Tailor Maid Care Solutions Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 25 and 29 January 2018. Tailor Maid Care Solutions Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It currently provides a service to older adults. Not everyone using Tailor Maid Care Solutions Limited receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

A registered manager was present during the inspection. 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. We were informed that the registered manager was leaving the service on 9 February 2018. The new manager was present during the inspection. They were in the process of becoming registered with the CQC. We will monitor this application to ensure any delays are acted on in a timely manner.

At the time of the inspection, Tailor Maid Care Solutions Limited supported 82 people who received some element of support with their personal care. This was the service's second inspection under its current registration. During our previous inspection on 6 January 2016, we rated this service as 'Good'. However, due to the concerns identified within this report we have changed the overall rating to 'Inadequate'.

During this inspection, we found on-going concerns with the punctuality of the staff. Staff did not always arrive on time and this placed people at risk of harm. People's medicines were not always managed effectively. The risks to people's safety had been assessed; however, people's care planning documents were not always reflective of those risks. Accidents and incidents were not investigated and recorded appropriately to identify themes to reduce to the risk of reoccurrence. There were not enough sufficiently skilled and experienced staff to meet people's needs. Effective processes were not always in place to ensure any allegations of abuse were actively investigated and reported to the relevant bodies such as the CQC or the local authority. People felt staff understood how to reduce the risk of the spread of infection in their home, but records showed staff had not received infection control training. People told us they felt safe when staff supported them in their homes.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service do not support this practice, clearer documentation was required to ensure all decisions made clearly evidenced that they were in each person's best interest. The majority of staff training was up to date. However, staff were not provided with regular supervision, this meant opportunities to monitor and improve staff practice may have been missed.

People's physical, mental health and social needs were assessed prior to commencing using the service;

however support had not always been requested from health and social care professionals to aid them in providing care in line with current legislation and best practice guidelines. When people required support with their meals, staff were available to help them. People were not always provided with information about how they could contact other health or social care agencies, such as chiropodists and opticians. This limited people's ability to make informed and independent decisions about their own care needs.

People felt staff were caring however, there were concerns raised by some relatives that their family members did not always receive the care they needed. People were not always introduced to new members of staff before they provided them with personal care. Information to support staff with communicating with people living with dementia was limited. People told us they had a care plan and had contributed to the information recorded in it. People were not provided with information if they wished to speak with an independent advocate. People and relatives felt staff treated them or their relatives with dignity.

Prior to starting with the service, assessments were carried out to ensure people's needs could be met. However, when people's care records were written, they did not always reflect these assessed needs, meaning people may not always receive the support they needed. Efforts had been made to review people's care needs with them and to act on their views. People's care records contained details about their personal preferences and life history to assist staff with supporting them in the way people wanted. Steps had been taken to provide information for people with a sensory impairment in a way they could understand, however further development in this area was needed. People's spiritual and cultural needs had been discussed with them. Most people understood how to make a complaint although some felt their concerns were not always responded to appropriately.

We have made a recommendation about improving the quality of people's care plans.

This service is currently suspended with local authority commissioners. This means they cannot currently provide care and support for any new people until they have made sufficient progress with the actions requested by the commissioners. Quality assurance processes were not effective in ensuring the risks to people's health, safety and welfare were addressed. The representatives of the provider did not have effective input into the management of this service. The service was managed by a well-meaning but inexperienced registered manager, who did not have the skills or experience to manage the service effectively. This has contributed to the poor experience some people have received. People's care records were not always handled and stored securely. The registered person had not always ensured the CQC were notified of incidents that had or could have an impact on people's health and safety.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff did not always arrive on time and people's medicines were not always managed effectively.

The risks to people's safety had been assessed however; people's care planning documents were not always reflective of those risks.

Accidents and incidents were not always investigated appropriately.

There were not enough sufficiently skilled and experienced staff to meet people's needs.

Effective processes were not always in place to ensure any allegations of abuse were actively investigated and reported to the relevant bodies.

People told us they felt safe when staff supported them in their homes.

People felt staff understood how to reduce the risk of the spread of infection in their home, but records showed staff had not received infection control training.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act 2005 had not been followed when decisions were made for people.

Staff were not provided with regular supervision, this meant opportunities to monitor and improve staff practice may have been missed.

People's physical, mental health and social needs were assessed; however, it was not clear whether support was offered in line with current legislation and best practice guidelines.

People were not always provided with information about how they could contact other health or social care agencies, such as chiropodists and opticians.

The majority of staff training was up to date.

When people required support with their meals, staff were available to help them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People felt staff were caring, although relatives felt people did not always receive the care they needed.

People were not always introduced to new members of staff before they provided them with personal care.

Information to support staff with communicating with people living with dementia was limited.

People were not provided with information if they wished to speak with an independent advocate.

People told us they had a care plan and had contributed to the information recorded in it.

People and relatives felt staff treated them or their relatives with dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People care records did not always reflect their assessed needs.

Efforts had been made to review people's care needs with them and to act on their views. People's care records contained information about their personal preferences and life history.

Some steps had been taken to provide information for people with a sensory impairment in a way they could understand, however further development in this area was needed.

People's spiritual and cultural needs had been discussed with them.

Most people understood how to make a complaint although

some felt their concerns were not always responded to appropriately/

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance processes were not effective in ensuring the risks to people's health, safety and welfare were addressed. The concerns identified during this inspection had not been identified by the quality assurance processes in place.

The representatives of the provider did not have an effective input in the management of this service.

The registered manager was inexperienced and did not have the necessary skills to manage the service well.

People's care records were not always handled and stored securely.

The registered person had not always ensured the CQC were notified of incidents that had or could have an impact on people's health and safety.

Tailor Maid Care Solutions Limited

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 checked 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.

This comprehensive inspection took place on 25 and 29 January 2018 and was unannounced.

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. Prior to the inspection, the Expert by Experience carried out telephone interviews to gain people's views in relation to the quality of the service provided. On the 25 and 29 January 2018, the inspection continued at the provider's office.

Before the inspection, we reviewed information we held about the service, which included notifications they had sent us. A notification is information about important events, which the provider is required to send us by law. We also contacted Local Authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was informed by feedback from questionnaires completed by a number of people using services, relatives and staff. We sent 129 questionnaires out and received 37 responses. These responses pointed out some concerns about staff punctuality and the quality of the care provided which led the inspection team to follow up on these matters during the inspection.

Prior to the inspection, we attempted to speak with 40 people. We successfully spoke with 16 people who used the service and three relatives. During the inspection, we spoke with two members of the care staff, the training officer, an administrator, the registered manager, the new manager and two representatives of the provider.

We looked at all or parts of the records relating to five people who used the service as well as staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas, staff arrival and departure monitoring system, meeting minutes and arrangements for managing complaints.

After the inspection, we asked the new manager to forward us their training matrix and company policies and procedures. These policies included the medication and mental capacity act policies. The manager sent these within the requested timeframe.

Inadequate

Is the service safe?

Our findings

People raised concerns with us about the punctuality of the staff that supported them. One person said, "The timekeeping is poor." Another person said, "They [staff] can be late and often don't let me know. Sometimes they have not arrived at all. I am going to leave as I can't put up with it." Another person told us staff arrived an hour and 40 minutes late. A relative said, "Sometimes the carers don't turn up and it worries me. I worry about people who have no family to speak for them." Another relative told us staff were regularly up to an hour late for their family member's morning call and this caused their family member distress. They told us their family member would start to get themselves up out of bed without staff support, which placed their safety at risk.

There was an electronic logging system in place that recorded when staff arrived at each person's home and when they left. The training officer told us that this enabled the office-based staff to monitor staff punctuality as well as monitoring how long staff stayed for each call. They told us there was no formal policy in place for when a call was regarded as being too late or too early. However, they told us it was accepted that calls 26 minutes or longer outside of the agreed time was regarded as late or early. We were also told by the training officer that not all staff used the electronic logging system and those that did, did not always use it correctly. This meant the records held did not fully reflect the actual arrival times and length of stays.

We reviewed the records that were held and found concerns with staff punctuality and the length of time they remained at each call. For the period 25 November 2017 to 25 December 2017, 15 of the 37 staff employed at the time, arrived at calls on average more than 26 minutes outside of the allocated time. For the period 26 December 2017 to 25 January 2018, 12 of the 34 staff employed at the time, arrived at calls on average more than 26 minutes outside of the allocated time. We noted one person's care plan stated they required a certain medicine to be administered at the same time each day. On four occasions, recorded on this person's daily records we noted staff had attended the person's home either too early, or too late to adhere to this time. We did note for the period 25 October 2017 to 24 November 2017 this number dropped to two out of 40 employed staff, with similar figures for further preceding months.

We noted for the period 25 November 2017 to 25 December 2017, 10 of the 34 staff employed stayed for less than 90% of the agreed time for each call. For the period 26 December 2017 to 25 January 2018, the figures were the same. We noted for one person on five occasions their daily records showed their agreed 45 minute call had lasted between 15 and 27 minutes, with no explanation why. The provider had not ensured processes were in place to ensure robust monitoring of staff arrival and departure times were carried out. The failure to arrive on time and to remain at each call for the agreed length of time could expose people to the risk of harm.

We raised these concerns with the registered manager and the representative of the provider. They acknowledged little had been done to monitor these issues during this period. The representative of the provider told us there had been a high turnover of staff during this period and this had meant the number of staff to complete calls had been significantly reduced. They told us they were confident that as they recruited more staff the impact on people would reduce.

These examples are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The people and relatives we spoke with, or who responded to our questionnaire did not raise concerns with us about how staff supported them with their medicines. One person said, "I have a medication call, they wear gloves and sign to say they have given it, then I sign too."

However, the provider had not ensured the proper and safe management of people's medicines. People did not always receive their medicines when they needed them. After the inspection, we were notified of an incident that had occurred in relation to a person's medicines that could place them at risk of harm. We have discussed this with Local Authority who are investigating this and we will be notified of the outcome.

Prior to the inspection, we received information from the local clinical commissioning group, which stated that care staff had not followed professional guidance in relation to the administration of a person's prescribed medicine. The failure to adhere to this guidance resulted in a procedure the person was due to have, being cancelled and rearranged, as it would have been too dangerous to proceed. We were told by the registered manager the staff member concerned was disciplined and removed from administering medicines until they had retaken their training. However, this placed the person's health and safety at severe risk.

We noted people's medicine administration records and daily records were not always completed in line with the requirements recorded in people's care records. For example, one person's care plan stated the person needed support with their prescribed medicines at 'tea time'. However, the person's daily records stated, 'no meds needed'. It was not clear why these medicines were not needed and whether the person had refused to take them. We also noted the person's preferred way of taking their medicines was not recorded; meaning new staff would be unaware of how to support the person in their preferred way.

Another person's records stated that because of a health condition they needed their medicines to be administered at a specific time of day. We noted the arrival times were generally consistent with the required time. However, there were four occasions in August 2017 when these calls had been between 30 and 75 minutes too early or late. All of these examples placed people's health at risk.

Records showed that all staff employed at the time of the inspection had received training in the safe administration of medicines, although for four of these staff their training was out of date. Spot checks of staff performance in the administration of medicines were carried out, however, due to the high turnover of staff and the limited time some staff had worked for the service, only 9 of the 27 staff had received these spot-checks. The registered manager and new manager assured us that staff competency to administer people's medicines would be reviewed immediately.

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

Risks to people's health and safety had been identified through initial assessment when they first started to receive a service. However, these were not always then further developed into meaningful risk assessments and care plans to enable staff to always support people safely. For example, one person had a condition that could result in them displaying aggressive behaviour to others. This had been identified on their initial assessment before they started to use the service. However, no further assessment of this risk or guidance for staff on how to support the person was in place. This placed the person and others' safety at risk.

Another person had been identified as at risk of choking. Guidance within this person's care plan stated when staff supported the person with eating they should avoid certain foods and prepare a 'fork mashable diet'. The person's daily records showed occasions where the person had eaten toast. We were told the person had the capacity to choose what food they ate, however this was not recorded in their care records. There was also no guidance on how staff should support the person if they did choke. This placed the person at risk of harm.

A third person had been identified as at risk of developing sore skin. No risk assessment had been carried out to determine the best way to support the person to reduce this risk. We found some references in the person's daily records of staff applying cream to one part of this person's body, however, when we spoke with a member staff they told us the cream should be applied to a different part of the body. No body maps were used to show where staff should administer this cream. This placed the person at risk of avoidable harm.

There were no effective processes in place to ensure that when accidents or incidents had occurred that these were appropriately investigated, recorded and actions taken to prevent them reoccurring. We asked the registered manager for a record of all accidents and incidents, which had taken place. They were unable to provide this. They told us when an accident occurred the details were recorded within each person's daily records. We asked the registered manager how they reviewed these to help them to identify any trends or themes. They told us no analysis was conducted. There was also no provider involvement in the review of any accidents or incidents or how they had occurred. There was no process in place to enable the provider to learn from mistakes made and to make improvements where needed. Due to the lack of records in place, we were unable to assess whether appropriate action been taken when accidents or incidents had occurred. The lack of robust recording and reviewing processes placed people at the risk of harm.

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

People told us they did not always get the member of staff they expected during the calls. One person said, "I don't get the same ones [staff] and never know who is coming. It would be better to know." A relative said, "It is varying these days. We sometimes get a regular member of staff, but it seems less often at present. This can be an issue as they don't know [family member] as well and therefore don't pick up on things as quickly."

We looked at the computerised staff rota system to establish how calls were planned and whether the right number of staff were in place for each call. Whilst we could see the appropriate number of staff arrived for each call, having spoken with the registered manager we concluded that there were not currently enough staff to meet people's needs. Calls were often late. During the inspection we repeatedly observed the registered manager try and cover shifts where staff were not available. They told us due to the high turnover of staff over the past two months ensuring each call was covered was not always possible. This resulted in them, or the training officer having to cover a number of shifts themselves, removing them from their office based duties. The registered manager also acknowledged that people did not always receive calls from the staff they expected. The lack of effective and experienced staff, arriving on time for each call, placed people's health and safety.

The representative of the provider acknowledged that staff numbers had been low recently and they were actively seeking to recruit new staff. They told us three new staff were due to commence work shortly once all pre-employment checks had been completed and further recruitment was on-going.

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

Recruitment procedures were in place that ensured the risk of people receiving care and support from unsuitable staff was reduced. Pre-employment checks such as proof of identification, references and criminal record history were recorded before new staff commenced work.

People who responded to our questionnaire and spoke with us during telephone interviews told us that when staff were present in their home, they felt safe. One person described the support they received from staff. They said, "They walk at the side of me when I move about, that way I feel safe. I think they know what they are doing." Another person said, "I feel safe with all of them." 100% of the 23 people who responded to our questionnaire told us they felt safe from the risk of abuse or harm.

People were supported by care staff who understood how to protect people from avoidable harm and how to keep them safe. A safeguarding policy was in place. This policy was designed to protect people from abuse, neglect and harassment. Staff could explain the different types of abuse and the signs they looked for when caring for people in their homes that might alert them the person was subject to abuse. However, effective processes were not always in place to ensure any allegations of abuse were actively investigated and reported to the relevant bodies such as the CQC or the local authority. The registered manager's knowledge of what needed to be reported was poor. Ineffective recording of incidents meant we could not be assured that the CQC or the local authority safeguarding team had been informed when they should have been. This placed people at the risk of avoidable harm.

83%, of the people who responded to our questionnaire and the majority of the people we spoke with told us staff understood how to reduce the risk of the spread of infection when in their homes. Staff had completed training that enabled them to support people with ensuring food was prepared hygienically and safely. However, staff had not completed infection control training to help them to reduce the risk of the spread of infection within people's homes. An infection control lead was not currently in place, however the new manager agreed this would be beneficial and would seek to address this.

Requires Improvement

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA. We found they were not.

On the provider's information return (PIR) sent to us before the inspection we were informed that 15 of the people supported by the service were living with dementia. However, we were informed by the registered manager that no mental capacity assessments had been completed for any person living with dementia. In one person's care records we found their mental health had been recorded as, 'dementia'. We found no other reference to this person's dementia throughout their care records. There were a number of forms signed by the person in areas such as medicines giving staff the authority to manage them on their behalf. We also saw a 'Mental Capacity Act Agreement' had been completed by a member of staff with the words 'not applicable'. There was no way in determining from the records completed whether this person was able to understand the documentation they were being asked to sign, nor guidance for staff in supporting this person with their dementia.

We found further examples. One person had again had their mental health described as 'dementia'. A medicines risk assessment had established that the person was 'unable to remember to take their medication'. However, no MCA assessment had been carried out to determine this conclusion. A number of 'consent' forms were included within the person's care records and these had been completed with the phrase, 'unable to sign', or, 'UTS'. There was no record of who staff had consulted to determine that the decisions made were in people's best interests.

The registered manager had limited understanding of the MCA and how it should be implemented to support people's rights. They had not ensured that where people were unable to make decisions for themselves, that the principles of the MCA were appropriately applied when decisions were made for them. Although staff had undergone MCA training, there was no process in place for reviewing their knowledge to ensure they protected people's rights when supporting them. The records used to determine whether people were living with dementia and were able or unable to make informed decisions were ineffective. This placed people at risk of decisions being made for them that were not in their best interest.

This represented a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not all staff received regular supervision of their role to ensure they were providing all people with effective care and support. The records provided by the training officer showed the more established staff who had been working for the service for a year or more had received a 'spot check' of their practice, supervision and an annual appraisal in the past 12 months. However, newer staff had not received a spot check or

supervision. 13 staff who had been working at the service since October 2017 had received no spot checks or supervision. Three of those staff had been working at the service for six months or longer. The lack of regular supervision of staff could place people's health and safety at risk through unsafe care and support being provided. The new manager told us they would be reviewing the training and supervision frequencies and would address these concerns immediately.

74% of the people who responded to our questionnaire felt that staff had the skills and experience needed to support them. The people we spoke with had mixed views with some agreeing, but some raising concerns. One person said, "I am confident they would know what to do in an emergency." A relative said, "On the whole the training seems fine. The staff usually respond to what I say to them." However, another person said, "They [staff] just seem to be a number these days. They haven't got the training and respect we had back in the day." Another person said, "Some carers are better than others at some things like giving me a wash." A staff member we spoke with told us they had some doubts about the ability of some staff to carry out their role effectively.

We noted staff had received training in areas deemed mandatory by the provider such as medication, moving and handling and safeguarding. When staff commenced their employment, they also completed training in other areas such as, dementia awareness and pressure area care. Some staff new to the service were also in the process of completing their Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

The majority of staff training was up to date, however, from the records provided, we noted three members of staff had not received an annual update for their medicines, moving and handling and medicines training. The failure to ensure all staff are suitably trained could place people's health and safety at risk.

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

People's physical, mental health and social needs were discussed with people and/or their relatives prior to them starting to use the service. This was to determine whether each person's needs could be met by the service and for more complex needs, whether support or guidance was needed from other professional bodies. However, records showed that when people's needs had been identified, the provider had not always sought professional guidance to ensure care and support was provided in line with current legislation and best practice guidelines. For example, a person had been diagnosed as having schizophrenia yet there was no best practice guidance in place for staff to follow to ensure they could support the person effectively.

The registered manager told us it was rare that people used other services at the same time as Tailor Maid Care Solutions Limited. We did note in people's records that people's GP's had been contacted when they had felt unwell. However, people were not always provided with information about how they could contact other health or social care agencies, such as chiropodists and opticians. This may limit people's ability to make informed and independent decisions about their own care needs.

People's care records contained information that would be used if they required a visit to their hospital or other health or social care service. However, due to the lack of detailed risk assessments that were in place, we could not be assured that the information was reflective of their current health and support needs. This meant people may not have received the appropriate care and support from services when needed.

Due to the type of service provided some people did not require the support of staff with meal preparation

or eating their meals. Some were able to do this for themselves or had relatives who would support them. Where people did receive support from staff, they told us they were happy with the way supported them. Some people told us they had meals prepared by staff. This was mostly frozen meals that were reheated by staff. Breakfast and sometimes sandwiches were prepared by staff and people told us they were asked what they would like to eat.

One person said, "I have frozen meals that they [staff] put in the microwave. I tell them what I want that day. They also do a sandwich for me and will leave a drink out." Another person said, "I am having bangers and mash today which I am looking forward to. Sometimes I'm not bothered to eat and [staff member] will make me a frothy coffee."

Care records contained guidance for staff on how to support people with making healthy food and drink choices. People's food likes and dislikes were also recorded. Where staff prepared food and drink for people this was recorded. When people had eaten their meals this was recorded in their daily records.

Requires Improvement

Is the service caring?

Our findings

We received some concerns from relatives who had responded to our questionnaire. One relative said, "I do not feel that my relative is being fully cared for in the way that I would like or feel is necessary. For example, my relative is not washed regularly and does not always have their clothes changed regularly." Another relative said, "They [staff] seem unobservant, like not noticing if [my relative] is wearing appropriate clothes."

48% of the people and 62%% of relatives who responded to our questionnaire told us they or their family members were not always introduced to new staff members before they started to provide care and support. We also received mixed feedback from the people we spoke with during our telephone interviews. One person said, "There is no list [of staff] and at the minute I get a group of carers, there seem to more and more [staff] leaving. They don't all introduce themselves and I have to ask which isn't nice really." This meant people did not always feel their views were valued and respected. A member of the care staff told us they had attended calls without knowing anything about the person they were there to support. The registered manager told us the process was for new members of staff to shadow more experienced staff and to be introduced to the people they would be supporting. However, they acknowledged that this recently had not always happened. The new manager assured us that when the new staff were recruited, all would be introduced to the people they would be caring for.

People had varying communication needs with some people living with dementia. Care records contained limited information for staff to communicate effectively with people and to enable them to engage with some people in meaningful conversation. However, for people who could communicate the views verbally to us, they told us they had formed positive relationships with the staff who supported them.

People told us staff respected their opinions and did not do things for them without their consent. One person said, "They are pleasant with me and do what I need."

Processes were in place to obtain people's views about their care. People told us they had a care plan and had contributed to its completion. One person said, "There is a book that tells staff what to do. I think it reflects my needs, well they do everything I want." Another person said, "They are all pleasant with me and do what I need. They sign the book each time to say it is all done."

Records showed telephone interviews were carried out with people, with people's views sometimes gained in person from visits by the registered manager or other office based staff. Where people were unable to communicate their wishes, relatives were consulted. Information was not currently provided for people if they wished to speak with an independent advocate about their care, or, if they wanted to speak with an advocate to act on their behalf. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. We were told by the new manager this information would be provided in an improved service user guide for people who used the service.

We asked the registered manager whether people had personal preferences that needed to be taken into account when scheduling staff rotas such as cultural or religious needs or if they had preferred staff. They told us that people who had preferences for certain staff members were accommodated wherever possible however, this had not always been possible recently.

The people we spoke with were largely positive about the staff who supported them. People felt that staff were kind to them and treated with them respect. One person said, "They are all nice people and I really appreciate that they do for me." Another person said, "They are very kind and ever so good. They are very respectful and support my independence."

96% of the people and 89% of the relatives who responded to our questionnaire felt that when staff supported them or their family member, they were treated with dignity and respect. The majority of the people and relatives we spoke with during our telephone interviews agreed. One person said, "They treat me with respect and we get along well." Another person said, "My main carer is very respectful. We have got to know one another and talk about our families." Another person praised the staff who attended their home but also described their visits as "a mad rush." One person raised concerns that their privacy was not always respected by staff and this compromised their dignity on occasions.

Requires Improvement

Is the service responsive?

Our findings

People's care records were inconsistently completed and did not always contain sufficient guidance for staff to support people with their assessed needs. Assessments had been completed prior to commencing with the service and people's current health needs were recorded however detailed care planning documentation was not always then included in people's care records. People living with conditions such as dementia, schizophrenia or depression did not have guidance in place for staff on how to support them to be able to respond effectively their needs.

A member of staff who responded to our questionnaire told us when they had raised concerns regarding people's care needs they had little support from the office based staff. They also said, 'When issues have been raised regarding service users there is very little to no feedback from the office, when asking about new service users you just get told to read the care plan which on occasions has not yet been delivered to the service user.' Another member of staff we spoke said, "Care plans are not always in place and do not always contain sufficient information about how to support people." They also gave us an example where a person was living with dementia and the information about supporting this person to eat did not reflect the person's needs.

We recommend that the provider seek advice and guidance from a reputable source to ensure that all care plans are reviewed and updated to accurately reflect people's current care needs.

We noted attempts had been made to carry out reviews of people's care and some people told us they had received visits from office based staff to discuss their care needs. After the inspection the new manager forwarded us a new document which would be used to review people's care records as well as gaining their views about the care provided. This will include reviews of risk assessments and care plans, as well as a six week review for people who had started to use the service, with a six month and annual review also taking place.

We saw people's care records contained details about their personal preferences and their life history. Care plans had also included the role of staff in helping people to maintain independence. This included the level of support people needed when personal care was provided. 87% of people who responded to our questionnaire told us the support they received from staff helped them to remain independent.

Some people supported by the service had a mental or physical disability. The registered manager told us they were confident that no person was discriminated against because of their disability, ensuring all people were treated equally by staff.

The registered and new manager had limited knowledge of the Accessible Information Standard. The standard ensures that provisions were made for people with a learning disability or sensory impairment to have access to the same information about their care as others, but in a way that they could understand. We saw some steps had been taken to support people with a sensory impairment. Larger print had been used in some documentation in parts of the service user guide; however, care-planning documentation was all

recorded in small print. This would make it difficult for people who were visually impaired to read. Having discussed the standard with the registered and new managers, they told us they would review how information was provided for people to ensure information was accessible for all.

People's care records showed their religious and cultural needs had been discussed with them and support was in place from staff if they wished to incorporate these into their life. The registered manager told us people did not currently have any specific religious or cultural needs that they needed staff support with, but they would ensure if people needed support, this would be provided. Records showed staff had completed equality and diversity training and the staff we spoke with could explain how they ensured people's human rights were respected.

57% of the people who responded to our questionnaire and all of the people we spoke with during our telephone interviews told us they knew who to contact if they needed to make a complaint. We received mixed views from people with the response they received. One person said, "You can ring the office if you need to complain about something. Sometimes you have to wait to be answered but it's not bad." One person said, "I am not sure they really listen. I requested they didn't send [staff member] again, but they did." Another person said, "The organisation [in the office] is rubbish. I always have to chase them. I am not happy with this company and will be looking for somewhere else."

The registered manager told us that they tried to ensure that when complaints were made they were investigated and that people received a response. We viewed the provider's register of complaints and saw when mistakes had been made they had written to or called the person to apologise and to explain how they would put things right. However, there was no oversight of the complaints to identify and act on any themes or trends. The new manager told us this would form part of improved future quality assurance processes.

Inadequate

Is the service well-led?

Our findings

This service is currently suspended with local authority commissioners. This means they cannot currently provide care and support for any new people until they have made sufficient progress with the actions requested by the commissioners. We have been in regular contact with the commissioners and will continue to do so until sufficient improvements are made and all required actions are completed.

The quality of the service people received from Tailor Maid Care Solutions Limited was placed at risk due to the lack of clear management and overall planning of care provision. The representatives of the provider were not aware of the issues raised within this report and lacked awareness of what was happening at the service. For the issues they were aware of, not enough had been done to ensure plans were in place to address them and to offer sufficient support to current management staff to carry out their role effectively.

There were widespread areas of concern that were having or could have a direct impact on the quality of the service people received. The concerns included a lack of awareness of the MCA and how it should be implemented to ensure people's rights were protected. Risk assessments and care planning documentation did not always reflect people's care needs. There was ineffective monitoring of staff arrival times and the length of time they stayed at each call. There was a lack of recording and analysis of accidents and incidents that occurred, with an inconsistent approach to staff training and supervision and concerns that office staff did not always act on complaints raised.

The representatives of the provider told us they did not have previous experience of adult social care and placed their trust in the running of the care provision side of the business to the nominated individual. The nominated individual we were told left the service in December 2017. They told us they had placed too much trust in this person's ability to manage the service, along with the registered manager and had not effectively addressed issues and concerns they had with them. They acknowledged that their lack of oversight over the care provision side of their business had contributed to the current failings.

The service was managed by a registered manager who tried to do their best for the people they supported. However, we asked the registered manager about the process they would follow if they needed to report concerns about people's safety to external agencies. They were unable to explain what they would do. They also did not have an understanding of the requirements of their role as a registered manager with the CQC to ensure they reported all notifiable incidents. The registered manager, whilst well meaning, lacked the skills, experience and expertise to manage the service effectively. This lack of experience has contributed to the significant failings in this service.

Quality assurance processes were ineffective in addressing any of the concerns identified during this inspection. The registered manager was unable to explain how they ensured that processes were in place to provide people with consistently high quality care and support. They were not fully supported by the providers in carrying out their role. No quality assurance processes were in place to assess the on-going competency of the registered manager and to address the growing areas of concerns throughout the business. Not all staff were held accountable for poor performance or failing to carry out their role in line

with the provider's aims and values. The lack of robust quality assurance process had enabled the decline in standards to continue and not acted upon, which has affected the quality of the service people received.

People's care records were not handled securely in the provider's office. When we arrived, we noted a large box of paper records were stored in the corner of the office. We were informed by the new manager that these records were "waiting to be burned." They told us these were records that were for people who had not joined the service or old templates and blank documents that were no longer used. However, due to the large of paper stored in this box we could not be assured that people's personal information had not been added to this uncovered and unsecured box. When we returned to the office for the second day of our inspection, we were informed that the box of records had been "burned". We raised concerns with the registered manager that people's records were not stored safely and line with the requirements of the Data Protection Act. We were assured by the new manager that this practice would stop immediately. This unorganised approach to the storing and destruction of people's records could place people's right to privacy at risk.

Some people told us they had been given the opportunity to give feedback about their care needs however, others had not. No-one we spoke with could recall being asked to complete a questionnaire about their views on how the service could be developed and improved. One person said, "I've had no questionnaire, and nobody has been out to see if all is well or if I need anything else." Others told us they were not aware who was currently managing the service. One person said, "I don't know who the manager is, nobody has ever been in touch." Another person said, "I don't know who the manager is. No one has been out to discuss any issues. I have had no questionnaires and cannot remember being asked if I need anything else, except by the staff on the day. I don't think my care plan has been updated since I started with the company a year ago".

These examples are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered persons are required to notify the CQC of certain changes, events or incidents at the service. Records showed that we had not always been notified appropriately. We reviewed the provider's records and found a number of incidents that had been investigated by the local authority safeguarding team; however, the CQC had not been notified. The submission of these notifications is important as it enables the CQC to assess whether a service is taking, or has taken, appropriate action when there is an allegation of abuse or if a person has been seriously injured. We discussed this with the registered manager. They acknowledged their process for submitting these notifications had not been followed.
This was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

The majority of people and relatives told us they knew whom to contact at the provider's office if they needed to discuss their or their relative's care. However, whilst some people felt communication with the office was effective, others raised concerns that office staff did always act on their wishes. One person said, "The office staff are very good there are no problems contacting them." Another person said, "I don't ring the office as [my family member] sees to it all, but it works well so it must be organised. All the staff are nice, no problems." Alternative views included; "You ring the office and sometimes they don't answer so you have to ring back." Another person said, "I tell [staff member] the times for example if I need an early call for a hospital appointment. I did that and no one turned up at all." Another person said, "The [staff] come when they want not when I want them to. I have spoken to the owner a couple of times and he does not seem to know what is going on. He does not seem to be on top of things. They just don't seem to be bothered at the company."

We raised these concerns with the representative of the provider. They acknowledged that more needed to be raise the quality of the service that people received. They told us that is was clear that the standards they expected of all staff had not met the required level. They told us more care staff as well as a new manager have been recruited. The new manager is currently applying to become registered with the CQC. The representatives of the provider have told us they will be applying to the CQC to become as 'registered person'. This is a person who has overall oversight for the running and management of the service. After the inspection, we were provided with new care planning and risk assessment documentation, as well as assurances about the future recruitment, training and supervision of the staff. However, we are not currently assured that these will be effective and sustainable.

The staff we spoke with gave us mixed views about their roles and whether they felt valued by the provider. One staff member said, "I feel supported, and the manager is responsive to my concerns. Although I do think there could be a few improvements." They also told us they were "aware of the people upstairs" and told us they thought they sorted out staff issues. They felt supported by the provider. However, other staff raised concerns with us. One staff member said, "I love my job but I feel let down. The service is not well led at the moment especially the last couple of months." They also told us they had not been informed about the recent changes with the management team and this had affected staff and the people they supported. They went on to say, "I have felt really low as I am not able to achieve in my job at the moment." Another member of staff felt that the service lacked organisation and some staff were left to do, as they wanted to. They said, "It does appear that the rotas are not fully thought out in advance and some care staff opt to visit certain service users to suit their own preference without too much notice or consideration for others."

The representatives of the provider acknowledged that staff morale had reduced over the past few months, which coincided with the changes in management, and some of the care staff leaving. They told us they planned to arrange a series of meetings with staff to reassure them that plans to improve were being put in place and they hoped this would start with the new manager.

The provider had not ensured that effective working relationships had been formed with other health and social care agencies. This meant that when people's needs changed staff were not always equipped to support people in line with other health and social care agencies recommendations and guidance.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating at the office and on their website.

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 18— 1.Subject to paragraphs (3) and (4), the registered person must notify the Commission without delay of the incidents specified in paragraph (2) which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity. 2.The incidents referred to in paragraph (1) are— a) any injury to a service user which, in the reasonable opinion of a health care professional, has resulted in— i. an impairment of the sensory, motor or intellectual functions of the service user which is not likely to be temporary, ii. changes to the structure of a service user's body, iii. the service user experiencing prolonged pain or prolonged psychological harm, or iv. the shortening of the life expectancy of the service user; b. any injury to a service user which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional in order to prevent— I. the death of the service user, or ii.an injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a); e. any abuse or allegation of abuse in relation

to a service user;

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for consent 11.—(1) Care and treatment of service users must only be provided with the consent of the relevant person. (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (g) the proper and safe management of medicines;

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing 18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must—

(a) receive such appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform