Calderdale Metropolitan Borough Council

Out of Hours Team

Inspection report

Horne Street Health Centre
Hanson Lane
Halifax
HX1 5UA

Tel: 07702817366

Date of inspection visit:
13 September 2016
14 September 2016
15 September 2016
20 September 2016

Date of publication:
28 October 2016

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

Our inspection of the Out of Hours Team took place on 13, 14, 15 and 20 September 2016 and was announced. We gave the service short notice to ensure the manager would be present. The service was last inspected in December 2013 when it had complied with all legal requirements inspected at that time.

The Out of Hours team is registered with the Care Quality Commission as a domiciliary care agency providing personal care and support to people in their own homes in the upper valley, central and lower valley areas of Calderdale. The team's office base is situated near Halifax town centre. At the time of our inspection the Out of Hours team was supporting 33 people to retain their independence and continue living in their own home.

The service should have a registered manager in position. 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. The registered manager had recently left the service and a new manager had been employed who had applied to be registered with the Care Quality Commission.

Appropriate systems were in place to protect people from risk of harm although some risk assessments required updating. People who used the service told us they felt safe with the care they received.

Policies and procedures were in place regarding the Mental Capacity Act 2005 (MCA) which helped to make sure people's rights were protected.

People were provided with care and support by staff who had the appropriate knowledge and training to safely and effectively meet their needs. We saw the skill mix and staffing arrangements were sufficient for the current needs of the service.

People told us they generally saw the same staff members and care and support was provided without staff rushing.

Safe and robust recruitment processes were in place. Checks to show staff were safe to work with vulnerable adults were undertaken prior to staff working at the service.

Staff received induction and training relevant to their role and were offered opportunities for on-going development. Regular supervisions, appraisals and spot checks had not taken place. The new manager was introducing a system to ensure these took place in future.

Staff turnover was low and people were generally supported by regular staff. Staff were able to tell us about people who used the service, their care and support needs and how they treated people with dignity and

respect. People we spoke with told us staff were considerate, caring and respected their dignity and privacy. People said they received a good standard of care and support.

We saw care and support was delivered in line with people's care plans and people were consulted about the care and support required. The manager had recently reviewed care records and saw these needed to be more detailed with more information about people's likes, dislikes and preferences.

Policies and procedures relating to the safe administration of medicines were in place. However, the recording of medicines was not robust.

People were supported to access a range of healthcare professionals. We saw evidence people's healthcare needs were met.

.
Staff were not currently supporting anyone with specific nutritional needs due to the nature of the service but ensured people were offered drinks to support hydration needs.

A complaints procedure was in place which enabled people to raise any concerns or complaints about the care or support they received. However, some people told us they felt concerns they had raised were not dealt with. The manager was implementing a more robust procedure to ensure all complaints were documented, analysed and appropriate actions taken.

People using the service, relatives and staff we spoke with were positive about the management team. Staff said they felt supported and the management team were approachable. Staff turnover was low.

The manager recognised there was a lack of quality assurance monitoring systems in place to monitor and identify any shortfalls in service provision and was taking steps to improve this. The service had received a lack of provider governance, support and oversight.

The new management team had planned monthly staff meetings throughout the year although we saw and staff told us these had not been held regularly before they commenced in post.

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

People told us they felt safe. Risk assessments were completed but some were out of date and required review.

The recording of medicines was not robust.

Safe recruitment procedures were in place and staffing levels were acceptable to support people's needs.

Accidents and incidents required more robust documentation with actions taken as a result.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent was sought wherever possible.

Staff training was up to date or booked, but there was a lack of supervisions and appraisals currently in place. Although the new manager was seen to be addressing this shortfall a period of sustained improvement needed to be seen.

People's healthcare needs were met.

Is the service caring?

Good

The service was caring.

Staff knew people well and people felt the standard of care and support was good.

People's privacy was respected.

People told us they were treated with dignity and respect and independence was encouraged.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People knew how to complain although complaints were not always formally documented. Some people felt the service was not responsive to their complaints.

Care records were variable in content and detail.

Care records did not always reflect what was happening in practice and had not been reviewed consistently.

Is the service well-led?

Inadequate

The service was not well led.

There was a new manager in post who recognised record keeping and quality assurance policies and procedures were inadequate.

The service had not submitted a Provider Information Return (PIR).

The service had not been adequately supported by the provider.

Out of Hours Team

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 13, 14, 15 and 20 September 2016 and was announced. The provider was given short notice because the location provides a domiciliary care service and we needed to be sure that the manager was available.

The inspection team consisted of two adult social care inspectors 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. The expert used had experience of domiciliary care services.

Before the inspection we reviewed information we had received about the service from the local authority commissioning and safeguarding teams as well as notifications received. 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. They did not return a PIR and we took this into account when we made the judgements in this report

During the inspection, we reviewed five people's care files, some in detail and other to check specific information, four staff files, medicine records, staff training information as well as records relating to the management of the service.

On 20 September 2016 we visited and spoke with two people in their own homes and one relative as well as a care and support worker. The expert by experience spoke with four members of staff and seven people who used the service on the telephone on 13, 14 and 15 September 2016.

Requires Improvement

Is the service safe?

Our findings

The nature of this service meant care workers were entering people's homes late at night and in the early hours of the morning when people were asleep. People we spoke with told us they felt perfectly safe with the arrangements which had been made. Comments included, "They make sure that I understand who it is", "They say your name and explain who they are so that you aren't frightened," and, "They are all very good; I've no grumbles."

Safeguarding procedures were in place. The manager demonstrated a good understanding of safeguarding and knew how to identify, act on concerns and how to make referrals to the safeguarding team. Staff had received safeguarding training. The staff we spoke with had a good understanding of how to identify and respond to any suspected abuse or concerns they had about people's wellbeing. They told us they would report any concerns to the manager who would take any necessary action or at night would speak with the emergency duty team. This demonstrated the provider had appropriate arrangements in place to help reduce the likelihood of abuse going unnoticed and helped protect people from the risk of abuse.

We saw detailed environmental risk assessments in relation to people's homes were in place to ensure the safety of the individual and staff. We also saw risk assessments in relation to moving and handling, skin integrity, falls and nutrition/hydration had been completed and action had been taken to mitigate any risks which had been identified. For example, an issue with one person's skin integrity had been identified and the action plan informed staff the district nurses and day time care workers were dealing with this. Another example was regarding a person whose moving and handling needs had changed and new equipment had been requested. This showed us appropriate action was being taken to mitigate any identified risks.

Some risk assessments we reviewed were not up to date. However, the manager assured us this was part of their action plan for service improvement.

The provider had policies and procedures relating to the safe administration of medicines in people's own homes which gave guidance to staff on their roles and responsibilities. The team leader told us all of the staff had received medication awareness training and were in the process of completing an accredited medication course.

At the time of our visit care workers were only administering prescribed barrier creams and eye drops. We saw medicines administration records (MARs) were in place which showed us these medicines were being applied/instilled consistently. However, the MAR chart for the person who was having eye drops instilled only stated 'eye drops' rather than the actual name of the drops. When we spoke with a care worker who was supporting this person they were able to tell us exactly which drops were being used. The manager had already recognised improvements in the recording of medicines were required.

We reviewed the staffing levels for the service and found these to be safe and staff turnover was low. The service was clearly divided into three geographical areas, each with two teams of two care workers who

covered the shifts. We saw there was a regular team supported by casual staff to cover sickness. All out of hours visits were 'double up' calls which meant two staff attended at all times. Staff and people we spoke with told us there were sufficient staff deployed to cover the care and support needs of the service. People told us staff did not rush their tasks and would chat with them if they were awake. Staff told us, "We are given the proper time to do the work and are given good training", "We are not rushed to do things," and, "We don't rush; we give them the time allocated."

The service did not use agency staff which meant people generally received care and support from the same staff. People we spoke with confirmed this, saying, "I have the same team; I like them," and, "I've been having care for 12 years; usually I get the same staff." The manager told us about two staff members who had been on long term sick and this was reflected in one comment from someone saying they didn't receive care from the same staff. They said, "At first I did, but just recently the lady has been off so at the moment they are struggling to get others to cover."

Effective recruitment procedures were in place to ensure staff were suitable for the role and safe to work with vulnerable people. This included obtaining a Disclosure and Barring Service (DBS) check and two positive written references before staff commenced work. We reviewed three staff files and saw correct procedures had been followed in all cases.

We reviewed the accidents and incidents log and saw only one incident had been recorded in 2016, concerning missed calls due to extreme weather conditions. However, we saw no actions had been taken at the time and the incident had not been reported to the emergency duty team which was the emergency protocol. We spoke with the manager who said the reporting of accidents and incidents was an area for improvement and would be discussed at the forthcoming staff meeting. We confirmed this was on the agenda and saw an action plan had been devised to ensure accidents and incidents were appropriately recorded and actions taken as a result.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care applications must be made to the Court of Protection. The service had not needed to make any applications to the Court of Protection. We found the service was working within the principles of the MCA.

Staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training and the manager had good knowledge of MCA legislation. Staff we spoke with felt they understood their responsibilities regarding MCA. One staff member commented, "We know to be careful and have had training on what to do," and another told us, "It's their choice to be in their own home."

Staff were able to give examples of how they sought consent when providing care and support. One care worker told us, "We explain all the way through and ask in advance," and another said, "When we are working we talk through things and say, "Would you like me to assist?"."

The manager and team leader told us the service worked closely with the out of hours district nursing teams. Care staff told us they were would contact the district nurses, out of hours GP service or emergency services if they were concerned about anyone's healthcare needs. People we spoke with commented they felt staff would support them if they felt unwell during a call. Comments included, "They would get the nurses out for me", "They would call the out of hours doctors; I know they would," and, "If I was unwell they would ring for a GP or ambulance." One person gave an example of how the care staff had supported them when they were unwell and said, "They rang the district nurse, made me comfortable in bed, put an incontinence sheet in place and did everything necessary; I knew the district nurse was on their way."

One member of staff we spoke with told us they thought they were helping people maintain good health by supporting them to stay at home. They said, "I do quality work and make them feel at ease and settled." Another staff member said, "We check for pressure sores, UTIs (urinary tract infections); if they are confused we might ring the district nurse."

People we spoke with told us staff were skilled in their roles and able to meet their needs. One person commented, "Of course they are (skilled)." We reviewed staff training records and saw training was up to date or booked. This included key areas such as moving and handling, first aid, infection control, MCA, safeguarding and medicines management. Some staff told us they had or were completing NVQ (National Vocational Qualification) training and other service specific training. Staff we spoke with told us they had

received a good induction and on-going training to meet people's care and support needs as well as support their professional development. Comments included, "We get really good training", "Oh yes; they [the service] are really up on training," and, "We have mandatory training every year and other courses that we might need."

We reviewed three staff files and saw a lack of regular supervisions, as some staff had not had a formal supervision for over a year. The manager told us they had identified the previous lack of staff supervisions as part of their improvement action plan. We saw a new supervision matrix had been put into place to include five planned supervisions for each member of staff over a 12 month period. The new manager had also put a system into place for annual staff appraisals. However, we would need to continuous improvement over a period of time to conclude these actions had been sustained.

We spoke with the team leader who told us the Out of Hours team were not currently supporting anyone with specific nutritional needs. They told us staff would make sure people were offered drinks to make sure their hydration needs were met. One person we spoke with told us staff always offered to make them a drink when they called and another said if they were awake staff would also get them a drink. Staff we spoke with commented on ensuring people had a drink when they left them and one staff member gave us an example of how they had previously supported a person who required thickening drinks.

Good

Is the service caring?

Our findings

People we spoke with said staff were friendly, kind and caring and spoke fondly of their relationship with the staff. Comments included, "You have a laugh and you build up that sort of relationship", "They are friendly; we have a laugh and a joke. They wait until I'm ready; if I take longer they are ok about it", "They're friendly, polite; always considerate, actually," and, "Very friendly."

Staff we spoke with appeared caring and considerate, most had worked at the service for many years and we saw staff turnover was low. Staff comments included, "I've been working on this job a long time." This meant people had built up good relationships with their care staff and care staff understood people's care and support needs.

During our discussions with staff they spoke with affection about those people they provided with care and support and spoke of long standing relationships and how they got to know someone new to the service. One staff member commented, "A happy person is a well-cared-for person." Another said they felt they knew the people they cared for well and told us, "We've had some people for quite some time." Another care worker said, "We've been with them for a long time and they get to know us." They described how they got to know a person in stages, saying, "Within a week or so we get to know them; sometimes with just smiles and gestures."

People told us they felt the standard of care was good. One person said, "They are first class," and another commented about the intervention of a care worker when they were unwell, saying, "They did it brilliantly."

The people we spoke with felt the care staff respected their dignity and privacy, particularly when giving personal care. One person commented, "Yes they get me up and take me to the bathroom; then they leave the bathroom while I'm using the toilet." They also added, "Staff are chatting with me all the time; there are no embarrassing pauses." Another person commented, "I'm not sure they can, but they do things like shutting doors." One staff member gave an example of how they respected people's privacy and dignity whist giving personal care and said, "If washing or changing we try to keep covered. If anyone else is in the house we just keep them away and explain we are doing personal care."

People told us they felt they were encouraged to be as independent as possible by the care staff. Comments included, "They leave my phone and water by the bed", "They let me get undressed myself", "They let you do as much as you can for yourself and do the things you can't do for you," and, "I always have a commode and a zimmer in case I need them; I've also got my (call) red button."

Some people we spoke with explained how they were offered choices about their care provision. One person said, "We've changed how they do things over the years; if I come up with an idea say, '"Let's try this" or they say, "Let's try that"."

We saw in some care files there was a 'one page profile' which gave staff information about important

memories, likes, dislikes and what was important to the individual. The manager told us they wanted to develop this information further to make the care plans more person centred. They said care workers had 'golden nuggets' of information about the people they supported, but these had not always been documented.

Most people told us they knew they had a care plan or recognised their information was in a file. One person said, "Yes, I've got one but I've never read it; I'm not bothered." However, another person explained how they felt very involved in the care planning and told us, "I've adapted my care around me. If I feel something is not working either they (care workers) or me suggest something and put it in the plan." However, one person we spoke with said they didn't have a care plan, commenting, "They keep saying they are going to give me one but I haven't got one yet."

We saw care files and associated records were stored securely at the office base and systems were in place to dispose of confidential information. This meant people's personal information was held safely.

The team leader provided each team of care staff with details of their nightly schedule. This contained information about the person's name, address, time and length of the call, door code, next of kin, brief details of the support the person required and any special instructions, for example, to ring if they were going to be late.

The team leader explained care workers would leave a telephone message for them if any issues had arisen overnight which were not of an urgent nature. This meant they could then deal with these when they picked the messages up the following morning.

Requires Improvement

Is the service responsive?

Our findings

We looked at five people's care records and found care plans varied in content and format. Some were more detailed than others. We saw people had been involved in planning their late night and early morning visits and how they wished care workers to conduct these. For example, one person requested staff let themselves in via the key safe, put the bedside light on, woke them up and then attended to their continence needs. The records of visits showed us staff had followed the care plan.

Another person we spoke with told us if they were asleep when care staff called they did not wish to be woken up and we saw from the night visit records staff adhered to their wishes. We saw another person's care plan had been written in a person centred way and detailed step by step how the person wished their care at night to be delivered. In another care plan we saw the person could become upset when personal care was being delivered. The team leader explained how they talked to the person about photographs to help settle them so they could deliver the appropriate care and support. However, this technique had not been documented in the care plan.

In one care file we saw there was a care plan in place for the person's day time calls but there was not one in place for the out of hours service. We spoke with a care worker who was providing support to this person who was able to describe in detail how their care was delivered.

Overall, we concluded people's care needs were being met consistently, but the care records did not always reflect what was happening in practice and had not been reviewed consistently. We spoke with the manager who recognised care records needed to be updated, reviewed and relevant information included.

Staff told us they felt the service offered responsive care. For instance, one staff member gave an example where staff rotas had changed to respond to a client's needs. Another care worker told us about the consistency of care provided, saying, "We work with each other. We have a way of working and all have the same standards."

Staff told us they respected people's individual cultural and spiritual needs although due to the overnight nature of the calls were not able to give specific examples. However, one staff member said, "We have Asian clients and know to respect their culture." We spoke with the manager about the diversity needs of the people the service supported. For instance, they told us they would like staff to feel able to explore people's diversity and sexuality when talking with them if appropriate, in order to offer more person centred care. We saw staff were offered equality and diversity training as part of their development.

The service had a complaints policy and we saw one documented complaint in 2016 with actions and outcomes. People told us they knew how to complain. Comments included, "I would go to the team leader, or maybe above them," and, "You just have to ring up, but there's been no need." One person gave us an example about how they had contacted the service about a care worker they hadn't liked when they first started using the service, saying, "I rang up and they changed the carer; I've been happy ever since."

However, another person told us they felt a complaint they had raised earlier in 2016 had not been resolved effectively. They said, "I struggled with that. I went through different levels and nobody was answering me. I even went on the 'complaints and compliments' bit but they never phoned me back."

We spoke with the manager who told us they thought staff were dealing with complaints informally and not documenting these. They commented about the need to ensure complaints were formally recorded so trends analysis could be done, lessons learned and service improvements made as a result. They showed us new procedures they were implementing and we saw this was an agenda item for the upcoming staff meetings.

Inadequate

Is the service well-led?

Our findings

When we inspected the Out of Hours team, both the manager and team leader had been in post for less than a month. The previous registered manager had recently left the service and we saw the provider had appointed a new manager within an acceptable time period. The new manager had applied to be registered with the Care Quality Commission and was currently going through the registration process.

We saw the service had received a lack of provider governance, support and oversight. The provider had recognised this and told us they would be contract monitoring the service in the future.

There was a lack of effective quality assurance systems and record keeping in place. For instance, we saw a quality assurance home visit had been made to a person using the service on 22 August 2016 which identified a lack of consent forms, personal profile page, individual care plan, support plan, individual risk assessment and medication profile in their care records. However, no outcomes or actions had been identified as a result of this. Another quality assurance visit in January 2016 had identified a lack of consent forms, support plan and personal profile with no actions identified. This meant systems and processes in place to enable the service to identify and improve where quality and safety was being compromised were not effective.

We saw the new manager had audited some care plans and had identified documentation which needed to be updated or improved. For example, they recognised care plans needed to be more person centred and more detailed, and medication profiles and 'one page profiles' needed to be updated. This showed us the manager was being pro-active in looking at where documentation was not as detailed as they required. However, these improvements needed to be embedded and other audits such as medication audits, daily records and call monitoring were still to be implemented.

A Provider Information Return (PIR) request had been sent to the previous registered manager and the nominated individual on 14 July 2016 with a deadline date for return of 12 August 2016. Neither request was accessed or submitted by the service. A notification was sent at the same time to the nominated individual who was given the opportunity to respond and provide an alternative email address so the PIR request could be appropriately managed. No such update was provided.

This was a breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The new manager recognised improvements to the service were required to the service and told us they were committed to this. They explained, "I'm really passionate about people who use the services. We have an outstanding staff team. We can recognise they've not had the support mechanisms." From discussions held during our inspection and the action plan already formulated, we concluded the management team were committed to making positive changes to improve the service.

Most people we spoke with felt they could not comment on the management of the service. One person we

spoke with felt the team was well managed and when asked why, explained, "Well, they come every night on time and do their job."

Staff we spoke with told us they felt supported and the management were approachable. From speaking with staff we concluded the service generally had a positive culture. One care worker told us, "I think the new manager will be good for the service," and another said, "[Name] is always at the end of the phone." Staff were aware a new manager and team leader were in place and one staff member told us, "If I had a problem I could just ring them; if not them, the next person (manager)." However, one staff member said although they could raise concerns at supervisions and team meetings, they had, "Brought up a few concerns but nothing done; not until this CQC came up," and commented, "Nobody took no notice."

Staff told us the team worked well together and supported each other. One care worker told us, "We work to the same standard, work together and have good communication," and another said, "We work with each other."

The new manager had reinstated staff meetings and had planned these on a monthly basis. One staff member commented team meetings had not taken place regularly and said the most recent team meeting was, "First team meeting since last year."

All the staff we spoke with said they would recommend the service to others. Comments included, "Of course; we've got a waiting list", "Yes, definitely," and, "Definitely; so many people need this service."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to assess, monitor and improve the quality and safety of the services provided. The service had not maintained accurate, complete and contemporaneous records in respect of each service user or the management of the regulated activity. The registered person had not sent the Provider Information Return to the Commission when requested to do so. Regulation 17 (1) (2) (a)(c)(d)(e) (f) (3)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014