Abicare Services Limited

Abicare Services Ltd

Inspection report

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Ratings

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

Overall summary

We conducted this announced inspection on 19, 20, 21 and 24 August 2015 in response to concerns that had been raised regarding the quality of care being provided by Abicare, particularly the high volume of missed calls

Abicare provides a domiciliary care service to enable people living in Basingstoke, Aldershot and Farnborough and the surrounding areas to maintain their independence at home. There were 168 people using the service at the time of the inspection, who had a range of physical and health care needs. Some people were being supported to live with dementia, whilst others were supported with specific health conditions including Multiple Sclerosis and Huntington's disease. At the time of the inspection the provider deployed 58 care staff to care for people and meet their individual needs.

At the time of our inspection the service had a registered manager but they were not actively managing the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. During our inspection the provider's area

Summary of findings

manager was covering for the registered manager, who was absent due to illness. We were informed by the provider that the registered manager had resigned from their position on 16 July 2015. Our records confirmed that the registered manager began the process to become deregistered on 19 August 2015.

People were not always protected from abuse and avoidable harm. Where abuse had been identified the provider had not taken immediate steps to prevent the abuse or taken action to ensure the abuse was not repeated.

The Provider had not ensured people were safe because they had not always provided care and support in accordance with people's individual care plans. People who required two care staff to support them with moving and positioning frequently had just one member of care staff attend to them, thereby placing people and care staff at risk of physical harm.

We found that the provider had not ensured that people had been protected from the risks of unsafe care because people's needs had not been appropriately assessed and reviewed. Care plans did not contain enough detail to enable staff to meet the individual needs and preferences of people. Where risks had been identified care staff did not always deliver care in accordance with the risk assessment management plans to keep people safe.

There were not enough staff to meet peoples' needs. People we spoke with were frustrated at the high level of missed and mistimed calls. The area manager told us this was because the provider did not have sufficient numbers of suitable staff to keep people safe and meet their needs. Committed care staff told us they were working extensive hours and were always stretched to the limit. The provider was actively recruiting more care staff, although current care staff were disillusioned and continuing to leave.

The provider did not have a robust selection and recruitment process and had employed care staff without obtaining all of the relevant information to ensure they were suitable to provide care and support to vulnerable people.

People did not always receive their prescribed medicines safely. Relatives told us that care staff were often in a hurry and did not always ensure people living with dementia had taken their medicines. This meant that people were at risk of harm from not taking their prescribed medicines.

People were not supported to have their assessed needs met by staff with the necessary skills and knowledge. People were sometimes mobilised without the correct equipment and advice from health professionals was not always followed.

Most people told us they were able to see other health professionals and that care staff knew about their appointments and supported them with these where required. Care staff had recognised changes in people's needs and raised concerns about their health with the office staff who then referred them to other professionals. However, some care staff were concerned that when they informed the office about people's changing needs nothing would be done until formal complaints were raised by the person or their relatives. The service was not responsive to people's changing needs.

Positive and caring relationships which had been developed with continuity of care staff were being undermined by chaotic rostering. People told us that they thought most of the care staff were kind and caring but the office staff were unfriendly and often rude. People told us that they were asked about their support and were involved in making decisions about their care and treatment. Some people told us they were not always spoken to in an appropriate manner and they were not always respected by the care staff.

Care plans were generic and focused on tasks, which did not reflect the different needs of each individual. The process for reviewing care plans did not make sure that people's care was reviewed regularly and changes were not always recorded in people's care plans or updated in a timely manner. This meant the provider could not be assured that care staff had the correct information and guidance about how to care for people based on their current needs.

People had experienced missed and mistimed calls which often led to them not being able to attend social events at day centres and different activities they enjoyed. They told us this had a big impact on their well-being and left them feeling lonely.

Summary of findings

The provider did not routinely listen and learn from people's concerns. Numerous complaints had been made to the CQC and the local authority because people had become frustrated with the lack of response to their complaints by the provider. The provider did not ensure care staff were supported or listened to, in order to drive improvements in the service.

Care staff told us the atmosphere in the office was not very friendly and at times openly hostile. Care staff were concerned about communication within the office due to the lack of action taken when they had raised concerns. Care staff told us there was chaos and confusion in the office. Without exception people told us the service was poorly managed and lacked leadership. People were disillusioned with the management of the service due to concerns regarding missed and mistimed calls. These concerns were then exacerbated by repeated failure to respond to complaints.

Quality assurance systems were in place but had not been operated effectively, which meant the provider had not identified the concerns discovered during our inspection. Failure to assess and monitor the quality of service meant the provider was unaware of areas that were inadequate and had not taken action to address them.

People were not always supported to have enough to eat or drink. Due to the high volume of missed and mistimed calls people often did not choose to eat as the time was not appropriate for them to eat/ wish to eat or drink anything, or were eating at the wrong time. People regularly experienced late breakfast calls followed shortly by early lunchtime calls. Relative's whose loved one's lived with dementia told us they had raised concerns with the provider because care staff were accepting their family member's first response, rather than encouraging them to eat or offering alternative options.

Care staff had completed training on the Mental Capacity Act (MCA) 2005 and understood their responsibilities. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to support people who do not have capacity to make a specific decision. Where people lacked the capacity to consent to their care, legal requirements had been followed by care staff when decisions were made on their behalf. The service had obtained consent from people before providing their care, which had been confirmed by people we spoke with or their relatives.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

During the inspection we identified a number of serious concerns about the care, safety and welfare of people who received care from the provider. We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and will report on this when it is completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from abuse and avoidable harm. Where concerns had been identified the provider had not taken immediate steps to prevent the abuse or take action to ensure the abuse was not repeated.

The provider did not ensure there were sufficient numbers of suitable staff at all times to keep people safe and meet their needs. Appropriate checks were not undertaken to ensure suitable staff were employed to support people in their own homes.

People were placed at risk because they did not always receive their prescribed medicines safely.

Is the service effective?

Inadequate

The service was not effective.

People were not supported by staff who had received adequate training, supervision and appraisals to carry out their roles effectively.

People were not always supported to have the food and drink they needed to maintain their health. The provider had not always followed the guidance of health professionals to ensure people were protected from the risk of malnutrition.

Care staff demonstrated an understanding of consent and mental capacity and supported people to make their own decisions and choices.

Is the service caring?

Requires improvement

The service was not always caring.

Positive and caring relationships which had been developed with continuity of care staff were being undermined by the level of missed or mistimed calls. People were not respected by office based staff, who were unfriendly and often rude.

People were usually involved in making decisions about their care, but were not always happy with the way that care staff interacted with them.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

People had experienced missed and mistimed calls which often led to them not being able to attend social events. This had a big impact on their well-being and left them feeling lonely.

Summary of findings

People's care plans were not personalised and lacked the information that

care staff required. Therefore people's needs were not always met.

The provider did not have an effective complaints procedure and people's complaints were not always responded to and acted upon appropriately and in a timely manner.

Is the service well-led?

Inadequate 

The service was not well-led.

The culture was not open and people's concerns were not

listened to or addressed by the provider

Poor management and leadership within the office had resulted in the poor organisation of care visits and care staff supervision, which had an adverse impact on the quality of people's care.

Quality assurance systems to monitor the service provided to people were not effective. As a result the provider could not be sure of the effectiveness and safety of the care provided to people.

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Detailed findings

Background to this inspection

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

The inspection took place on 19, 20, 21 and 24 August 2015 and was announced. The provider was given 48 hours notice of the inspection to ensure that the people we needed to speak with were available. The inspection team consisted of 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. The expert by experience had personal experience of community services providing care in people's homes for older people.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

Prior to the inspection we reviewed information held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also reviewed the provider's website, local authority contract monitoring reports and spoke with the commissioners of the service.

During the inspection we spoke with the area manager and the managing director who was also the nominated individual with overall responsibility for supervising the management of the service. We also spoke with the training manager, a community team leader, three community team supervisors and the administrator. We spoke with 35 people on the telephone to find out about their experience of the quality of care provided by the service and 12 other members of care staff.

We reviewed 17 people's care plans and nine care staff recruitment and supervision records. We also looked at information relating to the management of the service, which included audits of the service and the provider's policies and procedures.

We visited eight people in their own homes. We spoke with them about their care and looked at their care records. We observed some aspects of care, such as care staff preparing people's meals and supporting them to move. During the home visits we spoke with two further care staff. Following the home visits we spoke on the telephone with two health and social care professionals and the local authority care commissioners.

This was the first inspection of the service since it was registered on 23 June 2014.

Inadequate

Is the service safe?

Our findings

People were not always protected from abuse and avoidable harm. One person's relative reported concerns about the care being provided to their loved one which required the local safeguarding authority to be informed. The relative had complained to the provider's office staff who had informed the registered manager. The provider did not inform the CQC or local authority until four weeks had elapsed and the person's relative had already made an official referral to relevant authorities. This meant the provider had not worked in partnership with relevant bodies to protect people at risk. The provider's failure to take action as soon as they were alerted meant that people continued to be at risk from abuse and avoidable harm.

The provider had not investigated or responded without delay to these allegations. These allegations were subsequently substantiated and the provider had failed to take immediate steps to prevent the abuse or take action to ensure the abuse was not repeated.

We spoke with the daughter of an older person who left them at 7.15 pm awaiting the night time care staff to support them into bed. The person called their daughter in distress at 01.30 am the following morning as they were trying to get into bed themselves because the night time care staff had not arrived. The person was in pain endeavouring to change their clothes and upon the daughter's arrival was found to have injured their hand, for which they received outpatient treatment at the local hospital. The provider did not investigate to identify the cause of the injury. The provider failed to investigate and report these circumstances to the CQC or safeguarding authority. This meant the provider had failed to protect people by using incidents to identify potential abuse and take preventative action to keep people safe.

Care staff did not understand one person's mental health issues and spoke to them in a way which caused them distress. The person told us how this had upset them and made them feel emotionally distressed. This meant the provider had not protected the person from psychological abuse.

The delay in the reporting of notifiable incidents, failure to investigate and report safeguarding concerns and the failure to prevent abuse were a breach Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had policies and procedures for safeguarding people against abuse and we saw these documents were available and accessible to members of care staff. This enabled care staff to have the necessary knowledge and information to make sure people were protected from abuse. The care staff demonstrated their knowledge about who to contact to make referrals to or to obtain advice from at their local safeguarding authority, when responding to allegations or suspicions of abuse. Care staff had received safeguarding training during their induction, although this had not been updated during the previous year in accordance with the provider's policy.

Identified risks to people were not managed to ensure people were safe and protected from harm. One person we spoke with told us they were allergic to latex, which had been identified in their risk assessment. The risk assessment identified the person to be at risk of anaphylaxis which is a severe, potentially life-threatening allergic reaction. Care staff were therefore advised they must not wear latex gloves when supporting this person. Despite the risk assessment care staff still arrived wearing latex gloves exposing the person to the potential risk of anaphylaxis. The area manager told us they had now addressed these concerns by removing all latex protective gloves.

Some people told us , which care plans confirmed ,that two care staff were required to support them to move safely, for example when transferring from their bed to a chair. Without exception they told us that frequently only one care staff turned up or the second member of care staff arrived much later. This frequently led to one member of care staff moving the person or family members being asked to support one member of care staff, thereby placing them at risk of harm.

One person's relative told us, "The carers are lovely but often turn up single handed or the wait for another will be too long." Another relative said, "When one carer moves my wife I am really worried for her safety. I am scared she will fall from the hoist because the other carer is not there to support her. It's a terrible choice between the fear of her falling or sitting in soaked clothes for hours". Another

Is the service safe?

relative told us, "I am 68 and have got a bad back. They shouldn't be ringing me to help. This is happening two or three times a week." Two relatives told us they had received calls from the service stating they had no care staff available and said "Could you put them to bed?" The service were not meeting peoples' needs and people were at risk because staff were not available to deliver their assessed care.

The provider had not done all that was reasonably practicable to mitigate risks to people's safety. They had failed to ensure care staff followed good practice guidance to make sure the risk was as low as possible. This amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection we received information raising concerns about the quality of service provided by Abicare. These concerns mainly related to missed or mistimed calls. During the inspection 27 people (or their relatives) out of the 42 people we spoke with or told us they had experienced missed calls, which had caused them physical or emotional distress. People without exception told us they had experienced mistimed calls and rarely received rotas. If they had received rotas there were numerous unallocated calls shown. Care staff attending and times of attendance seldom reflected those shown on rotas received, which meant the rotas were meaningless for people

Many people supported by Abicare were older and frail, whilst some were living with dementia. People, or their relatives, told us it was important for them to know who was coming and when, so they felt safe and reassured. They told us that continuity of care from care staff they knew and trusted was also vitally important to their mental wellbeing. People and their relatives, told us they had experienced poor continuity of care and had 'lost confidence in Abicare. People did not feel safe or reassured by the quality of the service.

One person said, "I know you can't always have the same carers but I don't know most of the carers who come and they don't always know what to do." A relative told us, "Abicare just aren't coping. The service is awful. The stress of not knowing if anyone is coming, when they are coming or who is coming, causes us constant misery and worry." People did not receive a service which was safe and met their needs.

Another relative told us, "My mum's 95. Recently it was so late and the carers hadn't visited Mum for her bedtime call so she put herself to bed and went to sleep. In the morning we found a note saying they came late and didn't want to wake Mum up. Imagine if they had woken her up in the dark. She would have been terrified."

One person told us, "Sometimes they just don't turn up. It's a complete lottery and a shambles. If you manage to get through to the office all they do is say sorry but nothing ever changes."

People told us they had experience of calls being either far too early or late to meet their needs effectively. For example one person's relative told us how care staff recently completed a breakfast morning call at 11.30 am then other care staff returned at 12.15 pm to provide lunch time care. Another relative told us how the morning and lunch time care staff must have "passed in the road" as there was only five minutes between them. This was not appropriate to meet people's needs.

Without exception all of the care staff we spoke with told us they were frustrated with the level of missed or mistimed care calls. They said they were 'fed up' letting people down because of the chaotic rostering of care visits. Care staff told us they were working excessive hours, between 60-70 hours per week, and were regularly asked to work on their rest days. This was confirmed by the provider's roster system. There was a risk to the quality of care people received due to staff working excessive hours. Care staff told us they were always rushed which had an adverse impact on the quality of care they provided. One member of care staff told us they had been asked to cover 27calls between 07.00 am and 10.00 pm on a double shift, when 18 would be their norm. This was not appropriate or achievable without putting people at risk.

Supervisors with the appropriate skills and experience were covering unallocated care calls to reduce the risk of missed calls. On the first day of our inspection the office management team were delivering personal care in the mornings prior to attending the office and in the evening after office hours had finished. We reviewed one manager's duties and found they had not had a day off for over six weeks and had been continually working 12 to16 hours daily. This level of commitment was not sustainable and placed the individual's health and well-being at risk.

Inadequate

Is the service safe?

The recent transfer of care packages from another service had increased the number of care hours to be covered, whilst staffing levels had decreased. This meant there was no capacity to cover foreseen or unforeseen absences of care staff.

The area manager told us that the provider had a centrally based rostering team that scheduled established rounds into rotas, which were then amended by the local Basingstoke office staff with updated leave and unforeseen absence. The area manager told us a local supervisor had created confusion by altering established schedules within the rostering system to incorporate new care packages transferred from other agencies. The provider had recently sent a scheduling team into the Basingstoke service to reset the scheduled rounds and the area manager was confident this would improve the coordination of people's care visits.

The number of missed calls evidenced by the experience of people and care staff, corroborated by the service's lack of resilience to cover unforeseen staffing demands demonstrated the service did not have sufficient numbers of suitable care staff to deploy to meet people's needs and ensure their safety. These concerns amount to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate checks to ensure staff were recruited safely were not carried out. Some staff did not always have appropriate references in relation to their previous employment and there was not always evidence supporting how the provider had assessed applicants suitability for the post. All of the care staff files reviewed had deficiencies. Where references had been requested these had not always been received or did not address the care staff's suitability to support vulnerable people. The provider had completed Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider had employed one care staff although their DBS check had raised concerns about their suitability. The provider had not completed a risk assessment or detailed explanation rationalising how people would be protected from harm if this person was employed. Another member of care staff had provided no employment references but had a reference from a friend of the same family name. This meant the provider had not assured people were protected from the risk of receiving their care from care staff who were unsuitable to deliver support to people in their homes.

Staff and the area manager told us applicants attended an interview to determine their suitability. However, interview records were not always available to evidence how the provider had assessed applicants suitability to meet the requirements of the role.

The provider had not protected people by ensuring that the information required in relation to each person employed was available. This is in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always managed so they received them safely or as prescribed. Seven people or their relatives told us they had experienced recent medicines errors. Two people told us they had recently been given the wrong medicine at the wrong time. One person said, "My mum's had 30 different carers and some just do not know her. She has dementia and sometimes gets confused. The other day they gave her the evening medicine in the morning." Another person told us they had been supported with their medicines and had taken their lunchtime medicine in the morning. A member of staff told us that whilst attending a person's morning call they identified they had not been administered their evening medicines the night before. The relative of another person told us that they had complained to the office about numerous occasions when their loved one's medicines had not been administered but the situation had not improved. The provider had not made any notifications to the relevant authorities in relation to these concerns to confirm people were safe. The provider had not ensured that people received their medicines as prescribed.

Recording of medicines was unsafe. At the time of our inspection the area manager was unable to quantify how many medicines errors had actually occurred this year. We asked to review completed Medicines Administration Records (MARS) and were told they were filed in people's care plans. There were no MARS contained within the care records we reviewed. We reviewed the MARS provided by one person who used the service which showed there were gaps in the recording, indicating the medicines had either not been taken or not recorded.

Inadequate

Is the service safe?

Medicines were not administered safely. We spoke with the relatives of two people who were living with dementia who had raised concerns regarding staff not ensuring people had taken their medicines. One person had found tablets which had been recorded as administered in their mother's handbag.

On the day of our inspection care staff found some medicines on the floor of a person's house. The care staff could not confirm whether these were the person's morning medicines or whether they had taken their morning medicines. The care staff then supported the person to take the medicines without confirmation that they were actually prescribed to them. This meant the provider had exposed the person to the potential risks of an overdose or unknown consequences of taking unknown medicines. The care staff telephoned the office for guidance and the provider then implemented measures and enquiries to ensure the person was safe. The person did not experience any actual harm.

Not all staff had received medicines administration training. The care staff involved in this incident had completed their medicines training in March 2015. However the training audit completed by the training manager on 12 August 2015 identified that 38 care staff required to have their medicines training refreshed in accordance with the provider's policy.

Eight people or their relatives told us that the number of missed and mistimed calls had an adverse impact on the management of their medicines, especially if they had to be taken at specific times or with food. One person told us their father required to take his diabetes medicine at regular times and because of numerous missed or mistimed calls they could not be assured he received them at the correct time. This placed him at risk of harm from not controlling his diabetes.

These concerns meant that people had not been supported to take their prescribed medicines safely which was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People were not supported to have their assessed needs met by staff with the necessary skills and knowledge. Care staff had not been trained in supporting people who required their nutritional intake to be administered via a Percutaneous Endoscopic Gastrostomy (PEG). PEG provides nutrition to people who may have difficulty swallowing, using a tube to bypass their mouth. One person was identified to be at risk of malnutrition because some care staff were not giving them any nutrition via the PEG as they had not received the required training. The person told us that they were not confident that all care staff were competent using their PEG and that their regular member of care staff who knew how to use it was no longer visiting them. The provider's care staff failed to attend PEG training offered by relevant health professionals. This person was at risk of malnutrition because staff did not have the necessary skills and knowledge to support them using PEG.

The provider had not provided care in a safe way which amounted to a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported by care staff who had received all the training needed and had the skills they required in order to deliver effective care. The training manager told us they had completed a training audit in April 2015 which identified a large percentage of care staff needed to have the provider's required training updated. They were unable to provide this audit at the time of the inspection so any action taken in response to it could be assessed. The training manager completed a further audit in August 2015 which again identified care staff required training was not up to date. This audit demonstrated that out of 58 care staff 48 required medicines training, 36 required safeguarding training, 33 required pressure care management training, 31 required dementia awareness training and 23 required MCA 2005 training to be updated in accordance with the provider's own training policy.

Care staff who had recently transferred to Abicare from other services told us they had not completed an induction programme with Abicare. Care staff who had worked with Abicare for a longer period told us the training was excellent but had not been updated for a long time due to staff shortages. The training manager told us the local training manager had left the service in March 2015 which had an adverse impact on the delivery of required training. They told us they had recently arranged training days to address the training requirements but care staff were unable to attend due to a lack of staff. On the first day of our inspection the training manager was in the process of preparing distance learning packs as an interim measure. They told us this was to reduce the risk of harm to people receiving support from care staff who had not had their required training refreshed. Therefore staff had not received adequate training to meet people's needs and ensure safe and effective care.

Staff did not receive regular supervision meetings in order to support them in their role. The provider had a policy and procedure to ensure care staff were supported by regular one to one meetings with their supervisor, group supervisions and staff meetings, spot checks where their care practice was observed, and annual appraisals. There was no evidence within the care staff files we reviewed of any supervisions, spot checks, or appraisals. At the time of our inspection the provider could not produce any evidence to confirm staff meetings occurred. All care staff told us they had not received a supervision, spot check or appraisal. No care staff, other than those covering the Aldershot area knew who their line supervisor was. The training manager's audit completed on 12 August 2015 identified that all staff required supervisions and observations. This meant the provider could not be assured that people were receiving effective care, based on best practice, from care staff who had regular supervision in their role to make sure their competence was maintained.

The provider had not ensured care staff had received appropriate training, professional development, supervision and appraisal to enable them to carry out their role effectively. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to have sufficient to eat and drink. People or their relatives were concerned that the high volume of missed and mistimed calls meant that people often did not wish to eat or drink anything, or were eating at the wrong time. For example people regularly experienced late breakfast calls followed shortly by early lunchtime calls. This situation also frequently occurred between lunchtime and tea time. This meant that people often did not wish to eat or drink anything at the time of

Is the service effective?

the visit as they had recently consumed a meal. Relatives told us they were worried their family members were therefore missing an important meal daily. Relative's whose loved one's lived with dementia told us they had raised concerns with the provider because care staff were accepting their family member's first response, rather than encouraging them to eat or offering alternative options. They told us care staff were often rushed and readily accepted when people said they had eaten, when it was apparent they had not.

The provider could not be assured that people's nutritional needs were being met, which amounted to a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have access to healthcare professionals. Office staff were not responsive to concerns raised by care staff when they thought health professionals should be contacted. For example one person had injured their hands in a fall. However, the provider did not immediately arrange for these injuries to be examined by a health professional. During another example a person had a leg wound which began to bleed. Office staff failed to support care staff in arranging the appropriate support to have the wound redressed by a health professional. Often it took a relatives complaint before action was taken. We discussed this with the area manager who told us they had recently implemented a system where they were to be notified about all such concerns or changes. People told us that the area manager had contacted them to discuss their concerns and changes in their needs which may require referral to other health professionals.

People said the care staff always asked for their consent before they did anything. Care staff told us they had received training in the Mental Capacity Act (MCA) 2005 during their induction process but had not had this updated. Care staff training records confirmed this. The MCA 2005 provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. The provider had a copy of the Hampshire local authority guidance to support them in any formal recording of mental capacity assessments and best interest decisions. Care staff demonstrated an understanding of the principles of the act and described how they supported people to make decisions. People were cared for by care staff who had received relevant training and understood their responsibilities in relation to the MCA 2005.

Requires improvement

Is the service caring?

Our findings

People told us that they thought most of the carers were kind and caring but some were not and they did not like them providing their care. One person told us, "There is one carer who is just so rude and doesn't want to be here." A relative of one person raised concerns that their loved one's personal care had not been completed thoroughly on a previous visit. The care staff came out of the bathroom and waved a used incontinence pad under their nose then said, "Well I've changed this one" in a sarcastic manner. Another relative told us that their Family member could sometimes display behaviour which may challenge care staff, who were mainly kind and supportive. However, they told us they had raised concerns about one member of care staff who was rude and dismissive. When care staff were experiencing difficulties administering personal care to the person they shouted, "Tough, you can stay in a dirty pad all day." We discussed these concerns with the area manager who was aware of this and had implemented the provider's disciplinary procedures and ensured the person was no longer receiving support from this member of care staff.

Whilst most people told us their care staff were kind and caring they all said the office staff were unfriendly and often rude. One person told us when they rang to enquire why no care staff had arrived the office staff said aggressively, "They will be there when they are there." Another relative told us they were upset when care staff had not arrived to be told curtly, "We've got no carers we're not sending anyone."

We spoke with one relative who sometimes experienced seizures, although they were not supported by the service. They told us they were upset and disappointed by the lack of care and compassion shown by care staff on an occasion when they were supporting their loved one. They told us how they asked the care staff to move from the settee as they thought they were about to experience a seizure. Upon being told this the care staff immediately got up and left without offering any support or reassurance.

All care staff we spoke with told us how they were upset with the current quality of care being provided by the service due to the level of missed and mistimed calls. Twelve members of care staff told us they would have left the service but were committed to the people they cared for. One care staff told us, "They rely on me and I worry that they won't get the right care and support". Another said, "You can't help developing feelings for the people you support. That's why I'm still here because I know that when I'm there I do my very best for them and treat them like my own family."

People told us that they were asked about their care and were usually involved in making decisions about their care, but were not always happy with the way that care staff interacted with them.

People told us that most of the carers knew what they liked and provided them with the correct care. One care staff told us how they reassured people and put them at their ease before commencing their personal care. This was confirmed by the relative of one person who said "I know how busy they are but they always take their time and have a chat before doing anything and are continually reassuring and encouraging her."

Not all people had their privacy and dignity respected. A relative told us about their family member who needed support mobilising who was upset by a new care staff who said to them "Why are you walking funny?"

Most people told us that care staff respected their privacy and dignity when supporting them. One person told us, "The girls are wonderful. They talk to me all the time and ask me what I want and they never rush me. They are so patient with me." Another said, "They help me when I need it and always give me privacy."

We spoke with staff about how they made sure they promoted people's dignity. One member of staff told us, "I always think about my mum and dad and how I would like them to be treated. I make sure I know everything since my last visit so I know what they can do and when they need extra support."

People and their relatives told us that their care visits, particularly in the morning, promoted their independence for the rest of the day. People told us that missed or mistimed visits had an adverse impact on their independence. People and relatives told us it was distressing to wait until late morning, often in soiled clothes, waiting to begin their day to day life which made them miserable.

The systems to monitor people's views about their care and to ensure people felt that carers were caring towards them

Requires improvement

Is the service caring?

were not effective. There were numerous concerns and complaints raised by people and their relatives about the quality and consistency of care and appropriate action had not been taken by the provider to improve the service.

Inadequate

Is the service responsive?

Our findings

We found that care provided by care staff was not always personalised to meet people's needs. Four people told us that missed and inconsistent calls often led to them not being able to attend social events at day centres and other activities they enjoyed. They told us this had a big impact on their well-being and left them feeling socially isolated.

We spoke with care staff about their understanding of people's care plans, risks to their care and how they used them to provide the correct care for people. One care staff told us, "They are far too basic and don't provide enough detail about the person so you can get to know them and understand them." One care staff said, "A lot of the care plans need to be updated. We ring into the office but it seems to go into a black hole".

People's care plans did not all contain the person centred information that care staff required in order to get to know people and provide personalised. People's care plans had sections entitled 'Who am I'; 'My life so far'; 'My home and family'; 'Important things to me'; and 'Things which worry/ upset me'. This information was not detailed or so sparsely completed it did not provide any relevant person centred information. Care plans were generic and focused on tasks, and did not reflect the different needs of each individual. We found that some staff knew people's needs through working with them over a long period of time whereas other staff did not have this information and could only tell us about the care that was detailed in the care plans. People did not receive individualised person centred care.

Care plans did not provide important information regarding people's health conditions and how to respond to these. For example one person was living with autism. There was no guidance for staff to support the person appropriately whilst delivering their care. Not all care plans were complete. One person's care records included only the initial assessment completed by social services, and no information about their care at all. There was a risk that this person would not receive the care they needed.

One person told us, "My care plan hasn't been updated since January 2014." This person's care needs had changed and also they required additional support from other health professionals, which was not detailed within their care plan. Their care plan did not contain appropriate information for carers about their current needs. Care staff were aware of the support of other professionals but could not tell us about the change in needs for this person. Another person told us how the care staff were not all consistent in the care they provided. They told us, "Some carers don't know what they are doing and I have to tell them. They even need further training or haven't read my care plan." People's needs were not met by staff because their care plans had not been updated in response to their changing needs. The service was not responsive to people's changing needs and did not update care plans appropriately.

The process for reviewing care plans was not robust. Care plans often missed being updated and reviewed because there was no system in place to ensure all care plans were updated regularly. At the time of our inspection, office staff were reviewing each file to identify which people required a review of their care. The training audit completed on 12 August 2015 identified a list of overdue care reviews and risk assessments. No action had been taken to update care plans as a result because this crucial information had been lost and staff told us they did not have time to do this due to staff shortages. The provider could not be assured that care staff had the correct information and guidance about how to care for people based on their current needs. There was a risk that people would not receive appropriate care which responded to their assessed needs.

The provider had failed to make sure that people received care and treatment that was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not responsive to people's complaints. Complaints were not always dealt with in an open, transparent and objective way. Most people told us that they knew they could make a complaint, but not everyone was clear about the process. The provider had a complaints policy and procedure, which was contained within the care plans kept in people's homes, although most people were unaware it was there. The 42 people who had complained about either missed or mistimed calls all expected their complaints to have been formally recorded. There was no formal record, acknowledgement or investigation of these complaints available on the day of our inspection. The area manager told us that the provider's complaints system had fallen into disuse and that many verbal complaints had been dealt with "there

Inadequate

Is the service responsive?

and then." We noted that the provider had sent letters to people apologising for the poor quality of care they had experienced. People we spoke with told us they had received such letters but there had been no investigation into their individual concerns. Five people or their relatives told us they had been contacted directly by the provider's managing director but were disappointed by their reassurances, lack of improvement in the service since and failure to respond to them as promised. This meant that people's concerns and complaints had not been explored and responded to appropriately.

The provider's failure to record, investigate and take proportionate action in relation to complaints was a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The provider had systems in place to monitor and audit the quality of service provision but failed to operate them effectively. This meant the provider could not be sure of the effectiveness and safety of the care provided to people. The area manager told us that daily notes and MARS should be collected and audited monthly, then filed in people's care folder. During our inspection there was no evidence of these documents being collected, audited or filed. People and care staff told us their rotas did not account for staff travelling time. Care staff often had calls finishing at times when their next call was scheduled to begin. This meant that staff often arrived late for subsequent calls. People told us they had frequently complained and care staff also told us the management were aware of this.

The area manager showed us the monthly monitoring sheet which should be completed weekly by the registered manager. This detailed significant events including number of late, early and missed visits; complaints received; care staff on sick leave; care reviews and risk assessments due and done; supervisions due and done. This monitoring document should be reviewed and then returned by the provider indicating action to be taken. The area manager could not demonstrate that this process was being completed during 2015. The lack of audits meant the provider may not have a detailed understanding of the care being provided to people and how to effectively manage the service. We discussed this with the area manager who confirmed the provider's quality assurance system had not been operated effectively. There had been no audits completed by the provider of people's care plans, daily notes, MARs, risk assessments, staff files, complaints, people's or staff rotas. If these had taken place, the provider would have identified the issues that we identified at this inspection.

The provider had failed to effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not promote a positive culture that was open and honest. The area manager told us that since March 2015 Abicare had taken over the care packages of two other care agencies and had absorbed their care staff. This had led to a lack of morale and team spirit. Care staff told us the atmosphere in the office was not very friendly and at times openly hostile. Care staff told us there was chaos in the office with no clear leadership.

Without exception people told us the service was poorly managed and lacked leadership. People were disillusioned with the management of the service due to concerns regarding missed and mistimed calls. These concerns were then exacerbated by the repeated failure of the provider to respond to complaints. One person told us, "It is an absolute shambles. They haven't got a clue. I feel so sorry for the carers who do their best but the manager's are incompetent." A relative told us, "It's got to the stage where we don't bother complaining because nothing changes and you're wasting your breath." One care staff told us, "Nobody in the office takes ownership. They all pass the buck and nobody deals with anything. It's absolute chaos." Another care staff said, "It's a nightmare, rotas change regularly throughout the day, for instance mine has changed four times today." Another told us "Nobody takes responsibility for anything. Whoever you speak with just blames someone else."

All care staff, without exception told us they were disillusioned with the support from office staff. They were concerned about communication with the office staff due to the lack of action taken when they had raised concerns. Three care staff told us they had informed the office staff regarding concerns about people's welfare but nothing had been done. We spoke with the area manager and asked to see the incident and accident records but there was no evidence of these incidents or others being recorded. This meant that the provider could not be assured that risks had been identified from accidents or incidents to ensure there was no recurrence and people were protected from harm.

Without exception care staff told us that the organisation and coordination of care visits was chaotic. One care staff told us, "You don't know what's happening from one minute to the next. Your rota changes so many times during the day and it's your fault if you don't see it." Care staff told us they were demoralised and felt the provider did not value or support them. Care staff we spoke with were uncertain who their line manager was or the individual responsibilities of the office staff.

The area manager told us the poor quality of service currently being provided by Abicare, which manifested

Inadequate

Is the service well-led?

itself in the high volume of missed and mistimed calls, was mainly attributable to a lack of staff and a registered manager. All care staff thought the service would improve once a capable registered manager had been recruited.