Bloomsbury Home Care Limited

Bloomsbury Home Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 10 September and the 11 September 2018 and was announced.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults. On the day of our inspection, there were 33 people using the service, all of which received personal care.

At our last inspection on the 12 December 2017, we rated this service as requires improvement overall. We found breaches in regulation under the Health and Social Care Act, 2008. This was because risk assessments were not always in place. People's medicines were poorly managed. People who were at risk of neglect, malnutrition and dehydration did not have robust person-centred care plans for staff to follow. The provider did not have robust governance processes in place to mitigate concerns about the safe running of the service.

This is the second consecutive time the service has been rated Requires Improvement. This was because the provider had not made the required improvements needed and breaches of regulations remain. 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. 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 enough improvement is not 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 service's, 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.

Whilst some progress had been made since the last inspection, the provider did not have a robust oversight of medicines management, which potentially could place people at risk of harm.

People told us staff would sometimes turn up late, but when they were there they stayed for the duration. Information we inspected reflected this feedback. Running up to the inspection, the provider had given back a number of care packages back to the local authority because they were unable to deliver the care that had been agreed with people and commissioners.

Risk assessments had not always been updated when a change had occurred. Which meant information in some people's care plans was not always clear. Systems were not in place so that learning could be shared and used as a learning point, when events may have happened. We have made a recommendation about learning from events. Staff had access to PPE (personal protective equipment) such as gloves and aprons and equipment, which had been stored in a clean environment.

Since the last inspection, fluid charts had been introduced, but, for those who needed support to eat safely, or for those who may have been at risk of choking, it was unclear what action staff should take to mitigate these risks.

The assessment process did not design people's care or treatment with a view to achieving service users' preferences to ensure their needs were met. Training had not improved since the last inspection. There were gaps in staff training records and we were told that more training was being sourced.

Care staff understood their responsibilities in relation to safeguarding vulnerable adults and knew who to contact if they had any concerns over people's wellbeing and safety. At the time of the inspection, the police were carrying out an investigation in to an incident that had previously occurred.

The service did not have a registered manager in place, and had not had one in place since the last 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.

Systems had not been put in place to improve the retention and wellbeing of staff. Systems were in place to seek the views of people who used the service, but this information was not used to drive improvement. Governance systems were not robust and not consistently applied. Audits did not maintain or improve the quality of the service people received.

Further information is in the detailed findings below.

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 remains requires improvement.

People told us that the time staff could arrive could be variable and that they were often late.

There were ineffective systems in place to monitor the use of people's medicines.

Systems and processes were in place for the safe recruitment of suitable staff.

Is the service effective?

Requires Improvement

The service remains requires improvement.

Clear guidance was not always in place for staff to know how to support people to eat safely, if they were at risk of choking.

Staff were not given a consistent programme of thorough training, that enabled them to understand the needs of people who used the service.

Improvement needed to be made to meet the requirements of the Mental Capacity Act.

The service did not always focus on the continual assessment of people's needs.

Is the service caring?

Good

The service was good.

People told us that people were kind and treated them with respect.

Care was provided by small groups of staff which offered consistency and enabled people to get to know staff well.

People told us they were given the choice of having a male or female staff member

Is the service responsive?

Requires Improvement

The service remains requires improvement.

People had not been involved in their care planning and reviews of their care and support had not taken place.

There were processes in place to deal with people's concerns or complaints but this information was not used to make improvements to the service.

Is the service well-led?

Inadequate

The service remains inadequate.

The service had not had a consistent registered manager in post, and since the last inspection, the managerial oversight of the service had been inconsistent.

The provider did not have a robust governance system in place to ensure the quality of the service could be improved and sustained.

Bloomsbury Home Care

Detailed findings

Background to this inspection

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

This inspection was undertaken by one inspector, and an assistant inspector. The inspection took place on the 10 and the 11 September 2018. The provider was given notice of our inspection to ensure we could gain access to the information we needed. We also spoke with people using the service, their relatives, and staff by the telephone.

Before the inspection, we looked at information that we had received about the service. This included information we received from the local authority and any notifications from the provider. Statutory notifications include information about notable events which the provider is required to send us by law.

We were notified of an incident where a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with the CQC about the incident, indicated potential concerns about the management of risk of Bloomsbury Homecare. This inspection examined those risks.

Due to technical problems, the provider was not able to complete a 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. We took this into account when we inspected the service and made the judgements in this report.

During the inspection process, we spoke with four people and two relatives. We also spoke with the operational manager, the regional manager and five staff working in the service. Healthcare professionals and local commissioners were approached for comments about the service and any feedback received has been included in the report.

We looked at five people's care records and records relating to four staff members. We also looked at the

provider's arrangements for managing medicines, supporting staff, managing complaints, and monitoring and assessing the quality of the services provided.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, people were put at risk because the provider did not appropriately oversee and monitor the use of medicines. Boxes of sterile equipment were kept in close proximity of the toilet, and risk assessments were not personalised and detailed. At this inspection, whilst we had found that some improvements had been made, the provider had failed to improve the service sufficiently.

The provider continued to have ineffective systems to monitor the safe and proper use of medicines. Since our last inspection, staff had been trained in how to administer people's medicines and competency assessments were now being carried out. Medication Administration Records (MARs) had been introduced, and these were being audited. However, the audit process, was not used in a consistent way and had not been imbedded enough, to improve the quality of the service. For example, out of the seven MARs we inspected, four had not been audited.

Doses and instructions in people's care plans were not recorded properly. For example, one person needed a patch to be applied, but this detail was not included under the medication section of the care plan. There was no body map, specifying where this should be applied. The audit system in place had not identified that this was an area that needed to be improved.

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

A computerised monitoring system was used to monitor missed calls, via a secure work phone. Information relating to late visits, showed that these were fairly high. For example, in the weeks leading up to the inspection, there had been over 100 late visits. After the inspection, the operations director told us this figure was incorrect and that this was due to a technical problem.

The provider did not consider their staffing resources when taking on additional care packages. For example, prior to the inspection, there had been recent problems with staffing. In some areas, this had resulted in the provider giving back care packages to the local authority. One person said, "When they started they were good. But I had to wait. They gave me notice saying they could not find any staff in my area. But they were okay. I am with another company now."

The service provided staff with the appropriate infection control PPE (Personal Protection Equipment) such as gloves and aprons. Since the last inspection, sterile equipment had been moved and was no longer being stored in such close proximity to the toilet.

At our last inspection, environmental risk assessments of people's homes were not carried out for people who smoked. At this inspection, we found that overall, this had improved. Most people's information in relation to risk was up to date, and it was evident that regular audits of care plans were carried out. However, when a change had occurred, we found that this had not always been transferred to the care plan. This meant that information in some people's care plans was not always clear.

Care plans included guidance for staff to understand how to use specialist equipment, such as hoists. For those who had key safes, (a secure place for a house key to be kept) only staff involved with their care, and the office would have the access codes to obtain the key. This information was handled safely and securely, minimising the risk of unknown people accessing vulnerable people's homes.

Systems and processes were in place for the safe recruitment of suitable staff. Information inspected on the recruitment files for five members of staff showed they had completed an application form, provided a full employment history and their eligibility to work in the United Kingdom was checked. The registered manager had also undertaken a Disclosure and Baring Service Check (DBS) on all staff before they had started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal records and whether they are barred from working with people who use health and social care services.

People told us they felt safe with the staff that supported them. One person said, "I am happy with them I feel safe." One relative said, "Generally I feel that [Name] is safe. I am confident they do not put them at risk. Staff had received training and knew how to recognise and report any suspicions of abuse. Staff knew how to whistle blow and told us they would either contact the local authority or the CQC if they had concerns that people were not being cared for in a safe way.

When incidents had occurred, the provider was unable to demonstrate that the wider learning was shared, and used to consider what action may be taken to improve safety. We recommend that the provider looks at the way lessons are learned and how they can be communicated widely to support improvement.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, care plans around fluids and nutrition did not give staff the correct information. At this inspection, some improvements had been made, but the provider had failed to improve the service sufficiently.

Since our last inspection, fluid charts had been introduced to the care plan. But, for those who needed support to eat safely, or for those who may have been at risk of choking, it was unclear what action staff should take to mitigate these risks. For example, in two people's care plan, the local authority assessment had identified that speech and language professionals had been involved, but contact details of these professionals or their professional guidance had not been explored and was not reflected in this person's care plan. This meant that clear guidance may not have been available, for staff to know how to support this person to eat safely.

When people were at risk of choking there was no risk assessment in place for staff to understand what action to take in the event of an emergency. Following the inspection, we asked the provider to review the support they provided to people who needed help to eat and drink in a safe way, and to ensure that the guidance available to staff was clear and reflective.

At the last inspection, care plan's lacked person-centred information. At this inspection, we found there had been no improvement. For example, when randomly selecting care plans we found that one care plan indicated, they had 'mild dementia.' The referral from the local authority, stated that this person had Alzheimer's which made them more at risk of having increased anxiety. The care plan did not explore the impact the diagnosis may have had on the person's behaviour and care needs.

When people had additional health problems and were being supported by other professionals, details were not always recorded, and there was no evidence that staff had communicated with these professionals when needed. For example, one person who had been assessed as being at risk of developing pressure ulcers, had developed a red area. There was no evidence that this had been followed up. Another care plan stated within the referral information that this person had recently seen a dietician. There were no further details recorded, that would indicate the provider had followed up and included any recommendations, within the person's care plan.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Section (3) (a) (b) (i) of the Health and Social Care Act 2008.

An induction programme was in place, which took place during the first week of employment. Within the five staff files we inspected, staff had not completed the Care Certificate. This is an agreed set of standards that sets out the skills, knowledge and behaviours expected of specific job roles in the health and social care sectors. The operational manager told us that this was offered and had been completed, but that there were no certificates to confirm this.

Staff did not always receive adequate training, as necessary. At the last inspection, there were gaps in staff training records and we were told that more training was being sourced. At this inspection the provider had failed to give staff a consistent programme of thorough training, that enabled staff to understand and meet the needs of people who used the service. For example, we reviewed five staff files, and found two people had not been given specialist training. The training matrix showed significant gaps in staff training and development. When we spoke with the operations director about this they said, "Additional training was in the process of being sourced."

Staff did not receive appropriate training, as identified within the supervision and appraisal process to enable them to carry out the duties they are employed to perform. At our last inspection, we recommended the provider improved the oversight of actions developed from staff supervision to ensure that staff have the support and skills to practice safely. This had not improved. We found supervision records where staff had asked for further training, but no support had been given to develop or clarify the understanding of this staff member.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People told us that staff sought their consent before supporting them with various aspects of care and signed consent was obtained before care and support was provided.

At our last inspection, we recommended that the provider should complete capacity assessments, and carry this out in line with current legislation and guidance. The provider had failed to act on this recommendation. We found that the provider was not meeting requirements. For example, we asked to review care plans for people who may lack mental capacity or for those cognition may decline in the future. The provider told us they were not supporting anybody with a diagnosis like this. However, during a random sample of care plans, we found people who had a diagnosis of dementia Alzheimer's. The provider had not considered the requirements of the act. For example, this had not been explored or recorded within the care plan.

The regional manager told us that they needed training in the MCA framework, because this was an area of legislation they were unfamiliar with. The training matrix showed that only four staff members had completed Mental Capacity Act training. We noted, the operational manager provided us with an email confirming that a further training session had been booked.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Section (3) of the Health and Social Care Act 2008.

Good

Is the service caring?

Our findings

People were complimentary about the staff that supported them. At our last inspection some people gave us examples that indicated they were not always treated in a kind way. At this inspection no one raised this as a concern with us.

People confirmed staff were polite and included them about how they wanted their care provided. One person told us, "They do exactly what I ask. One day can be different from another. They keep me independent they are very good." One relative said, "[Name of person] wouldn't go with anyone. They would lead them a merry dance. They all came here and we all worked together to get them out. They sorted it out. [Name] loves it when they come."

Care was provided by small groups of staff which offered consistency and enabled people to get to know staff well. People told us they were given the choice of having a male or female staff member and their wishes were upheld. One person said, "They are very friendly. They are good at their job and you can interact with them." And, "They are very chatty all of them." A relative said, "[Name of staff] is a little diamond. They are so sweet. [Name of person] gets on with them so well."

People continued to be involved in decisions about their care, and about the support they were provided with. One person said, "They handle me very carefully. They ask, can I move your leg or, do you want your leg there. As far as I am concerned, they are caring."

People's privacy and dignity was respected by the staff working with them and described how staff maintained this when providing personal care. For example, by shutting doors and curtains and using a towel.

Confidentiality continued to be maintained at the service which meant that information held about people's health, support needs and medical histories was kept secure. Paper records which had confidential information were kept in a file in each person's home. In addition, electronic records were held securely in the service's computer system. This system was password protected and could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

People told us they received care that was responsive to their needs. One relative explained, "I can't fault them. [Name] needed to go into a home, so I could have a break for a couple of weeks. This has not happened before. [Name of staff] took us there. I do not have a car, we could have only got there by bus, but they insisted. They helped to get [Names] suitcase, while I took them for a walk around the grounds, to get them used to being somewhere new. [Staff name] kept them calm, I did not have to deal with it at all. I can't thank them enough." Despite people telling us that the service responded to their needs effectively, we found the provider had failed to improve this area of the service sufficiently. At the last inspection, we found that this area needed to improve. At this inspection we found this this area still had not been improved sufficiently.

The provider did not design people's care or treatment with a view to achieving service users' preferences to ensure their needs could be met. For example, the assessment process did not identify people's needs and preferences accurately, and had not been used to consider how to meet the full range of people's needs. The lack of having an initial assessment meant that the provider did not identify people's needs accurately and could not use this information to inform and plan person centred care. This had resulted in some care packages being handed back to the local authority. The provider could have minimised disruption to people and commissioners, by identifying that they were unable to meet people's needs earlier, by using an assessment process.

At our last inspection, we found that care plans were not always person centred and contained very little personal information. At this inspection we found that some changes had been made, and more personal information was being recorded. But, the provider did not consider how to use this information to support people to live in a more independent way.

We recommend that the provider uses information to ensure that care planning is focused on the person's whole life, including their goals, skills, and abilities.

We found that whilst reviews of people's care had taken place, the care plans had not always been updated. This meant that people's care plan may not have had the most up to date information, and over time, would contain inconsistent or inaccurate information. For example, one review stated that an air mattress was in place and confirmed the setting. This was not reflected in the care plan.

From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. This means people's sensory and communication needs should be assessed and supported. We found the service needed to make some improvements to meet this standard.

We recommend the provider considers what additional support people may need to communicate effectively and records this within their care plan.

At our last inspection, the provider did not always review peoples' complaints thoroughly. At this inspection,

this had improved. Complaints were logged and the details of any investigation was clearly recorded. None of the people we spoke with had reason to complain about the service. We noted, some compliments had been received. One said, "What a lovely, friendly, caring staff we have. They are fantastic at dealing with privacy and dignity."

At the time of the inspection, we were told, the service was not providing end of life care to anyone. We looked at the policies and procedures the provider would follow when someone was coming to the end of their life. We found that this area needed to improve. The provider did not have a policy or processes in place, which would inform the approach needed to support people at the end of their life. Staff had not been trained to understand the specific requirements to ensure that people ended their life well. We recommend the provider reviews its approach to providing care to people when they are at the end of their life.

Inadequate

Is the service well-led?

Our findings

Sufficient and timely improvements had not been made since the last inspection. This was because the service had not had a consistent registered manager in post, and the managerial oversight of the service had not been consistent. The provider did not have a robust governance system in place to ensure the quality of the service could be improved and sustained.

The provider continues to have multiple breaches of the regulations and had not fully complied with the requirements to drive up the quality of the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service.

After the last inspection, the registered manager had left, and the provider had failed to ensure that a registered manager was recruited to comply with their registration requirements. For example, someone had been recruited to the registered manager post, but left. Another person, had been recruited but quickly promoted to the operations director role.

At the time of the inspection, the regional manager, was applying to become the registered manager, but required training and development to progress within this role. A robust training and development plan had not been put in place to ensure that this person would be supported to be able to successfully transition in to this role, in a planned and supportive way. The operations director said, "We have worked it out together. It is just not written down. I will do this after the inspection.

The management team did not always know people's needs and were not always clear about the complexity of the support being offered to people. For example, we asked to see people's care plans who needed support with a textured diet or who had support from the speech and language team. The regional manager told us there were only two people who had these needs, or had previously needed support in this area. Whilst randomly selecting other care plans to review, we found one other person who met this profile. We asked the manager for people's care plan who smoke. We were told they did not support anyone who smoked. Whilst randomly selecting care plans, we found one person that met this profile.

Feedback from professionals highlighted a concern around communication. They said, "I have noticed over the last year, the manager changes regularly. This makes the point of contact difficult to establish, when trying to liaise about care. Other than that, they have worked well with me."
Establishing contact with people from the management team could be difficult, and was further hampered, by the system the provider used. For example, the providers main contact telephone number for the Essex office, was diverted to an office in Lincolnshire. We found that the staff running the phone line, struggled to connect you with anyone at the office in the Essex area.

The management team was not working consistently together and did not have a shared vision for the service moving forward. For example, in our discussions with the business owner, they said that their aim was, 'to grow the business.' The view of the operations director was not to do this until sustainable improvement had been made.

The provider did not have a defined governance process in place, and did not carry out a range of audits, which looked at key areas and improved the quality of the service. Care plan and medication administration audits had been introduced, since the last inspection. But these were not being used in a consistent and effective way. The systems that had been put in place to monitor the oversight of the service was not robust. For example, the medication audit had not picked up that body maps used to record creams and patches had not been returned or reviewed. The process of auditing the MAR's was inconsistent. For example, we looked at seven MARs, four had not been audited, two identified that there were improvements that needed to be made, but no action had been taken. Only one had been completed to a good standard.

The care plan audit that had been carried out, did not improve the quality of the service people received. For example, one audit had found that a person had a red area to the groin, and this needed following up. There was no evidence, either in the person's care plan, or within the audit to show that this had been done.

The provider had not defined the roles, of those who would be responsible at a managerial level within the organisation, for driving improvement. For example, the operations director told us that team leaders were responsible for carrying out audits. These staff members had not been trained in governance and auditing. Some staff members raised concerns about the welfare of the team leaders. One said, "They work the team leaders into the ground. They do everything, from manning the out of hours phone, to delivering care." This had resulted in a lack of defined roles and responsibilities around driving sustainable improvement forward at the level of those with the authority and position required.

Annual surveys were carried out, but there continued to be a lack of analysis. Action plans had not been implemented to look at ways the feedback could drive improvement. When negative feedback about the service had been given, there was no evidence that this had been acted upon and changes made. The provider had not considered how they could incentivise feedback from staff. Information received from surveys can be used to support providers to complete a robust business continuity plan, planning services in the future. The management team told us they did not have any business plan going forward.

At our last inspection, we found supervision records where staff had asked for further training, but no action had been taken to support staff to undertake further learning, when they had highlighted gaps in their knowledge. We found similar occurrences during this inspection.

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

At our last inspection, the provider did not check that staff had business car insurance in place, when taking people out. This had improved and copies of these documents were now kept within staff files.

Some staff spoke positively about the changes that had been made to the management team in the months running up to the inspection. They said, "The other manager was all over the place. I did not feel supported and I was left to get on with it. But now, we have a lovely new regional manager, and the regional manager. I can just ring them I feel more settled and sorted."

Regular team meetings did not take place, we found that two had taken place since the last inspection. One staff member said, "I have never been to a team meeting." The operational manager assured us that regular meetings were in process of being introduced. Since the last inspection the provider had been working with the local authority to look at ways they could improve the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not identify person centred intervention to peoples identified risks.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were inadequate processes in place to monitor the safety and quality of the service provided.