Bloomsbury Home Care Limited

Bloomsbury Home Care - The Butterfield Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We completed this inspection on 4, 5, 6, 7 and 8 July 2016. The inspection was announced.

Bloomsbury Homecare – The Butterfield Centre provides care for people in their own homes. The service can provide care for adults of all ages. It can assist people who live with dementia or who have mental health needs. It can also support people who have a learning disability, special sensory needs, a physical disability or who misuse drugs and alcohol. At the time of our inspection the service was providing care for 310 people most of whom were older people. The service covered Stamford, the Deepings, Bourne, Spalding and Grantham and surrounding villages.

The service was previously registered to operate in Lincolnshire and provided care to a small number of people in their homes who lived in Spalding, Grantham and Lincoln. This service was run from an office that was not based in Lincolnshire. In late Autumn 2015 the service won a much larger contract with the local authority that involved it providing care to people in their homes in Stamford, the Deepings and Bourne. As a result of this development the company decided to open a new office in Bourne from which to administer the extended services it had been commissioned to provide in Lincolnshire. We registered this new arrangement on 29 January 2016 and this was our first inspection since that date.

There was a registered manager in 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.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. This was because the registered persons had not always provided staff at the right time to safely care for people some of whom needed to be helped to use medicines. The procedure used to recruit new staff was not robust. Although most people had received the basic care they needed some people were not being reliably assisted to eat and drink enough to promote their good health. Furthermore, the registered persons had not always effectively resolved complaints. All of these problems resulted from the registered persons not operating a system of rigorous quality checks. A further shortfall involved the registered persons not telling us about significant events that had happened in the service and this had reduced our ability to make sure that people were kept safe. You can see what action we told the registered persons to take at the end of the full version of this report.

Possible risks to people's health and safety had not been effectively managed and this had increased the risk that avoidable accidents would occur.

Some people who paid for the service on a private basis had not always been provided with bills that accurately reflected the service they had received and had been over-charged.

Some staff did not have all of the knowledge and skills they needed in order to care for people in the right way and the registered persons had not consistently provided staff with the guidance and training they needed.

The registered persons and staff were following the Mental Capacity Act 2005 (MCA). This measure is intended to ensure that people are supported to make decisions for themselves. When this is not possible the Act requires that decisions are taken in people's best interests.

People were not always treated with kindness, compassion and respect.

People had not always been consulted about the care they wanted to receive. In addition, care was not always planned, delivered and assessed in a consistent way.

People had not been fully consulted about the development of the service and had not benefited from staff acting upon good practice guidance. However, the service was run in an open way and staff were able to speak out if they had any concerns about poor practice.

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.

Staff had not always been provided at the right time to care for people.

Medicines were not safely managed.

Background checks had not always been completed before new staff had been employed.

People had not been robustly safeguarded from the risk of financial mistreatment.

Suitable arrangements had not been made to help people stay safe by avoiding accidents.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received all of the training and support the registered persons said they needed.

People had not always been supported to eat and drink enough.

The registered persons and staff were following the MCA.

Staff had helped to ensure that people had access to any healthcare services they needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always experience care that was kind and compassionate.

Staff did not always promote people's dignity.

Confidential information was not consistently kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not always been consulted about the care they wanted to receive.

Although some people had not received care at the right time most of them had been given the basic assistance they needed.

Complaints had not been effectively managed and resolved.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality checks had not reliably identified and resolved shortfalls in the way care was delivered.

The arrangements for obtaining feedback to guide the development of the service were not robust.

People had not fully benefited from staff receiving and acting upon good practice guidance.

Steps had been taken to promote good team work and staff had been encouraged to speak out if they had any concerns.

Bloomsbury Home Care - The Butterfield Centre

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 registered persons were meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

Before our inspection visit to the service we reviewed any notifications of incidents that the registered persons had sent us since the last inspection. In addition, we contacted local health and social care agencies who pay for some people to use the service. We did this to obtain their views about how well the service was meeting people's needs.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of this type of service. The inspection was announced. The registered persons were given 48 hours' notice because they are sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be available to contribute to the inspection.

During the inspection visit we spoke a director of the company who also acted as the nominated individual. This is a legal role that the registered provider is required to fill so that there is a named person who is responsible for ensuring that the company complies with the conditions of its registration. We also spoke with the registered manager. In our report we refer to the nominated individual and the registered manager as being, 'the registered persons'.

In addition, we spoke with a team leader and a deputy team leader and examined a number of records in the service's administrative office. These records related to how the service was run including visit times, staffing, training and health and safety.

After our inspection visit the inspector spoke by telephone with 10 people who used the service and four relatives. In addition, our expert by experience spoke by telephone with a further 12 people who used the service and three relatives. Two inspectors then visited 20 people in their homes when they spoke with them and their relatives and examined documents relating to the planning and delivery of care. In addition, an inspector spoke by telephone with eight members of staff who provided care to people in their homes.

Inadequate

Is the service safe?

Our findings

The registered persons said that there were suitable arrangements in place to enable all of the planned visits to be completed at the right times. This included there being enough staff who were carefully organised into different teams to meet the needs of people who lived close to each other.
However, a majority of people and their relatives with whom we spoke said that they had serious reservations about this matter. They did not accept that the registered persons had ensured that there were the right numbers of staff available to deliver the visits that needed to be completed. In particular, they said that too many visits did not take place at the right time. A person commented saying, "Most of the staff are fine when they're here, but getting them here on time is the problem. They're often late or very late and then I'm not sure if they're going to turn up at all as no one contacts me from the office. Then to cap it all they can sometimes turn up too early without warning." Another person said, "They are usually late but I get used to it and so I get myself up and ready if this happens."

Most of the relatives we spoke with echoed these concerns with one of them remarking, "Although it's a bit better now when Bloomsbury first took over in Stamford in August and September 2015 the service can only be described as desperate. Actually, to all intents and purposes there was no recognisable service. Even now staff will often be late and then the visits are short and rushed so that the staff can get onto the next person. It's plain for everyone to see that the service doesn't have enough staff or doesn't organise them well because otherwise the visits wouldn't be in such a muddle."

We looked at records that described for six people when visits should have been undertaken and when they had been completed over a period of seven days in June 2016. Out of a total of 40 visits there were 21 occasions when staff had arrived either early or more usually late. In addition, records showed that 13 of the late visits had involved staff arriving more than 40 minutes late. We also noted that three of these visits started more than one hour late. Furthermore, records also showed that in the six months preceding the date of our inspection there had been at least 15 occasions when staff had not completed a visit at all. On some of these occasions when visits had not been completed on time or missed completely people had been placed at risk of harm because they had not been supported to change position safely, keep their skin healthy and manage their continence. The registered manager accepted that on other occasions the mistakes had seriously inconvenienced people and caused them anxiety that they would not receive the assistance they needed to be safe at home.

We noted that some people who lived with reduced mobility needed to be assisted by two members. This was because they needed to be supported by means of hoists the safe use of which requires two members of staff. Records showed that in the four months preceding our inspection there had been a number of occasions when only one member of staff had been provided. This had resulted in people not being able to safely use a hoist or in staff having to ask for assistance from relatives who were not trained to use the equipment. This situation had increased the risk that people would not promptly and safely receive all of the assistance they needed.

We noted that the reasons for incorrectly timed and missed visits varied but usually involved a combination

of shortage of staff, miscommunication between staff and poorly organised administrative systems. We saw that staff were organised so that they completed a number of 'rounds'. These rounds contained a list of all the people who were planned to receive a visit from the member of staff who was allocated to complete that round. The registered manager said that the size of each round was mainly determined by the number of staff who were available in a particular area. They said that in the case of some geographical areas shortages of staff had resulted in an increased number of visits being included in each round. The registered manager accepted that in turn this had resulted in a greater likelihood of visit times becoming unreliable. A member of staff said that they regularly had to 'juggle' visit times so that they could fit in all of the visits that had been given to them. They observed that if more staff were available there would be more opportunity to plan rounds that enabled visit times to be honoured. This was because there would be 'greater leeway' to accommodate unexpected events such as people needing more assistance with their visits lasting longer than planned, travel delays and staff sickness.

Members of staff told us that another problem was the way in which the rounds were sometimes organised. They said that on occasions they were not allowed enough time to travel between people's homes. They also pointed out that on other occasions some visits were even planned to start at the same time so that it was impossible for them to be completed in the right way. We examined some entries in two sets of records that staff had used in the week preceding our inspection visit to organise their visits. In the case of five visits we noted that staff had not been allowed any travel time at all even though in several cases the people concerned lived more than one mile apart.

Shortfalls in providing enough staff who were well organised had resulted in some visits not being reliably completed. This situation had increased the risk that people would not safely receive all of the care they needed.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Five relatives voiced concerns to us about how their family members were being assisted to manage their medicines. One of them said, "I am concerned that medicines aren't always handled in the right way. When I've called to see my family member I've often found unused medicines that staff should have given. If my family member has declined a particular tablet no one has told me and it's much more likely that it's just been forgotten by staff. Also, I've noticed time and time again that some staff don't keep a record of giving medicines as they should so it's not clear just what they've done." The registered manager said that in response to these concerns all staff had been provided with additional training and support to enable them to assist people to safely use medicines. In some instances this involved reminding people to take medicines at a particular time and at other times it entailed staff administering medicines by removing them from their containers and offering them to the person concerned. The registered manager also said that there were explicit procedures for staff to follow to record each occasion when they had administered a medicine or when someone had declined to accept a medicine. They said that this was necessary so that there was an accurate account of the medicines that had been used.

However, when we examined records of the training a number of staff had received we noted that some staff had not undertaken all of the training that the registered manager considered to be necessary. In addition, some staff told us that they considered they needed more training to safely manage medicines. This was necessary so that they knew more about why particular medicines were being used to enable them to better recognise if someone was unwell and needed to see a healthcare professional.

Staff told us that they were expected to clearly record each time they administered a medicine. However,

when we examined 10 sets of these records in each case we found instances when no entry had been made to show that a medicine had been dispensed in the correct way. Although we noted that the medicines in question had been removed from their packaging and were not present a lack of suitable records reduced the assurance we had that people had been assisted to use these medicines in the right way.

The registered manager said that since the service was registered there had been three occasions when staff had made a mistake and not administered a medicine at all to a person. However, a number of people and their relatives told us about a significant number of additional occasions. In addition, when we checked the records of eight visits that had been planned for a person who needed assistance to administer a time critical medicine we found that one visit had not taken place and three more had been started late. The registered manager said that when mistakes had been made action had always been taken to help prevent similar problems from reoccurring. This included the provision of specific additional training for the members of staff concerned and even disciplinary proceedings. However, we noted that the records describing these actions were either incomplete or had not been created. Therefore, we could not be confident that effective steps had indeed been taken to resolve the continuing problem.

Shortfalls in the management of medicines had increased the risk that people would not fully benefit from using medicines that were necessary to promote their good health.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way in which the registered persons had recruited three members of staff and records showed that a number of background checks had been completed. These included checks with the Disclosure and Barring Service to show that the people concerned did not have criminal convictions and had not been guilty of professional misconduct. However, we noted that other checks had not always been carried out in the right way. In one instance an applicant had not completed a suitably detailed statement of their previous jobs and another person had not submitted an employment history at all. In both cases there was no evidence to show that these mistakes had been identified during the recruitment process and so the registered persons could not be sure that they had obtained all of the necessary assurances about the persons' previous good conduct.

Shortfalls in the way staff were recruited had reduced the registered persons' ability to ensure that only suitable people were employed in the service.

This was a breach of Regulation 19 (2) (3) (a) Schedule 3 (4) (7) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said that senior staff completed a comprehensive assessment of possible risks to each person's health and safety so that effective action could be taken to reduce the risk of accidents. This included identifying potential risks such as trip hazards and preparing suitably detailed guidance to show staff how best to keep people safe. However, we found that the system to identify and resolve risks was not well developed. We examined documents completed by senior staff to show how they had managed possible risks for 14 people. In some cases the assessment had not covered all of the subjects that the registered persons considered to be necessary. In other instances assessments had been concluded with a single word. An example of the former involved the guidance provided for staff when assisting a person who lived with significantly reduced mobility. As a result of this they had to be assisted by two staff using a hoist following a particular sequence of tasks. The risk assessment did not contain any information about this matter and relatives told us that as a result there had been a number of occasions when staff had relied

solely on them to explain what they should be doing. Shortfalls in the way possible risks to health and safety were being managed increased the risk that people would experience avoidable accidents.

People said that they felt safe when in the company of staff. A person said, "I do find the staff to be kind in general and even though they're visit times aren't reliable I look forward to seeing most of them." Relatives were also reassured that their family members were safe in the company of staff. One of them said, "I think once they get here the staff are pretty much okay in the sense of being trustworthy."

We noted that most staff had completed training and had received guidance in how to keep people safe from situations in which they might experience abuse. We found that staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. Staff were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm. They knew how to contact external agencies such as the Care Quality Commission and said they would do so if they had any concerns that remained unresolved.

Records showed that the registered persons had been asked by the local safeguarding authority to respond to a significant number of concerns since the service was registered. These involved concerns received by the authority from people who used the service, relatives and health and social care professionals. The issues were wide ranging and referred to people being placed at risk of harm due to a range of problems related to missed and late visits, mistakes with medicines administration and a failure to provide some of the care that people needed. We noted that the registered persons had cooperated with the authority to investigate and resolve the various matters. However, the regularity and frequency of the various concerns that had been raised indicated that the service had not always protected people from the risk of abuse.

Most of the people who used the service had made various arrangements with the local authority who then paid for them to receive their home visits. However, some people paid for the service themselves. A relative of one of these people told us that they were not satisfied with the accuracy of the bills they received. This was because they were expected to pay for the full amount of time allocated for each visit rather than the actual and shorter time staff usually spent completing a call. The registered persons confirmed that this was how the invoicing system worked and when we checked the bill sent to a person we found that in effect they had been overcharged. As a result of this we could not be confident that people were always being asked to pay the right charges for the service they received and were suitably protected from the risk of financial mistreatment.

Requires Improvement

Is the service effective?

Our findings

We were told that some people who used the service needed to receive additional assistance to ensure that they were drinking enough to promote their good health. Some of this assistance involved staff gently reminding some people about the need to have enough fluids and then making sure that plenty of drinks were readily to hand. However, some people needed more help that involved staff monitoring how much people had drunk each day. We looked at the written guidance staff had been given to check that a person was drinking enough to avoid the risk of becoming dehydrated. We found that the advice was not sufficiently detailed to ensure that staff consistently supported the person in the right way. This shortfall was reflected in the way that staff were recording and checking how much the person in question had drunk. We looked at the records kept for the two days preceding our inspection and found the entries to be incomplete, contradictory and partly illegible. We also asked a number of staff about this aspect of their work and most of them were not confident about how best to ensure that people did not become dehydrated and for example did not know some of the warning signs to bear in mind.

We were told that some people were at risk of not having enough nutrition to promote their good health. We noted that in addition to staff making people's meals and encouraging them to eat some people needed to have special high-calorie food supplements that had been prescribed by their doctor. However, we found that staff were not always supporting people to take these supplements in the correct way. An example of this involved a person who should have received at least one food supplement every day. However, when we checked the records for 11 days during the three months preceding our inspection and found that on three of the days there was no evidence that the supplement had been administered. A relative spoke with us about this issue and said, "I can't tell you how frustrating it is to find that such a basic and simple task just doesn't get done. It's not difficult to give a food supplement but I've no confidence that Bloomsbury can organise doing it."

We noted that another person needed to be assisted to have a meal at certain intervals because they lived with a particular healthcare condition. The registered manager said that the visits this person received had been carefully timed so that a member of staff was reliably able to provide the correct assistance. However, when we examined records that described when 16 visits had been completed in early June 2016 we found that on seven occasions the member of staff had not arrived at the correct time and one visit had been missed altogether.

Shortfalls in the support provided for people to consistently have enough hydration and nutrition had increased the risk that people would not be fully supported to promote their good health.

This was a breach of Regulation 14 (1) (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said that it was important for staff to receive comprehensive support in order to ensure that they had the knowledge and skills they needed to care for people in the right way. We were also told that staff regularly met with someone senior to review their work and to plan for their professional

development. Some of the staff we spoke with told us that they had not had the opportunity to regularly discuss their work with a senior colleague and said that they would like to do so. However, records showed that most staff had regularly met with a senior colleague to review their work and to resolve any problems.

The registered manager told us that all new staff had received introductory training before working on their own without direct supervision. The training involved new staff attending three days of courses held in the service's office followed by a number of shifts when they shadowed more experienced colleagues. We were also told that new staff were expected to demonstrate that they had successfully learnt how to care for people before completing their probationary period. This was accomplished through being observed when providing care and by completing a workbook. However, both parts of this process were not well recorded and so we could not be confident that new staff had fully benefitted from their introductory training. In addition, we noted that the registered persons had not introduced the Care Certificate which is a nationally recognised way in which to ensure that new staff have all of the knowledge and skills they need.

The registered manager said that staff also received refresher training to ensure that their knowledge and skills remained up to date. However, when we examined records of the training completed by four members of staff we found that each person had not completed significant amounts of the training that the registered manager said it was necessary for them to undertake. These shortfalls were reflected in the lack of competency some staff demonstrated when speaking with us about their work. Examples of this included staff not always being confident about assisting people who were at risk of developing sore skin or who needed to be supported to promote their continence. People who used the service commented about this matter with one person saying, "I don't think that some of the staff do have all of the training they need because they sometimes ask me about quite basic things. I don't mind telling them but it's not really my job is it."

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. The registered manager and staff were following the MCA in that staff had supported people to make decisions for themselves. An example of this was staff gently explaining to people why it was important for them to always have their lifeline alarm within easy reach so that they could summons assistance in an emergency. A relative remarked about this saying, "I've found most of the staff to be conscientious and they look out for my family member giving them little reminders about everyday things such as making sure their smoke detector is working okay."

Records showed that on a number of occasions when people lacked mental capacity the registered manager had contacted health and social care professionals to help ensure that decisions were taken in people's best interests. An example of this involved the registered manager liaising with relatives and health and social care professionals about whether it was safe for someone to continue to live at home even with the support they received from the service. This action had helped to ensure that people who knew the person and who had their best interests at heart contributed to making the right decision.

People said and records confirmed that they had been supported to receive all of the healthcare services they needed. This included staff consulting with relatives so that doctors and other healthcare professionals could be contacted if a person's health was causing concern. Speaking about this a person remarked, "The staff have gently nagged me to call for the doctor when I've been off colour when otherwise I probably wouldn't have bothered."

Requires Improvement

Is the service caring?

Our findings

People and their relatives voiced different opinions about whether they received a caring response that met their needs and expectations. A majority of people were complimentary. One of them said, "I've found the staff to be excellent, nothing is too much trouble for them and they'll often do little extras." Another person said, "I couldn't ask for better care from the staff who visit me."

However, some people expressed significant reservations about this matter and gave examples that concerned them. A person who used the service told us that staff often spoke across them as if they were not there. The same person also complained to us that on one occasion a member of staff had used offensive language when describing the care they were providing. In relation to this we even noted an instance when offensive language had been used by the service in written information that described how staff were to care for a person.

Another concern involved staff not always respecting people's wishes with respect to maintaining good standards of personal hygiene. We were told that staff sometimes did not wear their uniform and that on occasions staff did not use personal protective equipment such as disposable gloves and aprons. A particular example of these concerns involved a person who told us that staff routinely assisted them to prepare sandwiches as their lunchtime meal. However, one of the staff concerned was said to often arrive with dirty hands and fingernails. We were told that in-spite of being asked to wear protective gloves they had not done so because they did not have any to use. The person said that even after they bought a supply of gloves themselves the member of staff still declined to use them. This person said that they had then chosen not to have their lunchtime sandwiches made for them when that particular member of staff completed their lunchtime visit.

People also voiced reservations about staff arriving smelling of cigarette smoke. We were even told that there had been examples of staff rolling their own cigarettes and wanting to smoke in the home of someone who did not smoke themselves. A person remarked about this saying, "I don't smoke and hate the smell of it. I never let anyone else smoke in my home so why should I let the care workers. But really, they shouldn't ask as they know I don't smoke and then I feel I'm being difficult when I refuse."

Other concerns included women who told us that male members had sometimes arrived to complete visits when they had specifically said that they only wanted their close personal care to be provided by a female member of staff. Two women told us that on occasions this had resulted in them having to decline being assisted to take a bath or shower because they did not wish to be seen when undressed. One of them said, "I don't like it when they send a man to do my personal care and I'd rather not have it all than be embarrassed undressing in front of a man. I shouldn't be put in that position." In addition to this a person told us that they had been frightened when they woke up to find a male member of staff who was unknown to them in their home. Another person said that they could not understand a member of staff who did not have English as their first language. They said, "What can you do I've told the team leader but the member of staff in question still keeps arriving here. I just can't follow what they're saying so I just sit their quietly and nod hoping that's the right response. I'm glad when they go. Other staff are fine."

Records showed that most people could express their wishes or had family and friends to support them. However, for other people the service had not fully developed links with local advocacy services that could provide guidance and assistance. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. We noted that the registered manager did not know about local agencies that provided an advocacy service. In addition, there were no examples of people being assisted to access advocates even though the registered manager acknowledged that this would have assisted some people who had made formal complaints to the registered persons about the service they had received.

Staff told us that they had received guidance about how to correctly manage confidential information. However, people who used the service expressed concerns about this matter. We were told that some staff were openly critical of their employer and made disparaging remarks about named colleagues. We were also told that some staff sometimes discussed the care they were providing for other people in a way that identified who they were talking about even if their names were not mentioned. Other people said that they were concerned to be told by staff that there had been occasions when local team meetings had been held in a busy fast food restaurant. A person said, "This doesn't sound very professional does it. I don't want staff talking about me and my care in a place where they can be easily overheard."

Requires Improvement

Is the service responsive?

Our findings

The registered manager said that each person had been provided with a written care plan that described in detail all of the assistance they had agreed to receive. We were also told that these care plans specified when visits to people's homes should be completed. However, we found that this account did not accurately describe people's experience of how their care was managed. During our visits to 18 people at home we found that five of them had not been provided with a care plan at all. Of the remaining 13 people only one person had been provided with a care plan that described in suitable detail the care to be provided. Even that care plan contained incorrect information about the times when visits should be completed. People and their relatives consistently voiced their displeasure at this situation. A relative summarised some of these concerns saying, "I've asked to be given a care plan on numerous occasions and absolutely nothing happens. It can't be right that a service just doesn't respond." A person also commented on this subject saying, "I can't tell you when my visits should be completed because no one has ever told me and I don't have anything in writing. If you're at home on your own it's quite an isolating experience which I think Bloomsbury doesn't always understand."

We were also told that each person had been regularly consulted about the care they received involving a senior person calling to see them or telephoning them. However, this arrangement was not well organised. When we visited the service's office we asked to see a selection of the records that the registered manager said were kept of each time a review meeting had been held. Most of the records in question could not be located and it was not clear if the reviews in question had been completed. People and their relatives consistently told us that they had not been invited to review the care provided and they considered this to a significant shortfall in how the service was organised. Speaking about this a person said, "No, I've never been asked to review the way I'm cared for. I think it's very bad really because how can Bloomsbury know how things are going with my care if they don't ask me." A relative remarked on this subject saying, "I don't think that the service is responsive at all. If you make a fuss and speak to the manager then he's polite and helpful but the onus is always on me. No one has ever approached me first and overall I do feel that it's a very basic set up where the day to day challenge of arranging visits takes over from the niceties of actually involving people in their care."

Most people and their relatives told us that they were not satisfied with the way in which staff were allocated to complete their visits. In particular, criticism focused on the fact that people were not informed about which members of staff were going to call to see them on a particular day. A person commented on this saying, "I never know who's going to call and I don't see why I can't be told in advance as Bloomsbury must have some sort of plan for each week." Another person remarked, "I just wish I knew who was coming each day." Other people said that even when they had been told informally by a member of staff that they would be calling again on a particular day, the arrangements were often changed at short notice. A relative reflected on this saying, "Actually, it is quite important for my family member to know who will be arriving because it reduces their anxiety. Too often with Bloomsbury the attitude is that it's okay as long as someone turns up. The service to me feels rough and ready."

A further issue that concerned people was the arrangements made to notify them when staff had been

delayed so that their visit was going to be significantly late. The registered manager said that when this occurred staff were expected to telephone people so that they could be reassured that their visit would be completed. However, staff told us that they did not routinely do this and people consistently told us that they usually just had to wait without any information about when to expect their next visit to take place. A person criticised the situation saying, "I need help to use the toilet and rely on the staff turning up roughly on time. On many occasions they've been late, no one has contacted me and I've been desperate to use the bathroom. I can't tell you how upsetting it is and Bloomsbury knows it but still the problems continue." Another person remarked, "No I never get a phone call stating they are going to be late". A relative also remarked on this matter saying, "I think that there's quite a casual attitude to this in the service. My family member has contacted me several times when their carer has been very late. My family member has been upset because they're waiting and don't know if the carer's going to turn up at all. Being at home on your own and waiting without knowing must be a horrible experience. The service just isn't good enough."

However and in-spite of the various reservations we have described, most people did consider that staff usually provided them with the basic care they needed. This included assistance to wash and dress, promote their continence and complete household tasks such as making their beds. We looked at the records that staff kept of each visit to double check this matter. Although most of the records were incomplete and some were partly illegible, in general they confirmed that people had been given most of the assistance they needed and expected to receive. A person summarised the view that was generally expressed to us when they said, "Once the carers are here even if they're late or a bit rushed, they do what they have to do. It might be basic and hurried but on most days I sort of get the help I need to manage at home."

People who used the service and their relatives had received a document that explained how they could make a complaint. The document included information about how quickly the registered persons aimed to address any issues brought to their attention. A number of people and their relatives spoke to us about having made a complaint to the registered persons and all of them were critical about their experience. A relative said, "I've given up to be honest with you. When the service first started I called the office on numerous occasions. Often no one even answered the telephone and even when they did no one had the courtesy to call me back. Recently things have got a bit better but I still don't have confidence in Bloomsbury to sort issues out." Relatives also commented on this subject with one of them saying, "I actually don't consider the service to have a complaints procedure at all. How can it have one when no one responds or you wait weeks for a response and then even when you do get a response nothing at all changes."

We were told that the registered persons had an internal management procedure that was intended to ensure that complaints could be resolved quickly and effectively. However, the registered manager was not able to give us a clear account of the number of complaints that had been received since the service was registered in January 2016. In addition, records given to us by the registered persons of the complaints they had received were not clear. Also, they did not correspond fully with our own records of the complaints that had been made to the registered persons about the services they had provided.

The registered persons' records showed that most of the complaints they had received had been made indirectly to the local authority either in its role as commissioner who purchases services from the registered persons or in its role as the safeguarding authority protecting people from harm. We reviewed a selection of these complaints and noted that people had repeatedly voiced concerns about incorrect visit times, missed visits, inadequate completion of care tasks and the difficulties people had experienced when trying to contact the registered persons. Although the registered manager said that each complaint had been fully investigated and resolved we were not able to be confirm this account. This was because when we reviewed documents describing how four complaints had been managed we found some key records to be missing or

incomplete. In the absence of these records the registered persons were not in a position to reassure us that they operated a robust procedure to manage, resolve and learn from complaints.

Requires Improvement

Is the service well-led?

Our findings

Some of the people with whom we spoke were complimentary about how well the service was managed with a person saying, "I think it's pretty well run. I get all of my visits, the staff are fine what is there not to like". However, other people and their relatives strongly criticised the registered persons' management of the service. Speaking about this a relative remarked, "Given the dire standard of service we have received it's simply not possible to conclude that the Bloomsbury has any recognisable quality management system. You can't have such a poor service and a good quality system can you. A reasonable person could not conclude that Bloomsbury is well managed."

The registered persons said that there were robust arrangements to ensure that people reliably received all of the care they needed. These arrangements included a senior member of staff completing 'spot checks' at least once every four months. We were told that these checks involved calling to a person's home when a member of staff was present to see how well care was being provided. However, we found that this process was not well organised. Some of the staff with whom we spoke said that they had not experienced a spot check taking place. In addition, when we looked at the records of the spot checks completed for four member of staff they were either missing or did not show that the checks had been completed as frequently as planned. We were also told that a detailed audit was completed each month of key records relating to the administration of medication and to the delivery of care. However, we also found that this system was not working as intended. When we looked at the records of these checks we were concerned to find them to be disorganised, incomplete or missing altogether. The registered manager told us that a new weekly check was being completed of the electronic call records completed by staff when they undertook a visit. It was said that this was necessary to identify problems leading to mistimed and missed visits. However again, there was no evidence to show that these checks were being completed in any recognisable way.

The registered manager told us that any accidents or near misses that occurred when people were receiving care were carefully analysed and recorded so that lessons could be learned to help prevent them from happening again. However, we were not able to clearly establish how many incidents had occurred since the service was registered. In addition, we were not provided with any records to demonstrate how well any necessary changes had been introduced. In the absence of this information we could not be assured that people who used the service were being suitably protected from the risk of accidents and injury.

The registered persons said that they had robust systems to receive and act upon feedback from people and their relatives. These measures included people being invited to complete an annual quality questionnaire and speaking with both of the registered persons by telephone. Although we noted that all of these measures were in place, we found that effective action had not usually been taken to address people's concerns. Examples of this involved people being critical about a number of problems that they had experienced since the service was registered and which we have already identified in this report. These issues included visits not being completed at the right times, staff not spending the correct amount of time with them, not being consulted about their care, staff not always correctly following good hygiene procedures and the ineffective management of complaints. A person commented on this matter saying, "I almost didn't bother with the questionnaire because there have been just so many problems with the

service and I'm weary with it and I'm not confident it can be changed." Another person said, "I think I filled in a questionnaire once but nothing is different."

We noted that the registered persons had not provided the leadership necessary to enable people to benefit from staff receiving and acting upon recognised good practice guidance. Examples of this included them not engaging with initiatives such as the 'Social Care Commitment' and 'Dementia Champions'. These and other schemes are designed to promote high standards of social care by championing the key features of person-centred care. By not actively engaging in good practice initiatives the registered persons had reduced the opportunities staff had to reflect upon and develop their professional practice to promote positive outcomes for people who used the service.

Shortfalls in evaluating the service had reduced the registered persons' ability to safely provide people with the care they needed.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered persons are required to tell us about significant events that happen in the service. These include any concerns that someone may have been subjected to abuse and accidents resulting in significant injury. Records showed that since the service was registered there had been a number of these events none of which had been notified to us in the correct way. This had reduced our ability to establish what had happened in relation to each event so that we could decide if any further assurances needed to be sought to ensure that people who used the service were kept safe.

This was a breach of Regulation 18 (2) (a) (iii) (e) (f) (g) (i) of the Care Quality Commission (Registration) Regulations 2009.

Staff told us that there were various arrangements at local level that were intended to help them to undertake their duties. These arrangements included being invited to attend regular team meetings when they could to discuss their work and iron out any problems. However, some staff doubted the value of these meetings. This was because they considered that problems such as unrealistic expectations of the number of visits they could complete could not be changed because they resulted from how the service was organised at central level. Speaking about this a member of staff remarked, "Quite simply. If we're given too many visits to do at peak times and don't have enough staff something has to give and it often ends up in late visits and sometimes in us having to rush. It's not complicated it's just basic maths and I don't think Bloomsbury fully understands it."

Staff were more consistently positive about the arrangements that had been made to enable them to speak out if they had any concerns about another staff member. They were confident that they could approach a team leader or the registered persons, would be listened to and that action would be taken if they raised any concerns about poor practice.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Care Quality Commission (Registration) Regulations 2009: Notification of other incidents. The registered persons had not notified the Care Quality Commission of specific events that had occurred that related to the service it provided.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA (Regulated Activities) Regulations 2014: Care and treatment. The registered persons had not ensured that care and treatment was provided in a safe way including the management of medicines.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA (Regulated Activities) Regulations 2014: Nutrition and hydration. The registered persons had not ensured that people's nutrition and hydration needs were reliably met.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good governance. The registered persons had not protected people who used the service against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of the service provided.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA (Regulated Activities) Regulations 2014: Fit and proper persons employed. The registered persons had not ensured that recruitment procedures operated effectively to ensure that persons employed could demonstrate satisfactory evidence of conduct in previous employment.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA (Regulated Activities) Regulations 2014: Staffing. The registered persons had not ensured that sufficient members of staff were deployed to reliably meet people's needs for care.