# Knowsley Home Care Associates Limited

# CASA Liverpool

## Inspection report

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Date of inspection visit:
30 October 2018
31 October 2018

Date of publication:
30 November 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This unannounced comprehensive inspection was carried out on 30 and 31 October 2018. This was our first inspection of the service since it registered with the Care Quality Commission (CQC) in July 2017.

Care and Share Associates (CASA) Liverpool is a domiciliary care agency. At the time of our inspection it was providing personal care to 132 people living in their own homes across Liverpool. CASA was established in 2004 and now operates domiciliary care services across the North West, North East and Yorkshire.

Not everyone supported by the service received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where personal care is undertaken we also take into account any wider social care provided.

During this inspection we identified a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the service had failed to adequately monitor, assess and improve the quality and safety of the service provided. You can see what action we told the provider to take at the back of the full version of the report.

The service did not have a registered manager at the time of our inspection. However, a new manager had been appointed since the previous registered manager had left the service. We noted that the new manager was in the process of registering with CQC. 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 a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We reviewed seven staff rotas and found evidence of 'call cramming'. This is when carers are scheduled to complete more calls than is physically possible within the timescale provided. For example, we saw that the times of carers' calls were scheduled 'back-to-back' and allowed no time for carers to travel between calls, regardless of the distance between their calls. We also saw evidence on the service's electronic records system to show that staff did not always stay for the scheduled amount of time, known as 'call cutting'. We acknowledged that there were several reasonable explanations for some of these instances. However, there was a lack of documented evidence to support these explanations nor could they reasonably account for every instance. This potentially left people at risk of not receiving all the care and support they need at the times they need it.

We discussed these concerns with the manager who acknowledged that they were not aware of this problem and explained that this had been the historical approach to rota scheduling at the service. During the days that followed our inspection the manager provided us with evidence to demonstrate that action had been taken to resolve these issues.

The service had systems in place to protect people from abuse and staff were able to explain what actions

they would take in the event of a person being at risk of harm. Records showed that safeguarding concerns were promptly and effectively managed by the manager. However, we had not always been notified of safeguarding concerns as we should have been.

Medicines management systems were in place. All staff had undertaken medicines training and had their competency regularly assessed. People told us they received their medicines correctly and on time. However, when we reviewed the service's electronic medication administration records (MARs) we saw that there were numerous gaps where staff had failed to confirm they had given people their medication or record any reasons a medication was not given. This meant that the service could not be assured that people always received their medicines as prescribed.

We found that the service's quality assurance and auditing processes were not always robust and effective. Overall, the service's approach to assessing, monitoring and improving the quality and safety of the service being provided required improvement, as it lacked organisation, structure and oversight.

People we spoke with gave us positive feedback about the quality of care they received from the service. People told us they felt safe with the staff and they received care from regular staff who they had got to know well.

Staff were safely recruited at the service ensuring that only staff suitable to work with vulnerable people were employed. All new staff completed a thorough induction process, which included office-based training and completing shadow shifts at the start of their employment.

All staff were up-to-date with training relevant to their roles and the staff we spoke with gave positive feedback about training provided at the service.

Staff told us they felt well supported in their roles. We saw they were supported with regular supervision and appraisal meetings, as well as 'spot check' observations to monitor the quality of their work.

Staff treated people with respect and helped them to maintain their dignity. Staff also supported people with their eating and drinking needs.

Complaints were managed appropriately. We saw that the service received very few complaints but when it did they were responded to promptly and effectively.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and to report on what we find. We found that the service was working within the principles of the MCA. We saw that the service had training, policies and guidance available for staff in relation to the MCA. This meant they were working within the law to support people who may lack capacity to make their own decisions.

The care plans we reviewed were person-centred and gave staff the information that they needed to safely and effectively meet people's needs.

## 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.

Medication administration records were not always fully completed therefore the service could not be assured that people always received their medication as prescribed.

Staff were safely recruited at the service.

The service had policies and procedures to safeguard people from abuse.

### Is the service effective?

**Good**

The service was effective.

Staff were up-to-date with training relevant to their roles and were supported with regular supervision and appraisal meetings.

Staff supported people with their eating and drinking needs.

People's rights were protected by staff who had knowledge of the Mental Capacity Act 2005.

### Is the service caring?

**Good**

The service was caring.

People told us the staff were caring and they received care from regular staff who they had got to know well.

Staff treated people with respect and helped them to maintain their dignity.

The staff we spoke with demonstrated a caring and enthusiastic attitude towards their roles at the service.

### Is the service responsive?

**Good**

The service was responsive.

People's care plans were person-centred and gave staff the

information that they needed to safely and effectively meet people's needs.

The service was responsive to people's individual communication needs.

Complaints were managed appropriately.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Staff rotas were not realistic which meant calls were not always made on time or for the length of time scheduled.

Quality assurance and auditing processes were not always robust and effective.

The service had not always notified CQC of significant events or safeguarding issues as required but we saw any such issues had been dealt with appropriately.

# CASA Liverpool

**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 unannounced inspection was carried out on 30 and 31 October 2018 by an adult social care inspector.

At the time of our inspection the service provided personal care to 132 people living in their own homes across Liverpool.

Before our inspection we reviewed the information we held about the service. This included 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 also looked at the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authority to gather their feedback about the service. We used this information to plan how the inspection should be conducted.

During the inspection we spoke with nine people supported by the service and seven people's relatives. We also spoke with 14 members of staff who held different roles within the service. This included the manager, regional operations manager and carers.

We looked at a range of documentation at the service's office including 13 people's care records, medication records, seven staff recruitment files, staff training records, accident and incident report forms, safeguarding and complaints records, audits, policies and procedures and records relating to the quality checks undertaken by staff and other management records.

Requires Improvement

# Is the service safe?

## Our findings

All the people we spoke with told us they felt safe with the staff. Comments included, "Oh yes absolutely, they do a marvellous job", "I do feel safe, they're always there for me" and "[The staff] are lovely, I know all of their first names."

All staff had undertaken medicines training and had their competency assessed before they supported people with managing their medicines. The registered provider had a medicines policy and procedure in place that staff were aware of and met good practice guidelines. A medication risk assessment was included in people's care plans, along with a consent agreement for staff to support people with their medicines. A medicines support plan was in place that included clear guidance for staff to follow to meet people's individual requirements.

However, when we reviewed the service's electronic medication administration records (MARs) we saw that there were numerous gaps where staff had failed to confirm they had given people their medication or record any reasons a medication was not given. As we have explained later in this report, we found that the service's quality assurance and auditing processes were not always robust and effective as the issues with these records had not been identified or adequately investigated and addressed. This meant that the service could not be assured that people always received their medicines as prescribed.

The service had systems in place to protect people from abuse and staff were able to explain what actions they would take in the event of a person being at risk of harm. Records showed that safeguarding concerns were promptly and effectively managed by the manager. However, we had not always been notified of safeguarding concerns as we should have been.

We saw that people had appropriate risk assessments in place and these were reviewed regularly. The risk assessments we saw gave staff the information and strategies they needed to safely manage these risks. For example, we saw that one person was cared for in bed and was unable to walk. Their care plan identified the various risks associated with this and gave staff guidance on how these risks could be mitigated. This meant that staff had the information they needed to safely manage the risks associated with delivering people's care.

People's care plan files held essential contact details for relatives, GP and other health and social care professionals to be contacted in the event of an emergency. Staff also had access to a member of the office team through an 'on-call' system outside office hours. This meant that in the event of an emergency or when staff needed support and guidance an appropriate person was available to contact without delay.

Staff were safely recruited and were supported with a thorough induction process. Criminal records checks, known as Disclosure and Barring Service (DBS) records, were carried out. We also saw that official identification, such as a passport or driving licence and verified references from the most recent employers were also kept in staff files. This helped to ensure staff were safe and suitable to work with vulnerable people.

The service had accident and incident recording processes in place. We found that there had been very few accidents and incidents at the service but they had been appropriately dealt with.

Staff had received training on infection prevention and control and staff had access to personal protective equipment (PPE), such as disposable gloves, where necessary. This meant that staff and people were protected from the risk of infection being spread.

Good

# Is the service effective?

## Our findings

People's needs were assessed before they were supported by the service. The information from the assessment formed the details of the care plans and risk assessments. People's needs in relation to equality and diversity were considered during the assessment process and included within the care plans. Such as age, disability and religion. People and their relatives told us they were involved in the assessment and care planning process and staff were able to effectively meet their needs.

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 or are helped to do so when required. 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. People who normally live in their own homes can only deprived of their liberty through a Court of Protection order.

We found that the service was working within the principles of the MCA. We saw that the service had training, policies and guidance available for staff in relation to the MCA. None of the people supported by the service were subject to a Court of Protection order but some had a lasting power of attorney in place. We saw evidence that the service worked alongside family members as well as health and social care professionals if a person did not have the mental capacity to make their own decisions. This meant they were working within the law to support people who may lack capacity to make their own decisions.

People told us that staff asked for their consent before doing things, such as supporting them with washing and dressing. We saw records that showed that people's consent had been sought by the service for the support they received. For example, people had been involved in and had contributed to the preparation of their care plans and had consented to them. We saw that when people lacked capacity to consent this was sought from those who had the legal authority to do so.

People and their relatives told us they felt the staff had the knowledge and skills required to do their jobs well. Comments included, "Yes, [the staff] know they are doing" and "Yes, the staff seem very competent."

All staff were up-to-date with training relevant to their roles and the staff we spoke with gave positive feedback about training provided at the service. This included manual handling, safe handling of medications, safeguarding, mental capacity, infection control, equality and diversity and dementia awareness. We also saw that staff had received training meet people's specific needs, such as conveen, catheter and stoma care and pressure care awareness.

We saw that all new staff completed a thorough induction process at the start of their employment, which included office-based training and completing shadow shifts. We noted that these shadow shifts were normally completed with people the member of staff would be supporting so that they had chance to get to know each other. New staff were then subject to a 'spot check' of their work in the first week of lone working.

All new staff also completed the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It gives staff who are new to care the introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

Staff were supported with regular supervision and appraisal meetings, as well as 'spot check' observations to monitor the quality of their work. Staff attended quarterly team meetings referred to by the service as 'huddles' and staff told us they felt well supported in their roles.

People told us that staff helped them to get enough to eat and drink. We saw that people's care plans gave staff guidance on how to support people with their eating and drinking needs. This included reflecting any preferences people had. Examples included, one person preferred herbal tea rather than regular tea or coffee and another person did not like breakfast cereals.

Good

# Is the service caring?

## Our findings

People told us the staff were caring and they received care from regular staff who they had got to know well. One relative commented, "[The staff] are lovely, every single one of them. They're brilliant with [relative]. It's normally one of the same four or five carers and they always let [relative] know who is coming."

We found that staff tried to support people to be as independent as possible. For example, making choices about what clothes they wanted to wear that day or enabling them to take care of as much of their own personal hygiene as possible. One person told us, "The staff are angels, they've really encouraged me and worked with me. I'm very happy with the service and I can't thank them enough."

All staff had received training on equality and diversity. We saw from people's care plans and the staff we spoke with that the service treated people as individuals with individual needs. For example, the service considered people's personal histories and any religious and cultural preferences.

We found that people's individual communication needs were considered by the service and staff were motivated to find solutions to communication barriers people may have. For example, we saw that the service had supported one person who only spoke Cantonese. Staff worked with the person's family to develop some flashcards to act as a visual aid to help staff to communicate with the person. This included images of personal care tasks, food and drink and moods to help show how the person was feeling. The manager told us that this really helped staff to develop a relationship with this person and ensure that they met all of their care needs.

All of the people we spoke with told us that staff treated them with dignity and respect. One relative said, "My [relative] doesn't talk but the carers always talk things through with them. [The staff] have got to know [relative], they've got a really good relationship even though [relative] is non-verbal. We have lots of friendly banter with [the staff]." Staff we spoke with could describe how they treated people with respect and helped them to maintain their dignity. For example, whilst supporting people to get washed and dressed.

The staff we spoke with demonstrated a caring and enthusiastic attitude towards their roles at the service. For example, one member of staff commented, "People we support become like part of your family."

We found that people's confidential information, such as care plans, was stored securely and only people who required access could do so.

Good

# Is the service responsive?

## Our findings

The care plans we reviewed were person-centred and gave staff the information that they needed to safely and effectively meet people's needs. People's care plans provided information about what was important to them, such as family and important relationships, preferred routines, hobbies and interests and religious and cultural preferences, along with guidance on how to support people with these preferences. This ensured that staff had some of the information needed to get to know people and clear guidance on how to support them. For example, we saw that one person was a keen football fan who enjoyed talking to carers about their favourite team and watching matches with the carers when this was possible. We also saw that the service considered people's small but nonetheless important preferences. For example, one person preferred warm water when they took their medication.

We saw that people's care plans were regularly reviewed to ensure the information they contained was accurate and up-to-date. For example, people who were new to the service received a phone call after one week to check all their needs were being met by staff following the care plan. Staff then visited the person after six weeks to carry out a similar review of the care plan which was then followed by six-monthly reviews. All the people we spoke with and their relatives told us they were aware of their care plan and had been involved in the care planning and review process. One person said, "Yes, I was involved in setting up the care plan, they came out and talked it all through with me." One relative said, "Yes, we were involved in the care planning from the off, they've been very accommodating."

People's care plans gave staff clear information on how to support people with any communication needs. For example, ensuring people who wore hearing aids or glasses were supported to wear them. We also noted that the care plans included guidance on any adaptations to staff's communication and body language, such as 'carers to speak slowly and clearly and give me time to reply'. This meant the service was acting in line with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for providers of NHS and publicly-funded care to ensure people with a disability or sensory loss can access and understand information they are given.

People told us that the service was responsive and could be flexible to meet their needs. For example, several people said that if they had an appointment to get to staff could usually rearrange their call time to ensure they were able to make appointments whilst still receiving the care and support they needed.

The service had a complaints policy and procedure in place that had been made available to people and their relatives. People told us that they felt comfortable raising any issues with their carers or office staff but they rarely had reason to do so. People commented, "I would feel very comfortable making a complaint but there's never been any need" and "If I had a complaint I would feel comfortable contacting [the manager] and I'm confident if I complained it would be dealt with." We saw that the service received very few complaints but when it did they were responded to promptly and effectively.

At the time of our inspection the service was not providing any end of life care. However, the manager had a plan in place for this by accessing end of life training for the staff and by working with other health

professionals, such as the district nurses.

Requires Improvement

# Is the service well-led?

## Our findings

During our inspection we reviewed seven staff rotas. We found evidence of 'call cramming'. This is when carers are scheduled to complete more calls than is physically possible within the timescale provided. For example, we saw that the times of carers' calls were scheduled 'back-to-back' and allowed no time for carers to travel between calls, regardless of the distance between their calls. We saw in one instance that a carer was scheduled to complete eight calls in a six-hour period. During this time they were supposed to deliver five and a half hours of care. Considering the travel time between the eight addresses, it was impossible for the carer to deliver this care as scheduled.

We also saw evidence on the service's electronic records system to show that staff did not always stay for the scheduled amount of time, known as 'call cutting'. We acknowledged that there were several reasonable explanations for some of these instances. However, there was a lack of documented evidence to support these explanations and could not reasonably account for every instance. For example, we saw records that showed a carer completed a 30 minute call in three minutes and another instance when a 60-minute call was completed in 19 minutes. This potentially left people at risk of not receiving all the care and support they need at the times they needed it.

Feedback from staff echoed these concerns. Staff told us that they were confident they met everyone's care and support needs but the lack of time allowed in between calls meant that calls were not always made on time. One member of staff commented, "Sometimes I need to start my shift earlier than scheduled to get through all my calls." Another member of staff said, "We meet everyone's care needs but we don't always have time to chat."

We discussed these concerns with the manager who acknowledged that they were not aware of this problem and explained that this had been the historical approach to rota scheduling at the service. During the days that followed our inspection the manager provided us with evidence to demonstrate that action had been taken to resolve these issues. For example, amending all staff rotas to allow for travel time and ensure staff workloads were realistic.

Shortly after our inspection the service had also put in place unique quick response (QR) codes in everyone's homes. Staff would use their phones to scan these codes to confirm their arrival and departure from people's homes. There was also a plan to have an office-based member of staff monitoring this information daily. This meant the service would have more robust and reliable information to confirm staff were where they were supposed to be and there for as long as scheduled.

The service clearly needs to make improvements to address the issues we have detailed above. However, it is important to note that we received some positive feedback about the reliability of the service from the people it supports. All of the people we spoke with told us that most of the time the staff arrived on time and usually let them know if they were running late. People also told us that the staff always stayed as long as they needed them and did everything they needed them to. This included staff checking there was nothing else they could help with before leaving.

We found that the service's quality assurance and auditing processes were not always robust and effective. For example, we found that audits of medication administration records (MARs) had not been kept up-to-date. Those that had been done did not adequately investigate and address the issues that had been identified. We saw other examples of the shortcomings in quality assurance and oversight, such as the fact that the 'call cramming' we found in the rotas had not been identified. We also saw that the service's electronic records system, which was fully implemented in June 2018, contained alert information that was no longer relevant. This meant that the alert function of the electronic records system lacked clarity and could not be used effectively. Overall, the service's approach to assessing, monitoring and improving the quality and safety of the service being provided required improvement, as it lacked organisation, structure and oversight.

Registered providers are required to inform CQC of certain incidents and events that happen within the service. For example, allegations of abuse. We reviewed the service's records relating to these sorts of incidents and found that we had not always been notified as we should have been. However, the records we looked at demonstrated that staff had taken all reasonable and necessary steps in these instances. We discussed this with the manager, who acknowledged this oversight and said they would ensure all notifications are sent as required in future.

The service did not have a registered manager at the time of our inspection. However, a new manager had been appointed since the previous registered manager had left the service. We noted that the new manager was in the process of registering with CQC. 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 a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that the manager was open, transparent and positively engaged with us during our inspection. This included times when we identified areas of concern requiring improvement. The manager's communication with us, along with their actions, demonstrated their commitment to continuously improving the service and delivering a high-quality service to the people supported.

Staff told us they felt there was a very positive and enthusiastic culture amongst all staff at the service. Staff said that they were well-supported and were listened to by the manager and office staff. Staff attended quarterly team meetings referred to by the service as 'huddles'. These meetings were used to share important updates with staff, such as changes to their electronic records system.

We saw that the service gathered feedback about the quality of its service from the people it supported and their relatives. For example, staff contacted people by telephone on a quarterly basis to seek their views and feedback on the service being provided. The manager told us that they were also in the process of developing a satisfaction questionnaire as another method of gathering feedback.

The service had up-to-date policies and procedures in place to support the running of the service and these were regularly reviewed.

Registered providers are required to display their most recent CQC rating both at their premises and on their website, if they have one. This should be done within 21 days of the final inspection report being published on the CQC website. This was the service's first inspection since registering with CQC so it did not have a rating to display. However, we expect the rating awarded in this final report to be displayed within the timescale detailed above.

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<br><br>The service had failed to adequately monitor, assess and improve the quality and safety of the service provided. |