Firstpoint Homecare Limited

Firstpoint Homecare Bristol

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

We carried out an inspection of the service on 5 and 11 January 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be in the office. This was the first inspection of Firstpoint Homecare Bristol at their Kingswood Office.

Firstpoint Homecare provides personal care to people in their own homes. At the time of our inspection 73 people were using the service supported by a team of 27 staff.

It is a condition of registration that the service is managed by 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. At the time of the inspection the service was without a registered manager. The previous registered manager left in October 2015. There was a manager who had been in post since August 2016 but as yet they had not applied to be registered with the Care Quality Commission (CQC).

We found the provider was not meeting the regulations around the safe management of medicines, safe recruitment, ensuring there was an effective induction and ongoing training of care staff. Systems were not effective in monitoring the quality of the service and statutory notifications were not being submitted as required by the CQC.

The manager told us in their completed Provider Information Return that monthly telephone reviews were used to ensure people's needs were being met and changes could be made if necessary. They reported that daily logs were audited weekly so that they knew what was happening in people's homes and allowed them to address issues promptly. However, these systems were not happening in practice.

We received positive feedback from people who used the service and relatives. They told us the care was personalised and they were happy with the service they received. They told us the majority of time they were supported by the same staff and they turned up on time and stayed for the full duration of the visit. People were happy with the support they received with their food and drink and people's day to day health was maintained. People told us they did not have any concerns about the safety of the service.

People told us staff were kind and caring and they were supported to make choices about their care. People were cared for in a dignified way and their independence was promoted.

Staff generally spoke positively about the new manager. It was evident this had been a difficult year with many staff and the previous registered manager leaving. The manager was working often alone in the office completing all the administrative tasks and planning the care and support to people. Recruitment had been ongoing since they took up post.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

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.

Medicines were not always managed safely on behalf of people. Recruitment procedures were not safe to ensure suitable staff were supporting people. There were sufficient staff and recruitment was ongoing.

Staff understood their responsibilities to protect people from abuse or avoidable harm and would report any concerns to the office. However, some staff had not received training in this area.

Risks were identified in relation to the care of people and minimised.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received a suitable induction and ongoing training.

Staff were aware of their responsibilities under the Mental Capacity Act 2005. However, not all staff had received training in this area.

People were supported with their nutritional and healthcare needs.

Is the service caring?

Good

The service was caring.

People told us staff were caring. People and their relatives were involved in the assessment process and felt they had a say in how they wanted to be looked after.

People had access to information they needed about their care.

Is the service responsive?

Requires Improvement

The service was responsive.

People received the care and support that met their individual needs which had been reviewed. However, care plans could give staff more guidance on how people would like to be supported.

People knew how to complain. Where a complaint had been made this had been investigated.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager working at the service. The manager had not registered with the Care Quality Commission. The provider had failed to notify us of the change of management and the interim arrangements. They had also failed to notify us of a safeguarding concern.

Systems and processes were not established or operated effectively in respect of monitoring the service.

Staff spoke positively about the manager and the open door approach.

Firstpoint Homecare Bristol

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 5 and 11 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be in the office. The inspection team consisted of one inspector.

Before the inspection, the provider completed 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.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We spoke with the local authority commissioners for the service. We spoke with four people who used the service and two relatives on the telephone. We also spoke with the manager, an office administrator, two senior care staff, five care staff and the clinical lead for the organisation. Their comments have been included in the main body of our report.

We looked at the care records for five people who used the service and other associated documentation. We also looked at records relating to the running of the service. This included staffing work plans policies and procedures, quality checks that had been completed, supervision and training information for staff and recruitment records for six staff.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe when receiving care from staff. They said they had the confidence in the small team of staff who were supporting them. One relative told us they did not always know in advance who was supporting their relative and there had been two occasions when visits had been missed before Christmas. They said their relative had not been at risk as they were able to assist. They said the manager was apologetic once they had been made aware and said they would investigate. Another relative told us they also experienced a missed visit when they initially used the service. However, they said the manager had responded to the call and completed the visit within half an hour. They told us they were happy with the response and generally felt their relative was safe when in the care of the staff.

The manager told us in their completed Provider Information Return, "We have safe recruitment policies in place which is followed and include face to face interviews, enhanced DBS and references". However, we found there was unsafe recruitment systems in place to ensure staff were suitable to work with vulnerable people. Of the six staff recruitment files we viewed five were incomplete. They did not contain two references or a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults. One of the applications did not include a full employment history. For two of the newly employed staff there was no evidence of an interview which would have evidenced any gaps in their employment or the lack of information had been discussed and verified. This meant the provider and the manager could not be assured these newly appointed staff had the skills, experience or were suitable to work with vulnerable people. The manager confirmed all four staff were working unsupervised with people. One of the members of staff on the first day of the inspection brought in their DBS certificate. The manager told us all staff were on a zero contract so where the full recruitment information was not available they would now stop them from working until it was in place.

This was in breach of regulation 19 (1) (a) (b) (c) (2) and (3 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper person employed.

People's medicines were not always managed safely. This was because there were gaps in some of the medication administration records (MAR). Staff were signing for the number of tablets given rather than for each prescribed medicine. There was no information about the medicines people were taking including the name of the medicine, the time and the dose on the medicine administration record. The clinical lead told us this documentation had recently been reviewed and now medicine records were recorded on a weekly record and staff only signed for the number of tablets people were taking where this was put in a dispensing device by the pharmacist. They told us staff were meant to attach a list of medicines each person was prescribed to the MAR but this was not happening in practice. There were three separate records, one for topical creams, and another for medicines that had been placed in a prepared dispensing device and another for those that were in the original packaging. This meant people could not be assured they were receiving their medicines as and when they were prescribed.

The MAR's were meant to be checked weekly to ensure there had been no errors. Not everyone's medicine

record had been returned to the office promptly. This meant weekly checks were not being completed. Where these had been checked with gaps noted or discrepancies there was no evidence these had been followed up with the staff member. We saw a large box containing people's medicines administration records. There was no order to these records and the majority had not had been checked.

This was in breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Care records included the support people needed with their medicines. This included a risk assessment on their ability to take their medicines safely. Where staff support was needed this was recorded in the person's care plan. Staff told us they had received medicine training in respect of the expectations and the recording. The manager told us staff competence was checked during the three monthly spot checks. This is where a senior member of staff would observe the practice of a member of staff in the course of their day to day work.

The provider employed 27 care workers to provide care and support for 73 people. The manager told us there were enough care to cover all scheduled home care visits. They told us they would not agree to any new packages of care unless there were sufficient staff. The manager told us recruitment of new staff was continual to ensure they could meet the needs of existing care packages and enable them to take on new people. The manager told us there had only been one missed visit in the last six months, which they had responded to immediately once they had been made aware. However, another person also told us about two missed calls, a tea visit and an evening call just before Christmas. We also saw a further visit was missed from looking at the electronic notes of a fourth person. The manager told us they were not aware of these.

People had been assessed in relation to priority of visits. The manager told us this enabled them to plan care and ensure people got the care they needed in the event of an emergency such as severe weather conditions. For example a person with diabetes, reliant on staff to assist with medicines and food with no family support was given a rating of red. Where as a person who lived with family who were happy to assist were rated a green. Priority was given to people with a rating of red with a visit being completed, then those rated as amber. Where people were rated as green then phone calls were made to ensure they were safe and managing their own care.

Staff confirmed they knew what to do in the event of an allegation of abuse being made. Three members of staff told us they would have no hesitation in reporting concerns to the office and knew these would be dealt with promptly and the manager would do the right thing. Only one member of staff was aware of the role of the local safeguarding team in respect of responding to allegations of abuse.

Two of the seven staff told us they had completed safeguarding training and this was updated annually. When we asked the manager who delivered the training for this we were told it was a senior care worker. There was no evidence this member of staff had completed training in this area to enable to them to teach the care staff. It was also evident from talking with staff they were not aware of the role of the local council in responding and investigating any safeguarding concerns or allegations. They told us their role was to report to the office.

There were policies and procedures to guide the staff on what to do if an allegation of abuse was made. The staff handbook included what to do in the event staff were concerned about the wellbeing of a person including when an allegation of abuse was made. There was also information in the service user guide which was available for people using the service on what they could do if they were concerned about staff practice. This directed them to the manager of the service. This meant people using the service and staff had access

to this information. The manager had raised an alert promptly and put suitable safeguards in place to protect the person.

Each person had a care file which contained information to keep them and the staff safe. Environmental risk assessments had been completed as part of the initial assessment process. These had been kept under review. People had personalised risk assessments. This could be risks due to the use of bed rails, a medical condition and the delivery of personal care. Where moving and handling equipment was used this was clearly described including the specific equipment to be used. Staff confirmed they received regular training in safe moving and handling training as part of their initial induction. A relative told us they were aware that staff could not assist with moving and handling but identified they could sometimes needed supported in this area. We fed this back to the care co-ordinator and the manager as this person may benefit from a reassessment. Where people required the assistance of a hoist staff and the manager told us this was always done with two staff. A relative confirmed two care workers visited them because a hoist was required to assist. They told us on the rare occasions they would assist the member of staff where the agency was unable to cover the second member of staff.

The manager told us they were a moving and handling assessor and took the lead for the agency. Another member of staff also told us they had completed this training in September 2016 and were able to train the staff in this area and had reviewed all the moving and handling assessments for people. Certificates were seen confirming they had completed the training and this was current for two years.

Staff told us they had access to equipment they needed to prevent and control infection. They said this included protective gloves and aprons. The manager told us staff were given sufficient uniforms to enable them to wash them regularly. Spot checks were carried out to observe whether staff were following the correct infection control procedures. This included whether the staff member was presentable and their uniforms were well laundered and they were using gloves and aprons. The provider had an infection prevention and control policy.

Staff working for the agency were employed on a zero contract which meant they were not guaranteed work. The manager told us about two care workers whose performance had come into question. The manager said they had not allocated any hours to these staff. There was a risk that because the disciplinary procedures had not been followed, these staff would then move to another care provider and put vulnerable people at risk. This also meant the staff were not protected in respect of their rights and employment law.

Requires Improvement

Is the service effective?

Our findings

Most people we spoke with thought staff were trained sufficiently to be able to provide the care and support they needed. Information we had received prior to the inspection via our survey from a relative stated, "My father has received a very sporadic service. He isn't treated with dignity or understanding of his illness. He has dementia. I have asked his main carer if she has been trained for caring with people with dementia. She insists that she has but always talks to him as if his feelings do not matter". Another relative told us in the survey, "My wife was given a care worker based on a walking career (they were able to walk to their destination) not her needs and we could not understand her language, my wife has dementia". The manager told us they supported people with varying needs which included supporting people living with dementia, a learning disability or mental health needs. We checked out whether staff had completed any training and found there was no evidence staff had completed training in dementia, supporting people who had a diagnosis of mental health or any specific training to enable staff to support people with a learning disability.

Staff told us they had an induction prior to them working with people. They said they had completed training in moving and handling and record keeping. When we asked if they had completed training in mental capacity, safeguarding, first aid, food hygiene, health and safety, person centred care they all confirmed this had not been covered. We spoke with the trainer who told us they were only competent to train staff in moving and handling and record keeping. This was highlighted to the manager who was of the understanding the trainer was covering all the topics required by Firstpoint Homecare Limited. They told us there were comprehensive workbooks and DVDs that staff were expected to watch and complete. Firstpoint Homecare train staff to become trainers. There was no evidence that the member of staff had completed this training to enable them to competently train staff.

The manager told us on day two of our inspection the role was being reviewed and an additional trainer would be appointed to assist. From reviewing the records of staff employed after September 2016 they had not completed a comprehensive induction. Three staff had not had any training and were working unsupervised. The manager said this was because they had worked in care prior to working for Firstpoint Homecare Limited. There was no evidence that their previous qualifications had been verified. There was no evidence staff had completed the care certificate. This is a nationally recognised induction for staff new to care, which was introduced in April 2015 for all care providers.

We checked whether the four staff that had worked for the agency for more than a year had completed any updates in the last 12 months. There was no evidence that any update training had been completed. Training was being offered to staff on day two of the inspection in respect of moving and handling. However, not all staff had signed up to complete this.

This was a breach of regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

The clinical lead and the manager told us Firstpoint Homecare Limited had developed some learning

materials called 'quick bits' for staff. These covered subjects such as mental capacity, continence and dementia. They said these were being rolled out to staff and there would be an expectation that staff would complete a knowledge test after they had read the information. The clinical lead also told us they were planning to give all staff a pocket guide to the mental capacity act which had been developed by Skills for Care. The manager told us staff could also apply for a loan towards training. One member of staff confirmed they had been supported to do a counselling course. The manager said this would be beneficial for staff where they had experienced a difficult situation in their role as a care worker.

Staff told us they received regular supervisions and spot checks from one of the senior care workers. A spot check was where a member of staff was observed when delivering care to ensure they were working to the expectations of the company. Supervision meetings were where an individual employee meets with their manager to review their performance and discuss any concerns they may have about their work. There was no tracker in place to enable the manager to monitor whether the 27 staff were receiving supervisions and spot checks at the required intervals. The manager told us these should be completed with all staff every 3 months. Annual appraisals had not been completed since 2015.

People using the service were presumed to have mental capacity to make their own decisions about their care and support unless there was evidence to the contrary. As part of the initial assessment the staff assessed whether the person had the capacity to make decisions about their care and support in conjunction with information from the commissioners of the service. Where people lacked the mental capacity to make informed decisions relatives and other social care professionals were consulted.

The Mental Capacity Act (MCA) 2005 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.

Care staff we spoke with told us they had not received training about the MCA. However, they were able to tell us that it was important for people to be included in any decisions about their care and where a person may lack capacity it was still important for people to feel in control and to be given a choice. Staff fully understood that they could not provide care and support without a person's consent. Where people refused care then this was respected and information shared with the office where there were concerns about a person's capacity.

People and relatives we spoke with told us the care staff clearly explained what they were doing before they started delivering personal care. Policies and procedures were in place relating to MCA and written consent. However, these would benefit from a review as the MCA did not include the five principles of the act which underpins the act and protects people's rights to make decisions. The written consent policy stated that any relative such as a parent, spouse, partner, child or grandchild could provide written consent to treatment. However, this would not be legally binding unless they had the legal responsibility to do so, such as a power of attorney. By the second day we were shown two updated policies. The written consent policy made reference to previous legislation which had now been superseded by the Health and Social Care Act 2014.

The manager told us no one they were supporting was at significant risk of malnutrition at the time of the inspection. However, where people had a reduced appetite then a food and drink record was maintained. Care plans clearly identified the support people required in respect of meeting their nutritional needs. Some

people had ready meals delivered to their homes, which staff then heated up during their visit. Staff clearly recorded people's nutritional intake or that they had made a jug of squash before they left or whatever the person preferred in the daily visit log. The manager told us they would liaise with family or the person's GP if they were concerned about whether a person was eating sufficiently.

Generally people or their families were responsible for meeting their health care needs such as attending healthcare appointments or liaising with their GP. However, staff told us if they were concerned about a person's health they would contact the office for advice who would then contact the person's family where relevant and other health care professionals. Staff gave us examples where they had made contact with the person's GP, contacted 111 or emergency services in respect of a medical emergency.

Good

Is the service caring?

Our findings

A relative told us, "The staff we have are excellent, two in particular (they named both members of staff). They told us that one of the members of staff had gone the extra mile on a number of occasions, which included colouring their relative's hair and waiting until an ambulance had arrived when their relative was unwell. This member of staff then volunteered to collect the relative from the hospital in the early hours of the morning in their own time. Another relative told us, "The staff pander to her every whim, they all very good". Another person told us, "We don't feel like a number on a list, we are very happy with the staff that visit us". The manager told us about other examples of how staff had gone the extra mile including assisting a person to move from their existing home to sheltered housing and another person where the same staff delivered a Christmas meal. The member of staff told us they did this to help the person as they were concerned they would not have a meal on Christmas day. This showed that some staff genuinely cared for the person and their family.

People told us the staff always explained to them what they were doing and asked them if they were happy before they started. Staff confirmed that they would always check with the person or the family if they were happy for the care to be delivered. One person told us, "The care staff always ask is there anything else they can do; they often put my dustbins out for me, or make me and my wife a cup of tea before they leave". Another person told us, "It's lovely my wife gets on really well with the carers she is always chatting with them which is nice because I am not a big talker, she looks forward to her visits".

A care worker told us they really enjoyed their job and felt it was really important to treat people in a dignified and respectful way. They told us they would treat people how they would like to be treated or their family member. They said it was important for people to get on with them as it was the person's home. The manager told us they tried to match people with staff with similar interests or personalities and where people reported conflicts about the personalities of care staff this was rectified. The manager told us it was very important that people got on well with their care staff especially as the care they were receiving was in their own home.

People's needs and dependencies were assessed when they first began to use the service and were regularly reviewed afterwards. The assessments were carried out by a senior care worker who, with the person's input, assessed what level of support a person required and how much they could do for themselves. This was so that people could be supported to be as independent as they wanted to be. A person told us, "Staff help me to do the things I cannot do but encourage me as much as possible". A relative told us, "The staff are very good sometimes my wife can do for herself and other times she cannot but the staff always support appropriately".

Care staff told us they knew about people's needs because they read people's care plans. They told us they read people's care plans before they visited for the first time in order to understand their needs and get to know something about the person they could talk about. People confirmed they were consulted about their care plans and had signed where relevant. One person told us they signed on every visit to confirm the staff member had supported them at the correct time and for the full duration.

People using the service and their representatives were involved in making decisions and planning their care and support. They were involved in the assessments of their needs which included discussions about the times of the care visits. A relative told us a representative of the agency had visited them to discuss their needs and they had felt very much part of the process.

People told us the staff treated them in a dignified and caring manner. This included respecting their privacy. People told us the staff always knock before entering their home and personal care was delivered behind a closed door.

The manager told us people were asked their preferences in respect of the gender of staff. However, there was no record of this happening on the assessment. The clinical lead told us the initial assessment form was being updated and this would be included moving forward. There was a policy on gender specific support which stated whilst they would try to accommodate as much as possible it was recognised this may not always be possible. The manager told us that no one had expressed a preference in respect of the gender of staff. However, from the telephone surveys we were sent after the inspection one person had stated they preferred male carers. The manager told us there was only one male care worker working for Firstpoint Homecare and whilst they would try to accommodate people's preferences they acknowledged this could be difficult.

People had access to their care plans and also the daily notes which were completed by care staff and kept in their homes. People therefore had access to information about their care and support. People also had a service user guide, which included information about the service and the standards expected of the care staff.

Requires Improvement

Is the service responsive?

Our findings

People told us they received the care and support they expected, that care staff were punctual and as far as possible, they received care and support from the same care staff. People told us they understood their care staff could sometimes be late and were usually kept informed if this was the case. They understood that often the traffic in and around Bristol could delay care staff or sometimes they had to respond to emergencies such as a fall or wait for an ambulance. One person told us, "On one occasion I was informed that the staff would be late and another member of staff visited me instead". It was evident people understood that in these unusual circumstances this was acceptable and often unavoidable.

People's needs were assessed annually or more frequent where their care needs had changed. The manager told us they had reviewed everyone's care plan in September 2016. A senior care worker told us there was now a dairy in place to ensure everyone was reviewed at least annually. The manager told us the senior care workers would assess new clients and ensure Firstpoint Homecare could meet their needs. They would then devise a care plan based on the service commissioned and the needs and preference of the person.

People and their relatives were involved in developing their care and support plans. Care plans contained basic information to enable staff to respond to people's needs. Information was minimal in some cases for example one person's care plan stated, 'To help me with the tasks I can't do', there was no further information for staff on what the person could and could not do. Another example was 'To assist with a shower'; there was no recognition that the person may have individual preferences in the way they were supported. Staff told us they always asked people how they liked to be supported. The manager told us they recognised that staff may not always have sufficient time to be able to read the full care plan and was in the process of implementing an overview sheet of what was required on each visit. They were in the process of putting this in place.

People and relatives we spoke with said they had a small group of staff who supported them. This varied depending on the package of care. One person told us they had three visits a day, seven days a week and were supported by a small group of six staff. Another person told us they usually had the same care worker unless they were absent from work or on annual leave. Everyone spoke highly about the care staff supporting them. Most people we spoke with told us that they did usually know which care worker was going to visit them. However, one person told us they did not receive a rota telling them which care workers would visit. We discussed this with the office staff and this was rectified by day two. There had been an omission on the system to ensure a rota was printed for them on a weekly basis.

People told us staff were caring and responded to any changes in the care they required. One relative told us the staff were excellent when their mother was unwell staying until the ambulance had arrived. Another relative described how sometimes staff stayed longer than what they should. They said sometimes staff stayed longer than an hour because their wife's condition would vary which meant personal care may take longer because she was more unsteady than usual. The relative told us the care staff had told them, that it did not matter and they would not leave until they had completed all that needed to be done. Another person told us, about how their care needs had increased and they had been supported by the agency to

increase their hours and supported to speak with the local authority who commissioned the service.

The service had a complaints procedure which was made available to people and their relatives. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. The service had a system in place for recording concerns/complaints and compliments. However, the manager was unaware of the tracker form was used by the company to centrally record any complaints, concerns or incidents. Complaints were kept in a file in the office. There had been one recorded complaint in the last twelve months. The complainant had been concerned that their complaint would not be investigated without bias. In response another manager had investigated the concerns. The complaint related to infection control procedures of a member of staff. It was evident all parties were spoken with to ascertain the facts. On this occasion the complaint was not substantiated. Information was fed back to the complainant. The clinical lead said that usually complaints would be investigated by either one of the clinical leads or a manager from another branch.

During the inspection the manager told us about an occasion that a person had raised concerns about the approach of a member of staff. There was no record of this in the complaint record or the actions that had been taken to address the concerns. The manager told us the member of staff no longer worked with this person. The lack of recording means the provider could not review all concerns and actions taken to address these.

People who used the service and their relatives told us they knew how to make a complaint if they were unhappy about anything. One person said, "I've never complained and I have no complaints." A relative said, "I would speak with the office if I was concerned but I do not have any complaints at the moment". Another relative said, "I cannot recollect how to make a complaint but there is information in the care file which we have". They told us they would speak with the office.

Inadequate

Is the service well-led?

Our findings

There was no registered manager who was responsible for this branch. The previous registered manager had resigned in October 2015. In addition a care co-ordinator and another member of office staff had left at the same time. In response the agency employed an office coordinator who commenced in post at the end of October 2015 and in August 2016 they were successfully appointed to the post of manager. They have yet to submit an application in respect of becoming registered with the Care Quality Commission. The provider failed to notify us of the change of manager or the management arrangements of the service.

This is a breach of regulation 15 (1) (b) Care Quality Commission (Registration) Regulations 2009 Notice of Changes.

The provider had systems to monitor the quality of the service but these were not being consistently applied. Monthly telephone monitoring calls had not been completed by the branch for the past 12 months. The manager told us they had not completed these since being in post but the head office had completed these recently. The manager said they had not been sent the results of these and would contact the Birmingham office. The manager sent these electronically to us shortly after the inspection. Calls had been made in November 2016 to 11 of the 73 people. This meant not everyone's views were sought. Whilst the majority of the comments were positive and people either rated their service as good or excellent because the manager had not been sent copies they could not act on any feedback given. For example one person stated they preferred a male care staff and another said they did not like some care workers and a third person said care staff were sometimes late. This meant whilst people's views were sought the branch did not always act on the feedback provided. The manager told us the head office had also sent surveys to people in December 2016. The manager told us they had not received any feedback as yet. We were told the surveys were sent out annually.

There were systems to check and review records that had been returned to the office. However, we found there was no organisation to these records and they were not held securely. Medicine and daily records were kept in boxes in the office. The manager said these should be reviewed weekly for the medicine records and monthly for the daily records. Many of the records had not been checked for the last three months. One person's records had not been returned for a period of three months. This person had started receiving a service in September 2016. The manager told us they were confident staff were completing these but they had not returned them to the office. The manager emailed the main care worker requesting these were brought into the office promptly.

Where the records had been checked there was no evidence that action had been taken where improvements were identified. For example, comments included gaps in the medicine record, lack of signatures on the daily records and staff not using black pen. The same comments had been recorded over a period of six months for some people. There was a section for the member of staff to record what action had been taken this had not been completed. The manager told us they regularly sent emails to all the staff reminding them to sign records, use black pen and to complete the medicine records. There was no evidence these discrepancies were followed up with the individual member of staff. One member of staff

confirmed they received these emails and found that actually it did not help morale but made them feel upset because it targeted all staff rather than specific individuals.

The manager told us senior managers visited the service on a monthly basis. They would review the systems in place and agree any actions that were required. The visits were recorded as part of the manager's supervision record. This meant that the action plan could not be shared with the office staff because the supervision record was confidential to the manager. The manager told us recently one of the clinical leads had done a mapping exercise to the regulations. However, it was not clear whether they had assessed the branch as being compliant or identified any actions. The information was more about signposting the manager to documents or policies and procedures rather than reviewing the quality of the service. We were told the clinical lead was planning to visit the office in February 2017 to continue the checks and devise an action plan. We signposted the clinical lead and the manager to our web site and the key lines of enquiry to assist in the checking of the quality of the service.

The manager had failed to ensure recruitment systems were robust, that induction and training and ongoing support such as appraisals had been completed in accordance to the policies and procedures of the company. There were no trackers in place to review whether these had been completed for all staff. Supervisions were held in a central file in the office and it was difficult to ascertain whether all staff had received supervision or a spot check because there was no overview record of when these had been completed.

We concluded the systems and processes were not established or operated effectively in respect of monitoring the service. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

During the inspection the clinical lead showed the manager how they should be recording incidents, accidents, missed visits, complaints and compliments on a central tracker. The manager was unaware of this. When we asked the manager if there had been any missed visits they told us they were only aware of one missed visit in the last 12 months. However, from our telephone calls and from looking at the electronic records for one person there had been four missed visits.

The manager told us they did not have an induction as such and a manager from another branch had spent one day with them. They said the manager showed them how to do the payroll and went through the IT system. The manager told us they were learning on the job and support was always available if needed.

The manager told us they were solely working in the office from October 2015 until November 2016 when an office administrator was appointed. During that period they were doing all the administrative tasks such as pay roll, recruitment and the planning of care. They had been supported by three senior care workers who completed care reviews, spot checks and supervisions with staff. Two of the senior care workers had recently been appointed to new posts one as the office administrator in November 2016 and the other as a trainer in September 2016. The manager told us the last 12 months had been very difficult but had managed to keep the agency afloat.

When the previous manager left we were told they had taken the majority of the staff leaving them with only four permanent staff. During this period the majority of the care calls had been covered by other employment agencies. The clinical manager confirmed that this branch had been in crisis but the newly appointed manager had done an excellent job in changing this whilst continuing to support people who received a service and the staff team. Some people using the service told us they had noticed an improvement in the management of the service over the last six months with consistent staff and better

communication with the office. Other people told us they had no reason to call the office and were happy with the service provided.

Staff spoke positively about the manager stating there was very much an 'open door policy'. The manager told us they promoted this approach as they recognised that it was difficult to hold staff meetings due to staff working in different parts of the city. They encouraged staff to visit the office weekly and liaised through emails and text messages. Two members of staff said, "On the whole the service was well managed but felt the manager was hesitate to take action with staff for fear they would leave". They told us the manager was very supportive of staff and promoted a good home life balance. This was echoed by another member of staff who said the manager listened and supported them to enable them to do their job but also supported them when they required time off for personal reasons. One member of staff told us they had worked for Firstpoint Homecare at the previous location and in three years they had three managers. They told us they felt the present manager was one of the 'best' and 'wanted the best for people'.

A relative said they had been very impressed with the approach of the office in Bristol but less so with the out of hours service which was managed from Birmingham. They told us there had been two missed visits which if the Bristol office had known about would have been covered. When we followed this up with the manager they told us that communication could be improved with the Birmingham office and they were not aware of the two missed visits prior to Christmas. We were told sometimes telephone calls were diverted to Birmingham during the week when people were unable to get through because the lines were busy. This meant people could always speak promptly to someone if they needed too. An email was sent by the Birmingham office to the Bristol office of any calls and action taken in response to the calls. A member of staff told us often they would receive a call from the Birmingham office and often they would have to explain the needs of people in respect of priority and telling them what they were requesting was not possible due to the travelling distance.

We looked at a number of policies and procedures including safeguarding, mental capacity and written consent, recruitment, training and supervisions. When we discussed these with the clinical lead we were told these policies and procedures we had looked at were no longer current and had been updated. The manager was then signposted to the current policies on the provider's Y drive. We were told policies and procedures were updated annually. We were shown a policy in respect of written consent which was in draft stage and had been written by a senior manager but this made reference to the previous legislation which had been superseded in 2014. This showed a lack of understanding of the legislation in respect of running a care agency.

We asked the manager about their role in reporting to the Care Quality Commission. The manager had limited understanding of what they needed to notify us of. The provider has a legal duty to report certain events that affected the well-being of a person or affected the whole service. We signposted the manager to our web site. The manager told us they had alerted the local authority to a safeguarding incident where a person was at risk. They had failed to notify us which meant we could not monitor whether appropriate action had been taken to safeguard the person.

The failure to send this notification was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The manager told us they met up with other managers working for Firstpoint Homecare Limited monthly where they were kept informed of any operational updates. They said they felt supported and would have no hesitation in contacting managers of other services for advice and support. In the provider information return the manager told us, "Managers meetings are in development to ensure dissemination of good

practice and lessons to learn from near misses and safeguarding experiences".

The manager completed the provider information return (PIR) in August 2016. Whilst they identified areas for improvements these had not been implemented. For example we were told further training would be offered to all managers which would include the CQC regulations and safeguarding. There was no evidence the manager had completed this training and they would benefit from training to build on her knowledge of the legislation and the expectations of the Care Quality Commission. The service they described in the PIR was not reflective of what we found during the inspection. For example we were told monthly telephone reviews were conducted with each person receiving a service. These had not been completed since the manager took up post. We were told staff had completed training in dementia, first aid, safeguarding adults, end of life care, positive behaviour support, fire safety and mental capacity training. We were shown a training matrix that did not demonstrate staff had completed this training. The dates were recorded as completing this in 2014 but many of the staff had not been employed at this time. One member of staff completed training in April 2014 but had not started working for the agency until November 2016.

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 15 Registration Regulations 2009 Notifications – notices of change The provider failed to notify of us about the management of the services. Regulation 15 (1) (a) (b)

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify of us about an incident of alleged abuse and incidents that effect the running of the service; Regulation 18 (1) (2) (e) (g)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person was not doing all that was practicable to mitigate risks. The registered person did not have systems for the proper and safe management of medicines. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person was not doing all that was practicable to mitigate risks from unsuitable staff being employed. Regulation 19 (1) (a) (b) (c) (2) and (3 (a) (b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person was not doing all that was practicable to ensure staff were trained. Regulation 18 (2) (a) (b)

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 The registered person's systems and processes were not established or operated effectively. There were a number of breaches found during the inspection in respect of Regulation 19 Fit and proper persons employed, Regulation 18 Staffing and Regulation 12 Safecare and treatment of the Health and Social Care Act 2008 (Regulated Activities). This was because the provider's systems for monitoring the governance arrangements had not been robust enough to identify shortfalls and areas for improvements. Regulation 17 (1) (2) (a) (b) (d)(e) (f)

The enforcement action we took:

We served a warning notice. The provider must be compliant with Regulation 17, section (1) (2) (a) (b) (d)(e)(f, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 23 March 2017. If the provider fails to achieve compliance with the relevant requirement within the given timescale, we may take further action.