Bloomsbury Home Care Limited

Bloomsbury Home Care Limited Bourne

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?	Requires Improvement

Summary of findings

Overall summary

Bloomsbury Homecare Limited Bourne provides care for adults of all ages in their own homes. It can assist people who live with dementia or who have mental health needs. It can also support people who have a learning disability, special sensory needs, a physical disability and/or who misuse drugs and alcohol. At the time of our inspection the service was providing care for 310 people most of whom were older people. The service covered Stamford, the Deepings, Bourne, Spalding and Grantham and surrounding villages. Between 1 January 2017 and 9 February 2017 (inclusive) the service completed 29,940 visits to people at home. This was made up of 11,731 to people living in Stamford and the Deepings and 12,966 to people living in Bourne. In addition, 3076 visits were completed in Spalding and there were 2167 visits in Grantham.

The service was run by a private company that was the registered provider. The chief executive of the company was also the nominated individual. This is a legal role that means the chief executive was responsible for assuring us that the service was well run. There was also a registered manager. 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. In this report when we speak both about the company and the registered manager we refer to them as being, 'the registered persons'.

At our last inspection between 4 and 8 July 2016 we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2008. These breaches were because the registered persons had not reliably ensured that visits were carried out as planned and people had not always been supported to manage their medicines in a safe way. In addition, some people had not consistently been assisted to eat and drink enough. Further problems had been shortfalls in the way new care staff were recruited and mistakes that had been made in the way complaints were resolved. Another shortfall was the registered persons not telling us about significant events that had happened in the service. This oversight had reduced our ability to make sure that people were kept safe. All of these problems resulted from the registered persons not having rigorous quality checks in place so that shortfalls in the running of the service could quickly be put right.

After the inspection the registered persons wrote to us to say what actions they intended to take to address the problems in question. They said that all of the necessary improvements would be completed by 31 December 2016.

At this inspection we found that although improvements had been made to the deployment of staff, visits were not always being completed in the right way. This was because some visits had not been undertaken at the right time while others had not been completed at all. As a result there was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the registered persons to take at the end of our report.

Although improvements had been made in relation to three of the other breaches, we also found that further progress was needed. This was so that people were always safely assisted to manage their medicines and were reliably supported to eat and drink enough. In addition, we concluded that quality checks needed to be still more robust so that remaining problems in the running of the service could quickly be put right.

In relation to the remaining two breaches, we found that sufficient improvements that had been made to the way in which new care staff had been recruited. We also noted that notifications had been submitted to us in the right way.

At this inspection we also examined other aspects of how well the service was running that were in addition to the breaches noted above. We found that people had not been fully supported to avoid preventable accidents, but people had been helped to obtain all of the healthcare they needed. Also, care staff knew how to keep people safe from situations in which they might experience abuse.

Care staff had not always been provided with all of the training and guidance they needed to be able to care for people in the right way.

The registered persons had ensured that people's rights were respected by helping them to make decisions for themselves. When this was not possible decisions had been taken in people's best interests.

Care staff treated people with kindness and compassion. People's right to privacy was respected and confidential information was kept private.

Some people had not been able to contact the service when things had gone wrong and lessons had not always been learned from complaints. However, care had usually been provided in a flexible way to enable people to make choices about what they wanted to do.

Although people had been asked for their views on the service some of them said that too little had then been done to make suggested improvements. Some care staff said that further improvements were needed to communication within the service and to the systems and processes used to organise their work.

People had benefited from care staff acting upon good practice guidance.

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 consistently safe.

Care staff had not always been available to promptly provide people with all the care they needed.

Medicines had not always been managed in the right way.

People had not been fully assisted to avoid preventable accidents.

People were safeguarded from the risk of abuse.

Background checks had been completed before new care staff had been employed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some care staff had not been given all of the guidance they needed to care for people in the right way.

Some people had not been consistently supported to eat and drink enough.

People were supported to make their own decisions and when this was not possible decisions were made in their best interests.

Care staff had helped people to obtain any healthcare services they needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion.

Care staff promoted people's dignity and respected their privacy.

Confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not always been able to contact the service when something had gone wrong.

Some people had not always promptly received care that met their expectations.

Complaints had not always been effectively managed so that lessons could be learned.

Care had been provided in a flexible way to enable people to make choices about what they wanted to do.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality checks had not always reliably resulted in problems being quickly put right.

People had been invited to comment on the service but their suggestions had not always been implemented.

Some care staff said that systems and processes used to organise their work needed to be improved further.

Care staff had been encouraged to speak out if they had any concerns about how well someone was being treated.

People had benefited from care staff acting upon good practice guidance.

Bloomsbury Home Care Limited Bourne

Detailed findings

Background to this inspection

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

Before our inspection visit to the service's administrative office we reviewed any notifications of incidents that the registered persons had sent us since the last inspection. In addition, we liaised with the local authority who contribute to the costs of some of the people who use the service. We did this to obtain their views about how well the service was meeting people's needs.

We visited the administrative office of the service on 13 February 2017 and the inspection team consisted of a single inspector. The inspection was announced. The registered persons were given a short period of notice because they are sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be available to contribute to the inspection. During the inspection visit we spoke with the chief executive, the deputy manager and the registered manager. We also examined records relating to how the service was run including care plans, visit times, staffing, medicines management and staff training.

After our inspection visit our inspector spoke by telephone with 15 people who used the service and four relatives. They also visited five people at home where they examined records relating to the care the people had received. In addition, our expert by experience spoke by telephone with a further eight people who used the service and five relatives. An expert by experience is a person who has personal experience of this type of service.

Most of the people with whom we spoke lived in Stamford and the Deepings. We wanted to focus upon how well the service was running in these areas. This was because nearly all of the concerns we have received

since the service was registered on 29 January 2016 had involved the service that had been received by people who lived there.

Requires Improvement

Is the service safe?

Our findings

At our inspection between 4 and 8 July 2016 we found that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We noted that suitable arrangements had not been made to ensure that sufficient members of staff were deployed to reliably meet people's needs for care. This was because in Stamford and the Deepings there were not enough staff who were properly organised to enable all planned visits to be completed at the right time and in the right way. Although this shortfall had not resulted in people experiencing actual harm it had resulted in people not promptly receiving all of the care they needed. In turn, this had resulted in people experiencing unnecessary distress and inconvenience.

After the inspection the registered persons wrote to us and said that they had taken a number of steps to address our concerns. These included appointing more care staff in particular in Stamford and the Deepings, re-arranging how staff in these areas were organised and developing more capacity to share workload with other providers. They said that all of these improvements would be fully implemented by 20 September 2016.

At the present inspection the registered persons said that there were suitable arrangements in place to enable all of the planned visits to be completed in the right way. In particular, they said that in Stamford and the Deepings there were more care staff who were carefully organised into new teams. However, some of the people who lived in Stamford and the Deepings with whom we spoke continued to voice reservations about this matter. While acknowledging that improvements had been made, they did not accept that the registered persons had done enough to ensure that visits were reliably completed in the right way. In particular, they said that too many visits did not take place at the correct time. Summarising this view a person commented, "The care staff do their best but Bloomsbury's organisation still isn't quite right. The staff can be late or very late and suddenly for no reason they turn up early." Another person said, "The care staff have not arrived a couple of times and I have had no food all day. Some days they arrive at 10.00am for my breakfast call which is too late." People living elsewhere were more positive with one of them remarking, "Given the traffic in Grantham the staff are pretty reliable actually. They turn up on time and do so in all weathers."

Some of the relatives of people who lived in Stamford and the Deepings echoed their family members' concerns. One of them remarked, "Although to be fair it's settled down quite a bit recently, the service is still not right on some days. On most days it's adequate but then a care worker simply doesn't turn up and my relative has to telephone me because they're upset." Elsewhere most relatives were complimentary with one of them remarking, "My mother tells me that the staff are quite well organised. They've been there at the right times whenever I've telephoned my mother and so the visits must be roughly right."

We looked at records for the visits completed in Stamford and the Deepings over a period of 10 days in February 2017. Out of a total of 70 visits there were five occasions when care staff had arrived either early or more usually late. Records also showed that across all of the areas during the course of 2017 there had been seven occasions when care staff had not completed a visit at all. The registered persons said that they

considered missed visits to be 'never events' in that they should never happen. They acknowledged that on some of these occasions when visits had not been completed on time or missed completely people had been placed at risk of harm. This was because they had not been supported to change position safely, keep their skin healthy and manage their continence. However, they assured us that there was no evidence to show that the people concerned had experienced direct harm as a result of these mistakes. Nevertheless, they also accepted that on other occasions the mistakes had seriously inconvenienced people and caused them anxiety that they would not receive the assistance they needed to be safe at home.

Records showed that the reasons for visits not being carried out in the right way continued to vary. However, they usually involved a combination of care staff being absent due to ill health, miscommunication between and within teams of staff and poorly organised work rosters. The registered persons told us and records confirmed that they were implementing a development plan to specifically address each of these issues. The focus of this was on continuing to recruit more care staff, strengthening the arrangements to retain care staff, employing bank care staff to cover for sickness and holidays and revising work rosters so that they were easier for care staff to follow.

However, we concluded that sufficient progress had not been made to meet this legal requirement. This was because people had not always received safe care due to shortfalls in the deployment of staff resulting in mistimed and missed visits. Consequently, there was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection between 4 and 8 July 2016 we found that there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We noted that suitable arrangements had not been made for the proper and safe management of medicines. This was because there had been a small number of occasions on which care staff had not supported people to use medicines in accordance with the prescribing instructions. These occasions had been additional to a larger number of occasions when mistimed visits had resulted in people not being helped to take medicines at the right time. There had also been another problem in that care staff had not always properly recorded each occasion when they had administered a medicine. As a result it was not clear that people had received all of the medicines that had been prescribed for them. Although these oversights had not resulted in people experiencing actual harm they increased the risk that people would not benefit from using medicines in the way intended by their doctors.

After the inspection the registered persons wrote to us and said that they had revised and strengthened the arrangements they used to dispense and record medicines in order to address each of the problems noted above. The improvements included providing care staff with additional training and completing more frequent and detailed checks of records relating to medicines management. A further development was said to be the registered persons more carefully establishing what had gone wrong when mistakes occurred.

At the present inspection most of the people with whom we spoke were confident about the way in which care staff helped them to manage their medicines. One of them remarked, "My care worker is very good and gets out my tablets for me and gives me them with a cup of tea." Another person commented, "The care staff are good and remind me if I'm running low on my medicines and help me get sorted out." Records showed that on most occasions medicines were being managed safely. We found that care staff had received additional training and knew how to manage and record medicines in the right way. We also noted that on most occasions care staff had correctly completed a record each time they had dispensed a medicine.

However, records showed that there had still been a very small number of incidents when medicines had been incorrectly administered. There had also been some examples of medicines not being given at the

right times due to mistimed visits. Nevertheless, these mistakes were significantly less frequent than had been the case at the time of our last inspection. Also, we noted that these oversights had not resulted in people experiencing actual harm. In addition, we saw that the registered manager had carefully established what had led to each mistake and had taken action to reduce the likelihood of them happening again.

Although further improvements still needed to be made to the management of medicines, we concluded that sufficient progress had been made to meet this legal requirement.

At our inspection between 4 and 8 July 2016 we found that there was a breach of Regulation 19 (2) (3) (a) Schedule 3 (4) and (7) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We noted that the registered persons had not always completed suitable background checks on new care staff before appointments were made.

After the inspection the registered persons wrote to us and said that they had strengthened the arrangements they used when recruiting care staff to address each of our concerns. They told us that all of the changes would be fully implemented by 30 September 2016.

At the present inspection we examined records of the background checks that the registered persons had completed before two new care staff had been appointed. They showed that a number of checks had been undertaken. These included checking with the Disclosure and Barring Service to show that applicants did not have relevant criminal convictions and had not been guilty of professional misconduct. Other checks included obtaining references from relevant previous employers. These measures helped to ensure that applicants could demonstrate their previous good conduct and were suitable to support the people in their home.

The improvements that had been made meant that the relevant legal requirement had been met.

People said that they felt safe when in the company of care staff. A person said, "In general, I like the staff and I think that most of them do care about their work. I feel sorry for them having to rush all of the time but they're fine with me." Another person remarked, "I feel safe when the care staff use the hoist. But quite often don't have enough time to do everything." Relatives were also reassured that their family members were safe in the company of care staff. One of them said, "I think that the staff are run ragged by Bloomsbury, but they're not uncaring people and yes I'm okay about them being in my family member's home."

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

Records showed that since our last inspection the registered persons had been asked by the local safeguarding authority to respond to a small number of concerns. This number was significantly lower than had been the case at the time of our last inspection. The concerns involved complaints received by the authority from people who used the service, relatives and health and social care professionals. We noted that most of these involved the impact of incorrectly timed and missed visits. Records showed that the registered persons had cooperated with the authority to investigate and resolve the matters.

At our last inspection we noted that the registered persons had not consistently promoted people's health

and safety by helping them to avoid preventable accidents. This included some of the care provided for a number of people who needed two members of staff to assist them. This was usually because they experienced reduced mobility and needed to be helped to transfer using a hoist or other equipment. We found that on a number of occasions only one care staff had been available to provide this assistance and this had increased the risk of an accident occurring.

At this inspection we noted that there had still been a small number of occasions when two care staff had not been available to provide the assistance in question. Some people who used the service and their relatives voiced concerns about this matter. One of the relatives commented, "We have had a problem at weekends with one carer turning up instead of two." Another relative remarked, "If the second carer is late then the first carer will use the hoist on their own. They say they have not got time to wait." However, records showed that the number of these instances was significantly lower than before. They also confirmed that none of the people concerned had experienced direct harm as a result of the shortfall in question. The registered persons assured us that they would continue to address this problem until it was fully resolved.

In addition, at this inspection we noted that a number of other improvements had been made in relation to promoting people's health and safety. These included care staff being provided with more training and detailed guidance including how best to help people to avoid trip hazards in their home. Records also showed that care staff had quickly informed the registered manager when there was a problem that needed to be addressed. On one of these occasions we noted that the registered manager had immediately liaised with healthcare professionals. This was necessary because a person had left hospital without the equipment they needed to enable them to be safely supported at home.

Requires Improvement

Is the service effective?

Our findings

At our inspection between 4 and 8 July 2016 we found that there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We noted that suitable arrangements had not been made to ensure that people were fully supported to have enough nutrition and hydration. Although this shortfall had not resulted in people experiencing actual harm it had increased the risk that people would not be correctly helped to eat and drink enough to promote their good health.

After the inspection the registered persons wrote to us and said that they had taken a number of steps to address our concerns. These included providing care staff with additional training. They also included giving care staff more detailed written guidance to better assist them when supporting people to eat and drink enough. They said that all of these improvements would be fully implemented by 31October 2016.

At this inspection some people who lived in Stamford and the Deepings were concerned that they had not always been given all of the assistance they needed to eat and drink. This was usually because their visits had been mistimed or missed. We noted that at least one missed visit and one mistimed visit had interrupted the care provided for a person who took their nutrition and hydration through a special tube. The person concerned relied on staff to help them to use the tube and so on both occasions they had not received all of the nutrition and hydration they needed. Other people said that some staff were 'slapdash' when they were in a rush and quickly made them a sandwich when it had been agreed that they would receive a hot meal. A person commented on this saying, "If it's cold weather I don't want a sandwich. I just don't argue anymore. It's easier to leave it and wait for my friend to warm me up some soup later on."

However, most of the people who lived in the other areas told us that care staff were helping them to eat and drink enough. Speaking about his a person remarked, "My care worker is pretty good and makes me my breakfast, lunch and tea every day. They always ask me what I want and they also leave me a drink and a snack for later on." In addition, most of the records we saw showed that staff were regularly helping people in all of the areas by making meals and drinks for them and reminding them about the importance of keeping their strength up.

Although further improvements still needed to be made to the way in which people were supported to eat and drink enough, we concluded that sufficient progress had been made to meet this legal requirement.

At our last inspection we found that there were shortfalls in the way care staff were provided with introductory training. At this inspection we found that the registered persons had strengthened key parts of the training provided for new care staff. This had resulted in care staff receiving more and better organised introductory training before working on their own without direct supervision. However, records showed that this initial training did not fully meet the requirements of the Care Certificate. This is a nationally recognised model of training for new care staff that is designed to equip them to care for people in the right way. The registered manager recognised that further progress needed to be made in relation to this matter and they showed us documents which confirmed that arrangements were in hand to address the oversight.

At our last inspection we also noted that some care staff had not been provided with all of the refresher training planned for them by the registered persons. Again, at this inspection we found that the registered persons had revised the way in which refresher training was provided. Records showed that this had enabled most care staff to undertake nearly all of the training that the registered persons considered to be necessary. We also noted that care staff were more regularly meeting with someone senior to review their work and to plan for their professional development. In addition, records showed that new arrangements had been made to ensure that care staff benefited from participating in an annual appraisal of their work.

We checked the knowledge and skills of 10 members of care staff and found that they knew how to care for people in the right way. Examples of this was included care staff knowing how to correctly care for people who were at risk of developing sore skin or who needed extra help to promote their continence. Other examples included us seeing first-hand how care staff correctly followed good infection control practices such as regularly washing their hands and wearing disposable gloves when providing close personal care.

However, our records also showed that since our last inspection there had still been a limited number of occasions on which particular care staff had not known how to provide care in the right way. These incidents included a member of staff not knowing how to safely use a hoist to assist someone who experienced reduced mobility. Another incident occurred when a member of staff had not been aware of how to correctly support someone who needed help to administer insulin. Nevertheless, records showed that the people concerned had not experienced direct harm as a result of the mistakes. In addition, we noted that the registered manager had taken action to help prevent the mistakes from happening again that included providing the care staff concerned with additional guidance and tuition.

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 found that the registered persons and care staff were following the Mental Capacity Act 2005 in that care staff had supported people to make decisions for themselves. We saw an example of this when a member of staff gently explained to the person why it was important for them to always have their lifeline alarm within easy reach. This was so that they could summons assistance in an emergency. A relative remarked about this saying, "I think most of the staff are looking out for their clients when they have the time and aren't rushing through visits to get onto the next one."

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

People said and records confirmed that they had been supported to receive all of the healthcare services they needed. This included care staff consulting with relatives so that doctors and other healthcare professionals could be contacted if a person's health was causing concern. Speaking about this a person remarked, "My main care worker is very good and has reminded me to contact the optician when I'm due my next check-up. That's important for me because I need to have them checked due to my medical condition."

Good

Is the service caring?

Our findings

People were complimentary about most of the care staff who they said were caring and kind. One of them said, "I do find the staff to be caring and nice people. I feel sorry for them having to work so hard and having to muddle along". Another person said, "I have no problem with the staff. I know that they would like to do more and spend some time just chatting but so often they can't because they've got to rush off." Relatives were also confident that care staff were kind and caring in their manner. One of them said, "Yes, the care staff are very kind and professional."

At our last inspection between 4 and 8 July 2016 some people gave us examples that concerned them. One person said that care staff sometimes spoke across them and even occasionally used bad language in their presence. At this inspection no one said that this was still a problem. We were present when two care staff called to complete a visit to two different people. We noted that they politely asked the people how they were and enquired about assistance each of them wanted to receive during the visit.

Another concern about which we were told at the last inspection was care staff not always respecting people's wishes with respect to maintaining good standards of personal hygiene. We were told that care staff sometimes did not wear their uniform and that on occasions care staff did not use personal protective equipment such as disposable gloves and aprons. At this inspection no one raised these concerns with us. The two members of care staff we saw during their visits to people's homes were neatly presented and were wearing clean uniforms.

Other concerns raised at our last inspection included several ladies who told us that male care staff had sometimes called to provide them with close personal care. This was the case even though they had specifically said that they only wanted their close personal care to be provided by female care staff. At this inspection people did not raise this matter with us as a particular concern. Also, we noted that a large majority of the care staff were female. The registered manager said that this made it easier for care to be provided in a way that respected people's personal wishes.

Records showed that most people could express their wishes or had family and friends to support them. However, for other people the service had developed links with local lay advocacy services that could provide guidance and assistance. Lay advocates are people who are independent of the service and who support people to make decisions and communicate their wishes.

At our last inspection some people who lived in Stamford and the Deepings expressed concerns about how the service managed and respected confidential information. We were told that some care staff were openly critical of their employer, while others made disparaging remarks about named colleagues. In addition, we were told that some care staff even spoke to them about other people who used the service. At this inspection people did not express any concerns about this matter. One person summarised the general view saying, "I think that the staff in general are more professional now. There are ones who like a natter a bit more than they should – but then again I encourage them I suppose by nattering myself. I don't think anything too confidential is discussed."

We saw that paper records which contained private information were kept in a file in each person's home. These files were placed discreetly out of sight when they were not in use. In addition, electronic records were held securely in the service's computer system. This system was password protected and so could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

At our inspection between 4 and 8 July 2016 we found that some people had not always been provided with a written care plan that described in detail all of the assistance they had agreed to receive. We also found that some people had not been fully consulted about any changes they wanted to make to the help they were given as they went along. At this inspection we noted that the registered persons had strengthened these aspects of how the service was run. During our visits to people at home we found that each person had been provided with a care plan. These documents provided a suitable account of the assistance each person said that they wanted to receive. In addition, most people told us and records confirmed that senior care staff had been to see them or had telephoned them every so often. This had been done to check that their changing needs for care continued to be met in the right way.

However, some people who lived in Stamford and the Deepings continued to not be satisfied with some of the arrangements used to allocated care staff to complete their visits. They were critical because they were not always informed about which care staff were going to call to see them on a particular day. A person commented on this saying, "Quite literally, I never know who's going to turn up. I have asked on numerous occasions to be sent a roster each week and have never had one." Another person remarked, "I've been promised a roster and then as usual with Bloomsbury nothing has arrived and I've just given up asking." Someone else told us that as a result of this shortfall they had not been confident to allow a member of care staff into their home. This was because they had not been told who would call, did not recognise their voice and could not establish their identity. They told us that as a result of this they had to arrange for a friend to visit them to provide essential care they needed to manage a healthcare condition. However, most of the people living in the other areas did not consider this matter to be a significant problem. One of them remarked, "There aren't that many changes to the staff who come to see me and I sort of know who's coming on most days because the staff work it out between them and tell me."

At our last inspection people generally had been concerned about the arrangements made to notify them when care staff had been delayed so that their visit was going to be significantly late. At this inspection some people living in Stamford and the Deepings were still concerned about this issue. One of them said, "I never know who is coming." Another person commented, "The care staff are not always on time. They can be up to two hours late and only sometimes call to let me know."

The registered manager advised us that care staff were expected to telephone ahead so that people could be reassured that their visit would be completed. However, we found that some care staff were still not clear about the correct procedure to follow. As a result of this we saw that different arrangements were being used. Some care staff said that they just worked as quickly as they could to make up time while some relied on colleagues in the main office to notify people. Other care staff told us that they usually telephoned people themselves if they anticipated being very late. One of them remarked, "I know it is a dreadful muddle isn't it. Even when I have told the office I'm running late when I do get to the next client the office still haven't told them. Naturally, the client has been upset because of not knowing if anyone's going to turn up."

Some people who lived in Stamford and the Deepings also told us that they continued to be concerned

about the arrangements that had been made for them to contact the service when they had a query. In particular, they said that too often when they dialled the service's out of office hours telephone number they could not get through or did not receive a prompt reply. A person spoke about this and remarked, "There have been occasions when I've dialled the on-call number because a care worker hasn't turned up and quite simply no one has returned my call. So I'm left there on my own with no one to turn to. Sitting at home alone you feel powerless."

We raised this matter with the registered persons who assured us that they had thoroughly reviewed how well the on-call system was working. They also said that as a result they had made a number of changes. These included providing both office staff and senior care staff with clearer guidance about responding to enquiries. We telephoned the on call service on four occasions during the day and at 6.00pm a Sunday evening. On each occasion the telephone was promptly answered.

At our last inspection some people who lived in Stamford and the Deepings told us that they were not satisfied with the amount of time that some care staff were able to spend with them. At this inspection some of these people repeated this concern. Summarising this view one of them said, "On some days the care worker rushes in, flies about and rushes off again. They do the main things they have to but it's not what I would call caring care." Another person commented, "One care worker stood in the doorway, asked if I needed anything and then left. She was here about three minutes." Some relatives were also unhappy about the way in which most visits were completed. One of them said, "Everything seems to be a rush and the absolute minimum seems to be the 'new-normal' for Bloomsbury." The records we looked at for the 70 visits completed in Stamford and the Deepings showed that most of them had been completed in less time than had been allocated. However, most of the shortfalls were a matter of several minutes and only a small minority had been completed in less than three quarters of the correct time. Also, other records we checked for some of these visits showed that in each case care staff had completed the tasks that were described in the persons' care plans. Nevertheless, we raised our concerns about this 'clipping' of visits with the registered persons. They said that they recognised the importance of the issue and accepted that shortened visits increased the risk of care staff rushing, making mistakes and not providing care in the right way. They assured us that the steps they had taken to provide more staffing resources as described earlier in our report would continue to address the problem.

In-spite of the various concerns people expressed most of them did consider that care staff usually provided them with the basic care they needed. This included assistance to wash and dress, promote their continence and complete household tasks such as making their beds. We looked at the records that care staff kept of each visit to double check this matter. Although some of the records were incomplete, in general they confirmed that people had been given most of the assistance they needed and expected to receive. A person summarised the overall assessment we were given saying, "Most of the care staff on most days give me the help I need. On most days it's rushed but I am able to manage at home as a result of their efforts. For that I'm grateful and things had got a tad better. You still couldn't say that it's anywhere near being a good service. But it's just enough and for Bloomsbury any improvement is welcome. "

People who used the service and their relatives had received a document that explained how they could make a complaint. The document included information about how quickly the registered persons aimed to address any issues brought to their attention. Several people living in Stamford and the Deepings and their relatives spoke to us about having made a complaint to the registered persons. Most of them were critical about their experience. One of the relatives said, "I did write to complain but I heard nothing more about it and then I telephoned and yes you've guessed it I heard nothing more about it." Another relative remarked, "We often have to phone to see where carers are. The office staff are not particularly helpful. We leave messages and they don't always return our calls." However, some people who lived in the other areas

recounted a more positive experience. One of these relatives remarked, "Once you actually get through to the registered manager, they're polite and they do look into things. In the end I got quite an apology for what had gone wrong and quite a detailed response."

We reviewed a selection of the complaints that had been received by the registered persons since our last inspection. We noted that as at our last inspection most of these referred to incorrect visit times, missed visits, inadequate completion of care tasks and the difficulties people had experienced when trying to contact the registered persons. However, although records showed that each complaint had been investigated too often the actions taken to put things right had not been effective. An example of this was changes that had been made to how particular senior care staff prepared and checked the work rosters that care staff used to plan their visits. We noted that on some occasions the improvements had not been sustained resulting in rosters not always clearly giving care staff all of the information they needed. The registered persons acknowledged that there continued to be problems in embedding improvements in the service. They said and records confirmed that measures were being introduced to resolve the problem. These included providing care staff with regular written updates about any changes that were being made to systems and processes and explaining what the changes meant for them.

We noted that there were a number of examples of the service respecting people's individuality and supporting people to make choices about the activities they wanted to do. One of these was the way in which care staff altered the timing of some of their visits so that people could be supported to go to day centres and attend family get-togethers. Another example was people being supported to keep in touch with relatives by telephone. In addition, a person told us about how they were assisted to meet their spiritual needs by care staff who had reminded them when a religious programme was due to be shown on the television. These examples showed that the care staff concerned recognised the importance of providing care in a responsive way.

Requires Improvement

Is the service well-led?

Our findings

At our inspection between 4 and 8 July 2016 we found that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We noted that suitable arrangements had not been made to protect people who used the service against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of the service provided. This shortfall had led to the persistence of problems in reliably completing visits so that people received safe and responsive care. It had also resulted in other problems in staff training and recruitment of new care staff. In addition, the registered persons had not been in a position to suitably demonstrate to us that accidents and near misses had been properly investigated. This was necessary so that action could be taken to help prevent them happening again. Another consequence had been the registered persons not ensuring that people fully benefited from care staff acting upon good practice guidance.

After the inspection the registered persons wrote to us and said that they had taken a number of steps to address our concerns. These were the introduction of new and more robust quality checks completed by the registered manager. They also included senior care staff calling more regularly to people's homes to receive feedback and to check first-hand how well care was being delivered. In addition, we were told that people had been invited to complete a quality assurance questionnaire that asked them how well the service was doing. A further improvement involved care staff using good practice guidance to develop the quality of the care they provided for people who lived with dementia. The registered persons said that together these changes would enable them to more effectively resolve problems so that the service was better able to meet people's needs and expectations. They said that all of these improvements would be fully implemented by 31 December 2016.

At this inspection we found that a number of improvements had been made. Records showed that more detailed checks had been completed in relation to a number of aspects of the service. These included staff rosters, visit times, the tasks completed during visits and the management of medicines. We also noted that more detailed checks were also being completed in relation to the recruitment of care staff, staff training and the management of accidents. In addition, records also showed that more visits had been completed to people at home both to receive feedback and to check on the quality of the care that was being delivered.

We also noted that the registered manager had arranged for three senior members of care staff to become 'dementia champions'. This involved them undertaking additional training and receiving regular updates about new models of care. We saw that this had enabled them to provide useful information and guidance for their colleagues.

However, some people who lived in Stamford and the Deepings and their relatives continued to not be wholly satisfied with the management of the service. Speaking about this a relative remarked, "The service is better that's true, but that's not saying much given how bad it was at the start. It's still not good enough and Bloomsbury needs to continue to improve. It won't be adequate until all visits are completed on time by staff who aren't rushing." Another relative said, "The staff are generally okay when they arrive but Bloomsbury's organisation is often unreliable and sometimes it's just plain chaotic." However, people living

in the other areas gave us a more positive assessment. One of them remarked, "I know that Bloomsbury has had problems elsewhere but in this area it seems to run okay and I get the care I need."

Although further improvements still needed to be made to the way in which quality checks were completed and improvements were sustained, we concluded that sufficient progress had been made to meet this legal requirement.

At our inspection between 4 and 8 July 2016 we found that there was a breach of Regulation 18 (2) (a) (iii) (e) (f) (g) (i) of the Care Quality Commission (Registration) Regulations 2009. We noted that the registered persons had not always told us about significant events that had happened in the service. These events include occasions when someone may be placed at risk due to abuse, neglect or an accident resulting in significant injury. By not always notifying us about these matters the registered persons' had reduced our ability to establish what had happened. They had also delayed us seeking any assurances that we needed to ensure that people who used the service were kept safe.

After the inspection the registered persons wrote to us and said that they had strengthened their procedures. This had been done to ensure that we would promptly be notified about any significant events that occurred in the service in the future. They said that this improvement would be fully implemented by 1 August 2016.

At this inspection we noted that the registered persons had correctly informed us about the occurrence of the events in question.

The improvements that had been made meant that the relevant legal requirement had been met.

Care staff told us that there were various arrangements at local level that were intended to help them to undertake their duties. These arrangements included being invited to attend regular team meetings when they could discuss their work and iron out any problems. However, some care staff working in Stamford and the Deepings considered that further improvements continued to be needed in how the service supported them. They said this was necessary to address problems including unrealistic expectations of the number of visits they could complete and disruptive last minute changes to their rosters. They also said that improvements needed to be made in the way visits were allocated so that they did not waste too much time going back and forth across town. Speaking about this a member of care staff remarked, "Most days now are sort of okay but other days can still just be chaos. The other day my roster was suddenly almost doubled because someone was off sick and there was no one else to do the calls. I had no hope of getting to the calls on time and the office staff just told me to do my best. I was well late by the end of the round, even with rushing – and of course the office staff hadn't told most of the clients I'd be late."

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People had not always received safe care due to shortfalls in the deployment of staff resulting in mistimed and missed visits. Consequently, there was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.