Care Quality Commission

Cheshire East Homecare Limited

Cheshire East Homecare t/a Surecare Cheshire East

Inspection report

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Tel: 01625468522

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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

We completed an announced inspection Surecare Cheshire East on 25 January 2017 and 30 January 2017. This was the first ratings inspection carried out at the service.

Surecare Cheshire East are registered to provide personal care. People are supported with their personal care needs to enable them to live in their own homes and promote their independence. At the time of the inspection the service supported 165 people in their own homes.

There was a registered manager at the service. 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 this inspection, we identified two Regulatory Breaches. You can see what action we told the provider to take at the back of the full version of the report.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care provided to people. Care records did not always contain an accurate account of people's individual needs and preferences.

The registered manager was not fully aware of their responsibilities to inform us (CQC) of any notifiable incidents that had occurred at the service.

We found that improvements were needed to ensure that topical medicines were managed safely.

The provider had not completed mental capacity assessments to ensure that where people were unable to give their consent, decisions were made in line with the Mental Capacity Act 2005 (MCA). Staff did not fully understand the requirements of the MCA. This meant that the provider had not considered if decisions were made in people's best interests if they were unable to do this for themselves.

Improvements were needed to ensure that staff had understood training provided to enable them to carry out their role effectively.

People felt safe when they were supported and staff had a good understanding of people's risks, although records we viewed did not always provide details of people's risks

There were enough suitably qualified staff available to keep people safe and the provider had effective recruitment procedures in place.

People were supported to eat and drink sufficient amounts in line with their assessed needs.

People were supported to access other health professionals to maintain their health and wellbeing.

People were supported in a caring and compassionate way that protected their privacy and dignity. Choices in care were promoted by staff and people's choices were listened to and acted on.

People and relatives were involved in the planning of their care. Staff knew people well and people told us they received care that met their preferences.

The provider had a complaints policy available and people knew how to complain and who they needed to complain to.

People and staff the registered manager was approachable. Staff were supported to carry out their role and the registered manager carried out checks on staff performance.

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.

Improvements were needed to the way medicines were managed.

Staff understood people's risks and the action they needed to take to keep them safe from harm. However, some improvements were needed to ensure records contained sufficient guidance for staff to follow.

People were safe from the risk of abuse because staff understood their responsibilities to identify and report suspected abuse.

There were enough staff available to provide support to people by consistent staff when they needed it.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had not acted in line with the Mental Capacity Act 2005 when people were unable to make decisions about their care and treatment. Mental capacity assessments had not been completed to ensure that people consenting on behalf of others was carried out in their best interests.

Staff received training. However, we found that the training provided was not always effective.

People were supported with their nutritional needs and staff ensured people had sufficient amounts to eat and drink.

People were supported by staff to access health professionals to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect by staff that were caring and compassionate. People were able to choose how they

were supported and staff took respected their wishes.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some improvements were needed to ensure that changes in people's needs and details of people's preferences in care were reflected in their records to ensure they received consistent and appropriate care.

People were supported by a consistent staff group who knew people well.

The provider had a complaints policy in place and staff were aware of how to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor and assess the quality of the care provided was not always effective in identifying and addressing concerns.

Records did not always contain an accurate and up to date reflection of people needs and preferences in care.

The registered manager had not notified us (CQC) of incidents that had occurred at the service as required.

Staff received checks on their performance to ensure that they supported people appropriately and actions were taken where inappropriate care was identified.

People and staff told us that the registered manager was approachable and staff felt supported in their role.

Care Quality Commission

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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 was 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 25 January 2017 and 30 January 2017 and was announced. We gave the service 48 hours' notice of the inspection because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the returned PIR to help in the planning of our inspection. We reviewed other information that we held about the service. This included notifications we received about incidents and events that had occurred at the service, which the provider was required to send us by law. We also looked at questionnaires that we had received from people who used the service and professionals to help us plan the inspection.

We spoke with seven people who used the service and six relatives, five care staff, the registered manager and the provider. We viewed seven records about people's care and seven medicine administration records. We also viewed records that showed how the service was managed, which included staff training and recruitment and records that showed how the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

People and relatives we spoke with told us that staff helped them with their medicines and they had no concerns with how their medicines were administered. Staff we spoke with told us that they felt competent to support people with their medicines and received competency checks to ensure they were administering medicines correctly. However, we saw that the medication administration records (MARs) for topical creams did not always contain sufficient information to ensure people had received their topical creams as prescribed. We saw that there were some gaps in the records and staff had not always recorded when topical creams had been applied. The MARs for some people did not consistently state whether the topical creams were required regularly or whether people needed their topical creams 'as required'. The records we viewed did not show that people's skin integrity had deteriorated but we were unable to ascertain if people had received their topical creams as prescribed.

People and relatives told us that staff knew how to support them safely in a way that met their needs. One person said, "The staff know what they are doing and I feel safe when they help me: One relative told us, "I can leave my relative knowing that they are in good safe hands". Staff were able to explain how they supported people to reduce their risks whilst they promoted peoples independence. The records we viewed showed people had been assessed for risks to their health and wellbeing. These included people who were at risk of falls, risks to a deterioration of people's skin and possible risks within the person's home. However, improvements were needed to ensure that the assessments gave staff sufficient information and guidance on how people's individual risks needed to be managed. For example; one person required their food to be prepared in a way that kept them safe from harm. This had been identified in the initial assessment but there were no details in the care plans for staff to follow, although staff we spoke with understood this person's needs. Staff told us that they sometimes had to provide care to new people when they were covering staff absences and this meant that there was a potential risk of people receiving inconsistent and unsafe care because records did not contain sufficient information about people's risks.

People we spoke with told us that they felt safe from the risk of abuse when they were being supported by staff. One person said, "I am delighted with the care. I feel absolutely safe at all times in the presence of the care workers". Another person said, "They [staff] are very good, very well spoken, they do make me feel safe". A relative we spoke with told us, "My relative feels safe and free from any harm or abuse". Staff were able to explain how they supported people to remain safe and the action they would take if they felt someone was at risk of abuse. Staff told us that they would report any concerns that someone was not being treated properly to the registered manager immediately. We spoke with the registered manager who told us the procedures they followed if they had been made aware of suspected abuse. They were aware of the professionals that they needed to inform and we saw that where there had been concerns about a person's safety they had reported this as required. This meant that people were protected from the risk of abuse.

People we spoke with told us that there was enough staff available to support them and that they stayed for the required time as assessed in the care plan. One person told us, "Sometimes staff are late but they always ring, it's only occasions when they have been held up due to an emergency. They [staff] complete all the tasks and they always ask if there is anything else to do". A relative said, "No problem at all, they [staff] are

never late and are very reliable. The staff take their time and my relative has never been rushed". Staff told us that they felt there was enough staff available to meet people's needs. One staff member said, "There is enough staff to cover people's care calls. I have enough time to get to calls and the only time I may run late is when there has been a problem at another call. I always ring the office who tell the next person on my rota". Another member of staff said, "We are a good team and we cover each other's calls if there is sickness or holidays so that people still receive care when they need it". We spoke with the registered manager who told us that they had a good team of staff and where there was sickness at late notice the permanent staff covered the hours to ensure people received their care and support. We saw that the provider had a system in place to assess the amount of staff required against the needs of people. This meant that there were sufficient staff available to meet people's needs and the provider had a system in place to assess these levels regularly.

We saw that the provider had a recruitment policy in place and the registered manager had followed safe recruitment procedures. The registered manager had undertaken checks that ensured staff that were employed at the service were suitable to provide support to vulnerable people.

Requires Improvement

Is the service effective?

Our findings

The 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. Staff did not have a clear understanding of the actions they needed to take when a person lacked capacity to make decisions. We asked staff what actions they needed to take if they felt that a person did not have the capacity to make certain decisions and we received inconsistent responses. One member of staff said, "I would speak to the family and ask them". Another staff member said, "We would hand it over in the daily records". The records we viewed did not always show if people had the capacity to make decisions about their care and who was the most appropriate person to make these decisions in their best interests. For example, one person's care records showed that they were unable to communicate their care needs effectively and staff told us that their relative made some decisions on the person's behalf. However, we could not see from their records whether the person's mental capacity had been referred to the appropriate authority to assess their capacity and that their relative was making decisions in their best interests. The provider had not ensured that staff had clear guidance to follow of whether this person had been assessed as having capacity to make decisions about their care. This meant people's ability to make decisions about their care had not always been considered appropriately in line with the requirements under the Mental Capacity Act 2005 (MCA).

People told us that they felt staff had the skills and knowledge to help them effectively. One person said, "They know what they are doing and when there is someone new they come in pairs so they can learn". Staff told us they had received an induction before they provided support to people on their own. One member of staff told us, "The induction I received was very good. I completed training and I shadowed another member of staff and was introduced to people I would be supporting before I started to provide care on my own. I felt ready to provide care for people". Staff told us that they had received training, which was updated regularly. However, we found that staff were not confident in their knowledge of the Mental Capacity Act 2005 and there were no systems in place to ensure that staff understood their training and or had sufficient knowledge to support people effectively. This meant that improvements were needed to ensure people were supported by staff who were trained effectively.

People who were able to consent and their relatives told us that they were involved in the planning of their care. A relative said, "Both myself and my relative were involved before the staff came in. I feel that we are both fully involved now". Staff told us how they supported people to understand the care that was being provided. One member of staff said, "I explain everything each time I provide support to people and make sure they understand and agree to the support". Records we viewed confirmed that people and their relatives had consented to their care.

People and relatives we spoke with were happy with the support they received from staff in relation to their food and drink. Staff we spoke with were aware of people's dietary needs and how they needed to support people to eat and drink in line with their preferences. For example, one person's needed a soft diet to ensure

they could eat easily without choking. Staff we spoke with were aware of this person's dietary needs and explained how they supported the person to have a varied diet and sufficient amounts to eat and drink.

People told us that staff knew how to support them if they felt unwell. Staff we spoke with explained the actions they took if they thought a person's health had deteriorated. Staff told us that they could tell if people were unwell because of their physical symptoms but also by how they presented such as, being more tired than usual. We viewed the daily records of people who used the service and saw where staff had informed the office if they felt a person was unwell and the appropriate professional had been involved. This meant that people were supported to have access to health professionals when needed.

Good

Is the service caring?

Our findings

People we spoke with told us that staff were caring and compassionate toward them. The comments we received from people and relatives included; "They [staff] are very good, they do everything for me and are kind and caring. They are brilliant always very pleasant", and "They are very caring indeed". One relative said, "The carers are wonderful my relative cannot communicate and they speak with them and treat them as a person. This gives me so much comfort to know". Another relative said, "Staff are so kind and caring. They use touch to communicate with my relative and I know they are happy as they acknowledge the staff even though they can't communicate well".

People told us that they were treated with dignity and respect when staff were supporting them. One person said, "Staff give me respect and dignity, I am very lucky to have such great staff, what more could I ask for". Another person said, "I sometimes have accidents and the carers are really good as I get embarrassed but they have given me reassurance. I feel so lucky to have kind and caring staff". People also told us that their privacy was respected by staff when they provided support. People told us that staff supported them with their needs in private. Staff told us that they always made sure that people's dignity and privacy was protected when they were providing care and support. One staff member said, "I always make sure people are comfortable with the support I am providing. Some people need reassurance and I put them at ease by talking with them".

People were given choices in the support they had and they told us staff always asked them what they needed. One person said, "The staff always ask what I want. They never go ahead and do things without asking me". Another person said, "The staff help me with everything I ask for. I get plenty of choice". Staff told us that they asked people before they provided support and took account of their wishes. The care records we viewed detailed how much support was needed and people's preferred times for their care to be delivered. Records we viewed showed that people were supported by staff at their preferred time and people told us that staff came at a time they preferred.

We saw compliments received from people and their relatives about the way staff provided care. The comments included; "Staff are all professional and caring", and "You go above and beyond and I appreciate your kindness", and "You have been amazing with my relative. I will recommend you to everyone".

Requires Improvement

Is the service responsive?

Our findings

Staff we spoke with knew people's preferences and were able to describe how people liked to be supported to maintain their independence, such as food choices and how people liked their care provided. Staff also understood different people's individual routines that they liked to follow. However, we found that the records did not always contain details of people's care preferences. Staff told us that they regularly supported the same people, but on occasions they covered other care calls when the regular care staff were unavailable. This meant that people may not be consistently supported in a way that met their preferences because records did not contain sufficient information to guide staff in how to meet people's individual care preferences.

People and relatives told us they had been involved in the reviews of their care and changes had been made to their care when their needs had changed. A relative said, "We were all involved when my relative first needed care. I am kept informed of any changes or concerns". Staff told us and we saw that when they felt a person's needs had changed they informed the office and recorded it in the handover for other staff who provided support. However, we found that this information had not always been transferred to people's care plans to ensure these contained up to date information that staff needed to provide consistent care. This meant that people were at risk of inconsistent care.

People told us that carers arrived on time and they had consistent carers who they knew well. The comments we received from people included; "They [staff] have never been late, they complete all the tasks and always ask if I need anything else doing. That makes me feel cared for", and "I am blind and they [staff] never let me down. If they are going to be slightly late they ring me. Staff always ask me if there is anything else to do after they have completed the tasks". A relative said, "I've had no problems at all. The staff are never late and are very reliable. They take their time and have never rushed my relative". People and staff told us that when a new member of staff was recruited they were introduced to people they would be supporting before they provided care so that people knew who would be attending. The records we viewed showed that people received their care at a time that they preferred by a consistent group of carers.

People and their relatives told us that they knew how to complain and they would approach the staff or the registered manager if they had any concerns. One person said, "I have all the details to complain in big bold letters in the book, although I've had no reason to use this". A relative said, "They [the office] are easy to contact, they say they will phone back and they do". Staff told us they would pass any complaints onto the office and recorded any concerns in the daily notes. The provider had a complaints policy in place. We saw that complaints were investigated and responded to although the system in place to record and monitor complaints, had not been completed by the registered manager. The registered manager told us that they were aware that they were not using the log and they would start using this as a tool to monitor any trends in the complaints received. This meant that although complaints had been actioned the registered manager was not following the provider's policy to monitor and log complaints.

Requires Improvement

Is the service well-led?

Our findings

We found that the monitoring systems in place to ensure that people received appropriate care and support were not always effective. We saw that a random selection of daily records and Medication Administration records were checked on a monthly basis to identify if staff were providing the care as required. We looked at the audits and found that some areas of concern had been identified within the audits and actions had been taken to reduce the likelihood of the concerns reoccurring, such as discussions in staff supervisions and meetings. However, other areas of concern had not been identified. For example, we found that there were gaps in the recording of topical medicines administered and the MARs lacked details of the frequency that medicines were required, which meant it was unclear whether people had received their medicines as prescribed. These areas had not been identified in the audits that had been carried out and therefore action had not been taken to prevent further occurrences. This meant that systems in place to assess and monitor the quality of the service provided were not always effective.

We found that some of the records did not provide an accurate and up to date account of people's needs and preferences. Staff we spoke with knew people well and were able to give detailed accounts of people's needs and how people preferred their care to be provided. However, the records did not always show what staff had told us. For example; one person was unable to communicate their needs and the records did not give staff guidance on how they recognised this person was in pain. Staff we spoke with told us that this person used facial expressions and hand movements to communicate their needs and they could recognise when they needed pain relief by looking at their face and gestures. This detailed information was not in the person's care plan and which meant staff that did not now this person well, may not have recognised and responded to this person's pain management needs. We also found that although staff knew people's preferences well, some people's records did not contain details of how people preferred their care providing such as; specific routines and whether people preferred a male or female carer to support them. We asked how records were monitored within the office to ensure that these were kept up to date and showed an accurate account of people's needs. The registered manager told us there was no system in place to check the care plans, but they would ensure they would address this gap by implementing a care plan audit. We will check this at our next inspection. This meant that at the time of our inspection, there was no effective system in place to monitor the care records to ensure these contained an accurate reflection of people's care needs and preferences.

We found that staff had received training in the Mental Capacity Act 2005 (MCA). However, we spoke with staff and found that staff did not have sufficient knowledge of the MCA and how they needed to support people in line with the principles of the Act. There had been no competency checks to ensure staff understood the training they had received. We asked the registered manager how they ensured staff understood the training they received and people received care in line with the Act. The registered manager told us they did not have a system in place to ensure people received support from staff that had received effective training. This meant that there was a risk of people receiving ineffective care because there was not a system in place to assess the effectiveness of the training staff received.

The provider did not have effective systems in place to assess, monitor and improve the quality of the

service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has a duty to notify us (CQC) of any incidents that had happened at the service, which enables us to monitor the service. For example; expected and unexpected deaths, serious injuries and alleged abuse. We found that the manager had not notified us of any incidents of alleged abuse that had occurred at the service. The registered manager had notified the local safeguarding authority of these incidents, but we had not been notified about these by the registered manager. It is important that we receive these notifications to enable us to monitor the service. The registered manager told us that they had not fully understood their responsibilities to notify us, but they would ensure that this would be undertaken in the future. We will continue to monitor to ensure that deaths and incidents are reported appropriately as required by law.

The provider had not notified the commission of incidents as required. This is a breach of Regulation 18 of the Care Quality Commission (Registration Requirements) Regulations 2009.

People and their relatives told us that the registered manager and office staff were approachable. They felt able to raise any issues they had and knew these would be dealt with appropriately and told us they would recommend the service to other people. One person said, "The manager is approachable. It is very well run. I am perfectly happy and I tell people if they need a carer to contact this company". A relative said, "We have tried a few companies and this company is fantastic. I would recommend this company to anyone". Staff we spoke with told us that the registered manager was approachable and listened to any issues or feedback about people they supported or the service provision. One member of staff told us, "The registered manager has always been approachable. The co-ordinators are also approachable and we can call out of hours if needed and someone always answers". We saw that staff received supervision with a co-ordinator and they told us that they found these sessions beneficial to identify any areas they needed to improve on to ensure they were providing care appropriately.

We saw and staff told us that a senior member of staff had undertaken checks on their performance whilst they were providing care to people. Staff told us that these checks were useful and it meant that they could improve if they were not carrying out the care as required. The records we viewed showed that regular checks were undertaken on staff performance and the outcome of the observations had been discussed with the member of staff. For example; we saw that some staff had been observed providing support without wearing a protective apron. We saw that this had been discussed at the end of the spot check and this had also been raised at the staff meeting. This meant there was a system in place to check staff were supporting people appropriately and action had been taken to make improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the commission of incidents as required. This is a breach of Regulation 18 of the Care Quality Commission (Registration Requirements) Regulations 2009.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.