Proline Care Limited

# Proline Care Limited - 4th Floor

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

This announced inspection took place on 14 and 15 March 2017. The service is a domiciliary care service and provides care and support to 160 people in their own homes.

At our last comprehensive inspection in October 2016 we found that the care and support people received from the service was inadequate. This was because people were not kept safe from the risk of actual and potential harm. Known risks to people were not properly assessed, reviewed or managed. There were insufficient numbers of staff available to meet the needs of people and people often experienced late or missed calls. The management of medicines was not safe which meant there was a risk that people did not get their medicines as prescribed. We also found that the registered provider had not ensured that all people who used the service were treated with dignity and respect and was not ensuring the care and treatment provided was with the consent of the relevant person. In addition the registered provider did not have robust systems in place to monitor the quality of the service and did not ensure that all complaints were investigated and responded to. Following the inspection we met with the registered provider who submitted an action plan detailing how they would improve to ensure they met the needs of the people they were supporting and the legal requirements.

We undertook this announced inspection on 14 and 15 March 2017 to check that the provider had followed their own plans to meet the breaches of regulations and legal requirements. We found that the registered provider had addressed some of the concerns that we had identified at our last inspection. However there were areas of further improvement required in respect of staffing levels, management of medicines and governance of the service.

There was a registered manager in post who was present throughout the inspection. 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.

Our inspection identified that whilst some changes and improvements had occurred within the service outstanding issues continued to place people at risk of receiving a consistent safe service at all times. Some people told us that the service had improved in some areas. Others told us it was not good in that there was a lack of staff and that people did not always know which staff member was to provide their care and at what time during weekends.

People told us that they felt safe with the staff who provided their care and support. People were not always protected from the risk of unsafe practice because risks associated with their health conditions had not consistently been assessed and staff did not have sufficient guidance on how to support people safely. There were insufficient staff numbers consistently available to meet people's needs in a timely manner. Some aspects of the management of medicines had improved but we could not consistently determine

from some records that people received their medicines as prescribed.

People told us that on day to day matters staff sought their consent before caring for them.
Records showed that consideration was given to people's needs under the MCA in care planning. We were unable to determine if staff had got the appropriate up to date knowledge and skills. People told us that they enjoyed their food and had a choice of food to ensure a healthy diet. People were supported to maintain their health.

People told us that they were supported by staff who were compassionate and caring. Staff we spoke with demonstrated a positive regard for the people they were supporting. Some decisions people had made about how they wanted their care provided had not been respected.

People told us that the service were not consistently responsive to their needs but told us that staff worked flexibly to support them. Care was planned with people's involvement but we found care plans were not always up to date with people's changing needs. There was an improved system in place to identify, record and report on complaints. However whilst people told us they knew who to complain to, they told us they were not confident that their concerns would be responded to appropriately.

Some people told us that were not happy with the way the service was managed in respect of weekend calls and communication from the management team. People had been encouraged to share their experiences of the service. Staff told us that they lacked confidence in the office management team. We found that whilst there were some systems in place to monitor and improve the quality of the service provided, but these were not always effective in ensuring the service was consistently well led and compliant with the regulations.

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

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

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?

**Requires Improvement**

The service was not always safe.

People were put at risk because some risk assessments did not contain sufficient guidance for staff about how to minimise the risks associated with their health conditions.

Staffing levels did not ensure that people's needs would be consistently met.

The systems in place for the management and administration of medicines needed to be improved to ensure people received their medicines safely.

Staff understood safeguarding procedures and were proactive in keeping people safe.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had not received all the training they required to meet the needs of the people they were supporting.

People were supported by staff who had developed a good understanding of their responsibilities when people did not have the capacity to make decisions.

People received the meals they asked for.

Staff supported people to access other health professionals if a person needed additional assessment and treatment.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People were supported to make choices about the care they received. However people told us that some decisions about how they wanted their care provided was not always respected.

People were supported by staff what were kind, caring and

thoughtful.

People's dignity and privacy were maintained.

## Is the service responsive?

**Requires Improvement**

The service was not responsive.

People did not always receive person's centred care. Care plans did not always provide staff with the information and guidance they needed.

People experienced late calls and could not expect the same staff supporting them during the weekend. The continuity of care was not consistent.

People knew who to complain to but were not confident the concerns had been listened to. The registered provider had improved their complaints processes.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The registered providers own action plan had not been effective in ensuring the improvements required were all fully achieved.

The systems in place to monitor the quality of the services provided were not always effective in identifying and actioning improvements needed.

People told us that some aspects of the service had improved but further improvement was needed.

Staff told us that they did not feel supported by the management team and were not confident that concerns raised would be addressed either in a timely manner or with due respect to confidentiality.

# Proline Care Limited - 4th Floor

**Detailed findings**

## Background to this inspection

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

This inspection took place on 14 and 15 March 2017 and was announced. The inspection was to follow up concerns identified at our last inspection. Prior to the first day of the inspection, the provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff were available at the office. We needed to ensure the provider could make arrangements for us to be able to speak with people who use the service, care staff and to make available some care records for review if we required them. The inspection team consisted of two inspectors and an expert by experience who spoke to people who used the service on the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

As part of our visit we reviewed information the provider had sent us in response to our last inspection which outlined the action they planned to comply with regulations. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received within the necessary timescale. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We refer to these as notifications. We reviewed the notifications the provider had sent us and in addition considered feedback provided to us by commissioners of the service and Health Watch. We used all this information to plan what areas we were going to focus on during our inspection visit.

During the inspection we spoke with 25 people who used the service and 10 relatives of people. In addition we met and spoke with the providers' representative, the registered manager, 1 care co-ordinator, 1 field

supervisor, 1 administrator and 10 members of care staff. We sampled some records, including four people's care plans, four staff files and the way the provider had applied their recruitment process. We sampled records maintained by the service about training and quality assurance to see how the provider monitored the quality of the service.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection on 4 and 18 October 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people were placed at risk by the lack of clear systems and records to ensure that people who needed support received their prescribed medication as directed. The provider's representative had produced an action plan of how they would respond to concerns raised.

At this inspection in March 2017 we found the provider had failed to ensure that the systems and records in place were sufficient to make the necessary improvements required for the safe management of medicines and remained in breach of this regulation.

We looked at how medicines were managed by the service. One person we spoke with told us, "I have help with my tablets from my carer……If I were left to my own devices, I probably wouldn't remember from one dose to the next whether I'd taken them, this way I feel safe knowing that I can't take too many or too few." Another person told us, "My carer gives me my tablets and a drink every morning……Sometimes at weekends I can be rather late taking them if the carers don't turn up on time which can be frustrating to say the least."

We found there to be no consistent approach to providing staff guidance in respect of the administration of PRN (as required medicines). A PRN protocol provides guidance for staff when people lack capacity to ensure these medicines are administered in a safe and consistent manner. We looked at the additional records for people who were using medicinal skin patches showing where the patches were being applied to the body. However, records we reviewed did not identify where the patches should be applied in line with the manufacturer's guidance. Following this inspection we received information that a medicinal skin patch for one person had been omitted by staff who were supporting them. This meant the person did not receive their prescribed relief medication.

We looked for evidence that topical creams had been applied as prescribed. The medicine recording charts and the appropriate body maps had not been consistently signed and completed and it was unclear if creams had been given or omitted at those times. We reviewed one person's care plan and daily notes which identified a prescribed cream was being applied to different parts of the body. It was not clear where the cream was supposed to be applied and this posed a risk that should the person be supported by a different member of staff they would not have known where the cream was to be applied. We received information following this inspection advising us that this had been rectified.

We found that there had been some improvements and care records listed most of the prescribed medicines that people needed. However, there was a lack of Medicine Administration Records (MAR) to clearly determine what medicines had been administered by staff and when. The management of medicines had not been audited effectively and had failed to identify the shortfalls we had found. The provider's representative told us that they had recently introduced a quality assurance medicine lead within the team to ensure records were being completed accurately and to check that people were receiving their medicines

consistently and as prescribed. During discussions with the providers' representative we were advised that staff had received an observational competence check to ensure that they were safe to administer medicines. However when we reviewed records we identified that there were some staff that had not received a competency check and there were no effective systems in place to monitor this.

The provider was not ensuring the safe care and treatment of people through appropriate management of medicines and this was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 12.

At our last inspection in October 2016 we found people were at risk of not receiving support needed to keep them safe and maintain their health. Reassessment information and up to date records had not consistently been made available for staff and a lack of detailed guidance about known risks placed some people at increased risk.

At this inspection we found that that some risks were being better managed than they had been previously. One person we spoke with told us, "I'm not able to get in and out of the bath on my own any more... I try to manage and have one every couple of weeks but I'll wait until I've got my regular carer because she is used to helping me in and out of the bath and I feel very safe when she is around." However, whilst most staff knew about the individual risks to people there were no risk management plans in place to guide staff about how to support people safely. People were still at risk of not receiving the support they needed to keep them safe and maintain their health. Records did not contain detailed assessments of the risks associated with each person's condition and how staff were to protect them from harm. Examples included risks related to peoples' skin integrity, moving and handling needs and catheter care. One person's care plan we reviewed indicated that the person required a thickener added to their fluids due to the risk of choking but when we spoke with staff they confirmed the person did not require this. We brought this immediately to the providers representative attention who sought immediate professional healthcare advice and confirmed the person did not require this support. This meant records had not been updated in line with people's changing needs. We found that risk assessments were inconsistent and required further improvements.

At this inspection in March 2017 we found the registered provider had not made the improvements required to ensure that care and support was provided in a safe way and remained in breach of this regulation.

The failure to ensure that care and support was provided in a safe way was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 12.

At our last inspection we found a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that enough suitably skilled and competent staff were deployed to meet peoples care needs safely and appropriately as had been identified as necessary.

At this inspection in March 2017 we found that improvements had been made during weekdays and that care was delivered in line with people's expectations and wishes. However the deployment of staff during weekends remained a concern. Most people told us that over the last few months the delivery of the service during week days had improved. One person told us, "Over the last few months, there have been big improvements in the way the agency works. At weekends however, it is still a problem….you never know what time the carer will arrive or who it will be, and I always end up having to phone the office to find out what time I can expect to see someone."

Some staff we spoke with told us they were concerned about staffing levels during weekends. One member

of staff told us, "There is just not enough staff at weekends. The patches [geographical areas of work] are disorganised and we are constantly late." The provider's representative acknowledged that they required additional staff and were continuing to recruit new staff.

At this inspection in March 2017 we found the registered provider had not made the improvements required to ensure that there were enough suitable staff working consistently to meet the needs of people who used the service.

Failing to provide staff in suitable numbers to meet the needs of people using the service is a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 18.

People told us that they felt safe with the support they received from staff. One person told us, "The carer uses a key safe to get in to my house, but she will always ring the bell and then as soon as she has unlocked the door, she calls out her name because she knows I worry about who it is coming through the door every morning." Relatives we spoke with generally felt their relative was safe when they were receiving care and support from the service. One relative told us, "Staff use a key safe to gain access to my mum's home. They always make sure it's shut when they leave so that mum feels safe."

A person who used the service told us, "I honestly couldn't fault the carers, I have never felt remotely like anybody was trying to bully me." Staff were able to demonstrate that they were aware of how to keep people safe from risks of potential abuse and knew how to recognise and report any potential concerns. One member of staff said, "If I witnessed any abuse, I would tell the office straight away and could report it to CQC [The Care Quality Commission]. We have a responsibility to whistle-blow if we see something that's not right." The registered manager had a clear understanding of their responsibilities to identify and report potential abuse under local safeguarding procedures.

People told us that they were kept safe in emergencies. All staff we spoke with described what actions they would take in the event of a variety of emergencies and were consistent with their responses. Staff described that they knew how to report accidents and incidents in a timely manner so these could be managed effectively.

We looked at the process used to ensure that robust checks were made of new members of staff. We reviewed four newly appointed staff files. The staff files showed that appropriate checks had been undertaken before staff started work and this helped to keep people safe. One staff member told us that prior to them starting work they had to complete some pre-employment checks and said, "I had a police check and had to provide references and different forms of ID [identification]." On two staff files we did find that although references had been sought they had not been validated to confirm their authenticity. We raised this with the provider who told us they would do this in future.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection on 4 and 18 October 2016 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the registered provider was not ensuring the care and treatment provided was with the consent of the relevant person. At this inspection we found that improvements had been made and the registered provider was no longer breaching this regulation.

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. People told us that they were supported in line with their preferred choices and that staff routinely asked for their consent before providing care. One person told us, "The staff ask my husband for his consent before washing him." Most of the staff we spoke with understood their responsibilities in relation to the MCA and most had received training. One member of staff told us, "I've had training on the MCA. It's all about if people can make decisions or not. Sometimes people need support to make decisions in line with their well-being." Where people using the service used bed rails, the registered provider had not established whether these restrictions were legally authorised and we found no agreement of consent from people. The provider's representative described examples of occasions where meetings had been held to ensure decisions were made in a person's best interest when they lacked mental capacity to do so for themselves.

People can only be deprived of their liberty so that they can receive care and treatment when it is in their best interests and legal authorised under the MCA. At the time of our inspection the registered provider had not needed to make any applications to the court of protection.

One person's end of life plans recorded that they did not want to be resuscitated if they were unresponsive to immediate lifesaving treatment. We noted that the appropriate documentation had been completed and was available in the person's care plan. However, not all the staff we spoke with were aware of the person's expressed instructions. This meant that the person's wishes may not be respected. The provider's representative advised that this concern would be rectified immediately and all staff would be informed.

People and their relatives told us that they had no concerns about the staffs skills and their knowledge. One person told us, "For the things I need help with, I think they're well trained. They always make sure they wear their disposable gloves and they change them between jobs." A relative we spoke with told us, "Staff use the hoist here. [they are] very skilled and all know what they are doing."

Staff told us that they had generally received training that was relevant to their roles and responsibilities. A member of staff we spoke with said, "Most of the training is on-line now but I've benefitted from it." At our

last inspection we identified that the systems in place to record staff learning and development were not up to date and that there was no effective system in place to monitor staff training needs or when refresher training was required. We found that there had been no improvement in this area and we were unable to determine if staff had got the appropriate up to date knowledge and skills. We noted a number of gaps in staff training records in key areas such as safeguarding, medicines and first aid. The provider's representative advised us that all the relevant information would be recorded and monitored on one system following this inspection.

Most staff told us that they had received one to one supervisions which gave them the opportunity to reflect on their performance. Records confirmed that supervision had improved following our last inspection but the frequency of supervisions had not met the registered provider's expected levels. Some staff we spoke with told us that their knowledge, competency and learning was monitored through unannounced 'observation spot checks' on their practice. Whilst the number of providers checks on staff had improved since our last inspection we noted that that the frequency of the spot checks had not met the registered providers expected targets.
All the staff we spoke with told us that they had received an induction when they first commenced working at the service. One member of staff said, "I did some on-line training prior to starting work." We saw that the registered provider's induction programme included the Care Certificate standards [a nationally recognised set of standards used for induction training of new staff]. This ensured that new staff had the skills and confidence to carry out their roles and responsibilities.

People told us that staff always gave them choices with regard to their food, and staff respected their decisions. One person we spoke with said, "My carers make me breakfast and lunch and I change my mind most days as to what I fancy but they are very patient with me and never mind making whatever it is I'd like on that day." Staff told us that meal choices reflected people's cultural preferences and staff we spoke with could describe people's individual eating and drinking preferences. Whilst records did not consistently contain current information about people's dietary needs the staff we spoke with knew who had risks associated with eating and drinking and how they needed to have their foods prepared so people could enjoy their meals safely.

People told us that the staff who supported them would call the doctor or other health professional if they asked them to. One person said, "They [the staff] have rung the district nurses when necessary." Relatives told us that the service was effective in alerting them when their relatives became unwell. One relative told us, "Staff know what they are doing with [name of person] catheter." Staff we spoke with told us they were able to speak directly to district nurses if they had any concerns about people's well-being. They also confirmed that they could contact their managers if they had any concerns about a person's health.

Requires Improvement

# Is the service caring?

## Our findings

At our last inspection on 4 and 18 October 2016 we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the registered provider did not ensure that all people who used the service were treated with dignity and respect. At this inspection we found that although improvements had been made and the registered provider was no longer breaching this regulation further action was still required.

The service did not provide a seven day service that gave continuity of care to people. People, their relatives and staff told us that staff changes were often made at short notice and that they did not receive support from consistent staff as regularly as they would wish. We spoke with people who used the service who expressed their confidence in a reliable and regular team of staff during weekdays. However, most of the people we spoke with voiced their concerns about weekend staff and told us they did not have regular staff and could not always be sure when and who would be coming to see them. One person said, "I did choose my times that when I started with the agency and I have to say that over the last few months, it has got better particularly Monday to Friday when I can usually now guarantee I will be up around my usual time and also go to bed at my usual time. Weekends can be very different and I could find carers one day coming an hour earlier than I want, or the next day coming nearly an hour and a half later than I'd like. It's the uncertainty that I really struggle with, I have to say." Another person we spoke with told us, "My daughter has spoken to the office on numerous occasions but it has still not managed to get any improvements to the service at weekends. Admittedly during the week, things are better but for two whole days at weekends it is a totally different service, or disservice to be more accurate."

People we spoke with told us that they were well cared for by staff. One person we spoke with told us, "I have to say, that all of the carers are very patient and I've never had any problem with any of them trying to rush me or making me feel that they want to hurry up so they can get onto the next client." Another person told us, "Put it this way, I wouldn't want to have to do their job. It can't be easy going from one person to the next all day long and constantly rushing to get everybody done, but for all the trouble they have, once my carers come through the front door, they make me feel like I'm the only person they've got to look after that day." Relatives we spoke with spoke positively about the way staff supported their loved ones. One relative said, "Staff are wonderful."

One person who used the service told us, "I have no complaints whatsoever against the carers themselves, I think they have a very difficult job to do in difficult circumstances and they usually manage to keep a smile on their face and have a conversation with me at the same time as doing my personal care." Staff we spoke with were positive about their role and the relationships they had developed with the people they supported. They could describe individual preferences of people and knew about things that mattered to them. Staff told us and we saw that they gave people choices and involved them in making decisions about their care and day to day life. One member of staff told us, "I give people as much choice as possible, for example about the food they want; the times they need us and the clothes they want to wear." Records we reviewed contained information about people's likes, dislikes and individual preferences. For example one person's care record stated issues of importance to the person and included information about the person's

pet cat, the person's religion and that they liked to watch sport on television.

We saw that the service had supported people to express their individual preferences for care. People had been asked for their preferences for male or female carers and the service had accommodated their requests. People told us they had been involved in the planning of their own care. One person told us, "I remember being asked what time I would like my calls and whether I was comfortable having a male carer, but I did say I would rather have female carers looking after me as they help me with my shower most days."

People we spoke with confirmed that staff promoted their dignity and privacy. A person who used the service told us, "The carers wouldn't dream of doing anything until the curtains are closed and the door shut. I've never had any problems with that area of their work." Another person told us, "I'm bedbound these days and I can't always see when the sheets and my nightdress are getting a bit on the soiled side. The carers are very good though and they always say to me that it's time to change the sheets or my nightdress and they never make any bother about it and will usually put the washing in for me before they leave. I hate lying here in dirty clothes or dirty bedding so I am really grateful to know that they take the time and effort to change things for me." Staff were able to describe a wide range of actions they undertook each day that promoted and protected people's dignity.

Staff told us they encouraged people to do things for themselves to ensure that they promoted people's independence. One member of staff told us, "I encourage people to do as much as they can for themselves." Staff we spoke with had a good appreciation of people's human rights. A member of staff told us," People have got their own rights…if we can go in there…. how they want things done. It's their life and their home." People told us that the staff maintained confidentiality. One person said, "I've never heard one of the carers talking about anybody else that they've been looking after, other than if they've been held up because somebody has been ill before they've got to me, but they've never told me any details about who it was or how they were ill." Staff we spoke with described the importance of ensuring that people's rights to confidentiality were maintained. One staff member told us, "I don't discuss other people outside of their own home. It's not right."

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection on 4 and 18 October 2016 we identified a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the registered provider had failed to ensure that there was an effective system in place for receiving and responding to all complaints. At this inspection we found that although improvements had been made and the registered provider was no longer breaching this regulation further action was still required.

People told us that they knew how to contact the registered provider and would have no hesitation in doing so if they were not satisfied with the standard of care. Since our last inspection the registered provider had reviewed and updated their complaints procedure. We looked at complaint records held within the services office. We saw that when complaints had been made the registered provider had systems in place to investigate and respond. This included ensuring the person who had made the complaint received the outcome of the investigation. However, seven of the people we spoke with told us that they did not feel they were responded to properly or listened to and on occasions their concerns had not been addressed. One person said, "I know really well how to complain about something but I have found in the past that nothing ever happens about anything, so it's hardly worth bothering about."

Some people we spoke with told us that the registered provider had not been responsive to their request to change aspects of their care, for example the frequency or timing of their calls. One person we spoke with described how unhappy they were with the times of their call and said, "Part of the reason for me having carers at that time, was that I would be able to spend more time with my family and friends, and I do during the week, but at weekends when it's mainly the family I'd like to spend time with, I can find myself waiting in forever for a carer to arrive to help me get ready in the morning." Another person told us, "I've never had any problem with the carers themselves or with what they do. The only way my freedom is restricted is usually at weekends when I never know quite what time I'm going to get a knock on the door for my visits. It is frustrating that this mainly happens at weekends, because that's when my family are usually free and I have more opportunity to do things with them, if I can guarantee I'm going to be ready in time." One relative we spoke with told us," The timings are no good at weekends….not enough time in-between calls."

People and their relatives, when necessary, confirmed they had been involved in the initial assessment process with how care and support needs would be delivered. One person told us, "I'm fairly easy going, but I suppose my regular carers do know that I like things to be done in a certain way and with them, once I've told them I don't have to tell them again." Another person said, "Now I have mainly regular carers, it has been much easier for me to explain to them how I like things to be done, and I've only had to explain it once, and they now know."

People and their relatives told us that they had been involved in formulating the person's care plan. Some care plans reflected people's individual care and support needs. Although staff demonstrated a good knowledge of people's needs some care plans did not reflect people's current needs and were not consistently detailed enough for people who had complex support needs and requirements. We saw that some people had been involved in the reviewing of their care plan. One person told us, "I did have a review

meeting a few weeks ago when someone came from the office to visit me…... I don't remember being asked much else other than was I alright." A number of relatives we spoke with told us that they had appreciated being involved in the reviewing process, when needed.

People told us that they received care and support from the staff who understood their individual needs. One person we spoke with said, "If it wasn't for my carers coming in to look after me, my family would have insisted on my moving into a care home by now because I know they do worry about me. However, this is the family home and I really want to stay here as long as I possibly can and I know that having the carers four times a day means my family at least are reassured that I'm alright and being looked after." Staff we spoke with knew people well and could describe individual preferences of the people they were supporting.

We were told and records showed that there was a multi-cultural staff team available from a variety of cultures and with a variety of linguistic skills that was reflective of the people using the service. The registered manager told us that they matched people, where possible, with staff who understood their faith and were able to communicate in the person's preferred community language. Records we looked at confirmed this matching took place where possible.

People we spoke with told us that maintaining relationships with their families and friends was important. One person said, "I go out to lunch once a week with my friends and if it wasn't for my carer coming to get me up and ready in the morning I wouldn't be able to do that and I really enjoy just having a change of four walls and being able to have a chat with my friend each week." Another person told us, "I do sometimes have a visitor here when my carer comes either at lunchtime or teatime, but they are very good and will usually ask if they can make a cup of tea for my visitor."

Inadequate

# Is the service well-led?

## Our findings

At our last inspection on 4 and 18 October 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have effective systems in place to monitor the quality and safety of the service provided. Systems in place had failed to identify and address issues we identified in respect of medicine management, management of known risks, and impact from insufficient staff being available to meet known support needs of people using the service. Following the inspection in October 2016 the registered provider had produced an action plan of how they would respond to concerns raised at our last inspection.

At this inspection in March 2017, although the provider had started work to address the areas of improvement as identified in their plan, some actions were still outstanding or had not been completed as had been planned. The provider remains in breach of this regulation as they had not taken the action required to ensure that effective systems would be in place to assess and monitor that the service would consistently deliver high quality, safe care. The management, leadership and governance of the service had not been effective.

The provider's representative and the registered manager acknowledged and agreed with the concerns noted during this inspection. Although the provider's representative had taken action to improve how they monitored the quality of the care people received, the improved monitoring system in use was not always effective. For example, we found that monthly audits of care files had been completed but they had not identified the shortfalls in care and support that we had found. Some people's care plans were not accurate, lacked detail and did not reflect people's current needs. There were inconsistencies in the completion of medicine records and the failure to safely administer medicine had not been noted and acted on. People were generally happy with the service provided during week days. However, the systems in place had not identified that the service provided to people during weekends did not meet their expectations and needs. The views and experiences of people related to weekend calls had been sought but had not been utilised to improve the service. Risks were not always assessed and actions were not always put in place to mitigate risks to people. Records were not maintained consistently and checks were not in place to make sure staff had the information they needed to provide appropriate care for people. The systems in place had failed to identify that some guidance was general and did not reflect people's individual needs. In addition there were no effective processes in place to record staff training to ensure that people were supported by staff with the appropriate knowledge and skills. The systems in place had failed to identify that 15 out of the 74 staff employed by the service had not received regular supervisions and 59 staff had not received observational competencies which had not met the registered providers expected targets.

These issues regarding good governance of the service were a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 17.

People and their relatives expressed their views about the service. Most people told us that their care and support was good during weekdays but expressed their concerns about weekends. A person who used the service said," Don't get me wrong, they have made big improvements since last year, but I really don't think

they're in a fit state for me to recommend them to anybody else until they get the weekend problems sorted out and recruit more carers."

People did not always express confidence in the management team and expressed concerns about the response from office staff and the lack of effective or timely response to concerns. One person said, "When I have phoned up [the office] and asked to speak to a manager, I've never been told who it was and they usually don't bother to phone me back anyway." Another person told us, "It's a struggle to find even a manager to talk to as when you phone the office they are invariably not there and then never phone you back."

The registered provider operated an out of hours on call system so that people or staff had access to advice and assistance in an emergency situation. One person told us, "At weekends, I have the number on my speed dial because I have to phone it so regularly." Another person said, "I phone this number more than I phone the normal office number during the week because during the week I don't really have any problems, as they all wait until the weekend."

We found that the provider did not operate a positive open culture. Whilst the staff we spoke with were knowledgeable about how to raise concerns, they were not confident that the management would address these in a timely manner. One member of staff told us, "I ring and ask to speak to the manager, but she never gets back to me." The majority of the ten staff we spoke with told us that they did not feel supported by the office management team. We found that the main issues communicated to us from staff were around staffing levels at weekends and poor communication within the office. The majority of the ten staff we spoke with told us that the office management team were unsupportive and unprofessional, however, staff did feel they were able to discuss any issues with the provider's representative. The majority of the ten staff we spoke with told us that they felt unable to speak in confidence to the majority of the office management team. A member of staff told us, "You can't speak to anyone in confidence in the office."

We saw that the registered provider had improved the ways they sought the views of the people who used the service. People told us this was done through questionnaires, telephone calls and review visits. One person told us that they had received a recent telephone call to ask if they were happy with the service that was being provided. The provider's representative advised us that questionnaires had recently been sent out to people using the service to find out their experiences of using the service. They advised that the overall analysis of the surveys would be completed and feedback would be used to inform practice and drive up improvements to the service.

Discussions with the registered manager identified that they had kept up to date with developments, requirements and regulations in the care sector. For example, where a service has been awarded a rating, the provider is required under the regulations to display the rating to ensure transparency so that people and their relatives are aware. We saw there was a rating poster clearly on display in the office. Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. The registered manager had ensured that notification systems were in place and that staff had the knowledge and resources to do this.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider was not ensuring the safe care and treatment of people through appropriate management of medicines. Regulation 12 (2) (g)<br><br>The provider had not assessed the risks to the health and safety of people who used the service and had not taken action to manage known or related risks. Regulation 12 (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure that there was enough staff working in the right place and for the right duration. regulation 18 (1)(2)(a) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have robust systems in place to monitor the quality of the service.<br><br>The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service.<br>Regulation 17 (1) (2)(a)(b) |

**The enforcement action we took:**

We served a Warning Notice requiring the provider to become compliant with this regulation by a set date.