across the services owned by the provider also had a meeting every Friday, with the provider to discuss improvements, observations, improvements. However, there were no records to demonstrate what discussions had taken place and the outcomes from meetings.

An organisational safeguard raised against the service in 2017 raised concerns that the registered manager and provider did not have proper oversight of the quality of care provided at the service. The registered manager told us that they wanted to introduce a number of new things to ensure that they could demonstrate they did have oversight. They held staff meetings monthly and for those who did not attend the manager told us they were sent emails of any actions. However, they did not take minutes of meetings taken.

As there were no record's we could not confirm whether concerns raised by staff and external agencies had been discussed and whether any action was being taken to manage these concerns.

Audits of care plans were carried out every six to eight months. The registered manager told us he was unhappy about the care plans quality and referred to the concerns highlighted in a recent quality report by the local council. We reviewed care plans audits but these only highlighted what information was missing. It did not identify actions to take, by who, and when the actions would need to be carried out. It was not clear who had responsibility for ensuring the care plan quality.

Team leaders carried out audits of care entries at the end of each month however, the registered manager was not able to provide us with outcomes of these audits. Team leaders had not identified concerns that we found in regards to medicines management as discussed in the safe domain, and person centred care and risk monitoring as discussed in the responsive domain.

The provider attempted to get people involved in the development of the service through annual surveys. However, there was a lack of analysis, and actions plans had not been implemented following feedback. Surveys were completed within people's home with staff, and consequently the service had received a significant number of surveys back. Although as they were not confidential it would be difficult for the provider to ensure that surveys were an accurate reflection of people's views. Lack of analysis of the results of the survey did not demonstrate they were used to drive improvement.

Very few staff had completed their surveys. The provider had not considered how they could incentivise feedback from staff. Information received from surveys can be used to support providers to complete a

robust business continuity plan, planning services in the future. The registered manager told us they did not have any business plan going forward. This meant that we could not be assured of the sustainability of the service.

Due to the amount of safeguarding referrals from the service and a recent quality report from the local council, the provider and registered manager had had a number of meetings with the local authority. Action plans had been devised with the local authority to support improvement. However, timescales for improvement had not been met.

One of the concerns in particularly was around the safety of medicine administration. We also found these concerns and have documented them in the safe domain. We spoke to the registered manager about the lack of progress in this area and they told us they were also unhappy with the medicines processes. They told us they had been trying to implement a new MARS which would record instructions and require staff to electronically swipe to state medicines had been given. However, as the provider did not agree with the local authority that there was an issue they had not been keen to act on previous advice. Following the inspection we found that the new systems due to be implemented in the third week of December had still not been implemented.

The service had received a number of visits from the local authority who had raised a number of concerns. The registered manager and local authority had also raised a number of safeguarding's relating to the care and treatment of people. The commission had received a number of whistle-blowers at the service stating that there were missed visits, bullying culture and staff had to hurry people during visits. However, the provider did not agree or act on feedback given by external organisations. The lack of monitoring of some areas of the service was poor and consequently we could not find evidence of how the service learnt from things that went wrong.

The lack of good governance systems in place is a breach of Regulation 17 of the Health and Social Care Act, 2008.

The registered manager told us that they had introduced a number of new initiatives to try and incentivise staff to stay. This included a monthly outstanding service award for staff who did something exceptional where they receive a £50 bonus and certificate. However, this was alternated across all the provider's four locations, so it was not a frequent offer. The registered manager told is "I hope it can be extended to all locations each month so more staff can benefit." One member of staff said, "There was a £50 bonus introduced and we were told it would happen monthly. I've only known it to happen once."

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 9 HSCA RA Regulations 2014 Person-centred care Care plans did not identify person centred intervention to peoples identified risks. This included pain management, person care needs and promoting of independence.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were poorly managed and recorded. Processes in place to monitor the safety of medicines had not identified errors made.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs For those with identified risk of malnutrition and poor hydration, care plans did not address what actions staff should take to mitigate these risks.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not thoroughly investigated, and the service did not learn from mistakes made.

Regulated activity	Regulation

Personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

There were inadequate processes in place to monitor the safety and quality of the service provided.