Into Care Limited

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Inspection report

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Overall summary

This inspection took place on 23 and 24 February 2015. The provider was given a short period of notice of the inspection. This was the first inspection of this service since registration of the provider and agency office in November 2014.

The service is a small domiciliary care agency that was currently providing personal care to one person.

A registered manager was in post. 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.

We found the management of medicines was not safe. Care workers were not aware of what the medicines they were administering were for, and there were gaps and anomalies in the medicines records. We found a discrepancy between the dose stated on the medicines record and on the medicine bottle for one medicine. No audits of medicines arrangements had taken place.

We found the recruitment of new workers was not sufficiently robust. Full employment histories had not been taken up. Gaps in employment and some deficiencies in references had not been addressed.

Some risks to the person who used the service had not been fully assessed in areas including their nutrition, medicines and swallowing difficulties. Advice from other professionals regarding risks had not been incorporated into the person's care plan, leading to potentially unsafe practices. This meant the person was potentially exposed to unnecessary risks.

Staffing levels were sufficient to provide safe care to the person who received 24 hour care from two staff at all times. We found that the care workers were very caring and sensitive in their approach to the person receiving a service.

However, care workers had not been given a comprehensive induction to their roles, and had not received ongoing training, or appropriate advice on the prevention and reporting of abuse.

Individual care workers had not received appropriate supervision of their work performance and had not attended any team meetings. There was no evidence to demonstrate how staff had been supported and managed to provide the care required and to confirm their competency.

Records showed a lack of understanding of the process for assessing the mental capacity of the person receiving care and what steps had been taken in relation to consent and best interest decisions made on their behalf.

Summary of findings

The registered manager had failed to comprehensively assess people's individual needs before starting to provide the care. Care plans were sensitively written, but did not provide clear instruction and written advice from professionals had not been followed. Care plan reviews had not been undertaken and care workers were providing care which was not described in the care plan.

We found the service was not well-managed. The registered manager had failed to ensure the appropriate recruitment and training of care workers, and had failed to give them adequate support. There were no clear systems for auditing the quality of the service, and record keeping was poor, with many documents unavailable for inspection.

Written policies were not being followed and there was confusion regarding what the company's policies and procedures were in practice.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These related to assessment of needs and care planning; consent; risk assessment; medicines management; supporting workers; recruitment; and assessing and monitoring the quality of service provision.

This service had been in operation for five months in which time it had provided care to two people within their own homes. Despite the clear input and involvement of a company director and a registered manager we identified multiple shortfalls which demonstrated a failure to operate effective systems to monitor the quality of service provision.

This in turn meant that risks relating to the health, welfare and safety of people receiving a service had not been identified, assessed or managed.

You can see the action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not fully safe.

Risk assessments had not been carried out, and risks assessed by other agencies had not been incorporated into the person's care plans.

There were enough care workers to provide the service safely, but care worker recruitment was not robust.

The management of the person's medicines was not safe.

Is the service effective?
The service was not effective.

Care worker induction processes were flawed, and workers had not received all the training necessary to meet the person's needs.

Care workers had not received appropriate supervision of their performance.

Is the service caring?
The service was caring.

The person's family told us their care workers were committed to the well-being of the person and demonstrated a caring and sensitive approach in their work.

Is the service responsive?
The service was not fully responsive.

Care plans did not reflect all the needs of the person receiving care.

Care workers were giving some care not described in the care plan, and failing to give other care required in the care plan.

Is the service well-led?
The service was not well-managed.

Records were not complete and did not fully describe the care given.

Policies were unclear and contradictory.

Systems were not in place for the effective auditing of the quality of the service.

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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 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.

The inspection took place on 23 and 24 February 2015 and was announced. The provider was given 48 hours' notice of this inspection because the location is a small domiciliary care agency and we needed to be sure the office was manned when we visited.

The inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed all the information we held about the provider and location, including notifications of significant incidents, safeguarding information, whistle-blowing and complaints. We contacted the local authority and NHS commissioners of care packages.

In the course of the inspection we looked at the care records for the one person receiving care from the service and the care records of a person who used the service until recently. We talked with the registered manager, the company director and two care workers. We visited the home of the person receiving care, with the permission of the person's spouse, and discussed their care experiences, spoke with care workers and looked at records held in the home.

Is the service safe?

Our findings

We spoke with the spouse of a person using the service. This relative told us they felt safe when the care workers were in the house and trusted them completely.

We looked at how the person using the service was supported with their medicines. Staff records showed that care workers had been given on-line training in the safe handling of medicines as part of their induction, and workers confirmed this. We asked two care workers if there had been any checks made regarding their competency in administering medicines. Both told us that no checks on their competence had been carried out.

We looked at the medicines administration record (MAR) for the person and saw a list of codes describing reasons for the non-administration of any medicines. We also saw what appeared to be the top of another line of codes, but which had not printed properly. We asked staff about this. They were not aware of whether there should be another line of codes. The list of medicines and the directions for taking them were handwritten on the MAR and information had been added and deleted, without any signatures or dates. This meant it would be difficult to identify who had taken responsibility for recording the person's prescribed medicines on the MAR, if it was necessary to investigate a mistake with administration. We found, for one prescribed medicine, a discrepancy between the maximum dose instructions on the MAR and the dosage directions on the medicine bottle. We brought this to the attention of the care workers, who had not noticed the discrepancy, but who phoned the pharmacy to confirm the prescribed dose.

We saw a document titled 'medical stock sheet', which listed the person's prescribed medicines. No stock counts of medicines had been recorded and care workers told us they had not been instructed to count the medicines. We found that no member of the management team had recorded any checks of medicines stocks, when visiting the person's home. We asked the care workers if they knew what the purpose of the medicines they were administering were. They were unable to tell us. This meant the service was not following current guidance from the Royal Pharmaceutical Society on the handling of medicines in social care.

We found no assessment regarding the management of medicines. Completion of MARs was inconsistent, with staff using different codes to those instructed on the MARs. No in-house training on completion of these records had been provided in the completion of MARs. A number of gaps to confirm administration of medicines were noted in the MARs, mainly in relation to prescribed creams and a calcium supplement. The registered manager stated MARs were checked each week and any gaps were identified and brought to the attention of the individual staff member. However, there was no evidence that the gaps found by inspectors on the days of inspection had been identified by the manager or acted upon.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment and selection records for three of the care workers currently employed and one former employee. We saw applicants had completed employment application forms. In three of the application forms, a full employment history had not been provided. For example, one applicant had an unexplained gap in employment between July 2007 and September 2009. Another applicant recorded only one employer from December 2013, but the person's references showed two other employers since that date. The registered manager and director told us they only asked applicants to supply the history of their last ten years employment. One applicant had not signed the section declaring the truth and accuracy of the information contained. An employment reference for one applicant had been received on 12 November 2014, but their application form was dated 25 November 2014. One reference had not been signed, and this had not been followed up by the registered manager or director. When asked about these observations the director's response was that she had worked with all the current staff at her/their previous employer, and "knew they were okay." These findings demonstrated that the recruitment process was insufficiently effective and that all relevant checks on staff had not been carried out.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service safe?

We looked to see if the service had carried out an assessment of any potential or actual risks to the person receiving a service. We noted the person had needs relating to their nutrition, swallowing, medicines, continence, positional turns and exercise. We found no initial or other assessment of these risks had been recorded by the service. We saw a moving and handling assessment which referred to the wrong gender. We saw a dysphagia (difficulty in swallowing) risk assessment which stated, "All food to be pureed and all fluids to contain thickeners." However, we saw, in the person's nutritional care plan, this advice was not being followed. This meant the person was exposed to unnecessary risks to their health.

A 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) advanced directive was in place. We saw this been wrongly interpreted in the person's care plan as meaning an ambulance should not be called if the person deteriorated. We asked one care worker how they interpreted this part of the person's care plan. They told us "it was hard to explain", but they assumed it meant they were not to call an ambulance if the person had a heart attack or passed away. When prompted, they told us they would still call assistance for other health issues. We noted the DNACPR document stated that the decision not to resuscitate should be reviewed every three months, but that the date of the last review was recorded as "16/3/14".

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw it was an integral part of the provider's policy on safeguarding that all employees would complete an 'understanding abuse' work book, and would be given the opportunity to read the national guidance document entitled 'No Secrets' on the recognition and reporting of abuse. We were offered no evidence that these commitments were honoured in practice. When we asked the director about this she agreed the company did not use a safeguarding workbook. This meant staff had not been given appropriate advice on the prevention and reporting of abuse.

Sufficient numbers of staff were employed to meet the care package where two care workers were required to deliver care 24 hours per day. The registered manager and the director told us they were also involved in delivering some of the hands on personal care and this was confirmed by daily records, the care workers and the person's spouse.

Is the service effective?

Our findings

We spoke with the spouse of the person using the service. They told us they could not fault the service, and that the person's needs were being met effectively.

We asked the registered manager and the director for evidence of staff induction. They led us to care workers' individual personal files where induction was recorded on a single undated sheet with headings and tick boxes. Records showed induction training covered up to eleven areas and took the form of on-line computerised. Induction training records were undated. Induction did not include training in, health and safety or fire safety. We asked two care workers what their induction had entailed. They described how this had taken place on the same day as their interviews for the post of care worker. Neither was able to describe their induction in any detail. We noted the service's policy on recruitment and induction specified that workers would be given a formal induction to National Training Organisation standards within six weeks of employment. When we asked the two care workers if they had undergone this induction process they both told us they had not received this induction training.

We asked to see the staff training matrix, but were told this was not available, due to computer problems. We found no evidence of staff having been given appropriate training in the management of medicines in their current employment, other than as a small part of their care worker induction. The registered manager and the director stated all staff had received this training at their previous employment. We found, from training records and from talking with care workers, they had not received appropriate training in the maintenance of skin integrity or in end of life care which was relevant to the care they were delivering.

We asked the director about the frequency and type of supervision given to care workers. We were told supervision was provided every six weeks although the provider's supervision policy stated workers should receive supervision four times per year. When we asked the director what supervision had been given to care workers she replied that four supervision sessions had been planned but had been cancelled and that no supervisions had taken place since the service had started to give care to the person on 23 December 2014. We asked two care workers what formal supervision they had received since taking up post (one in late December 2014; one at the beginning of January 2015). Both said they had not received any formal supervision of their work in that time.

We found that staff had not been properly inducted, trained or supervised and that suitable arrangements were not in place to ensure that staff were appropriately supported.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a mental capacity assessment had been carried out by a named senior care worker for the person using the service. However, this assessment did not specify the decisions to be made by or on behalf of the person; was not dated; had no 'best interests' decisions recorded; and showed no evidence of consultation with relatives, professionals or other relevant parties. This meant that the assessment was not completed in line with the Mental Capacity Act 2005.

We saw that a 'service consent form' on the person's care record had not been completed. We found a document for giving consent to the administration of the person's medicines, but saw this was unsigned and undated, and did not include evidence of consultation with the person's GP and pharmacist, as required by the document itself. We found no evidence of consent having been obtained and recorded regarding issues such as personal care or the sharing of confidential information with other professionals.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were shown the staff handbook which included details of expectation in relation to privacy, dignity, confidentiality of people; principles and values; personal safety and lone working; standards of conduct and performance; equality and diversity; and discriminatory practice. Care workers confirmed that they had been given copies of this handbook by the provider.

Is the service caring?

Our findings

We spoke with the spouse of the person using the service. They told us their care workers were "absolutely lovely" and said they couldn't thank them enough. They told us they had been fully involved in their spouse's assessment of needs and had given detailed advice to the registered manager about the person's preferences. We were told the person had periods when they were quite vocal regarding their needs, and that care workers listened to, and acted upon, the person's directions.

We found no evidence in the care record that the person or the person's spouse had been involved in the planning, decision making or management of the person's end of life care. There was no care plan regarding their end of life care. We found no 'best interest' decisions had been recorded regarding this aspect of their care. We found no evidence of the input of specialist palliative care professionals.

The person's spouse said that the person's privacy and dignity were protected at all times: "They make sure the blinds are shut, and they ask any visitors to leave the room whilst they are giving personal care."

The person's care records were written in a sensitive and respectful way that put the person at centre of the care service. For example, care workers were guided to always involve the person in all conversations and discussion.

Care workers we spoke with demonstrated a very caring approach to their work and talked with sensitivity about the person's needs. It was clear they took their role seriously and sought to act in the best interests of the person and their spouse.

The staff handbook also displayed good values of person-centred care and sensitivity of approach. It stressed the importance of respecting people's dignity and privacy, and maintaining confidentiality at all times.

Is the service responsive?

Our findings

We spoke with the spouse of the person using the service. They told us they had been fully involved in the assessment of the person's needs and in the planning for their care. They said they were sure they would be involved if any changes were needed to the person's care. They told us the care workers gave as much choice as possible and both respected and responded to the views of the person and the person's spouse. They described how the care workers tried to incorporate as much choice as possible into the person's daily activities We were told the service was consistent and reliable, with the same four care workers working the regular day and night shifts.

We looked at the assessments the provider had carried out to establish the person's needs. We found all but one page of the assessment was undated, making it difficult to be certain when it was drawn up. We found some sections, including the activities assessment and the contact details for the person's GP, had not been completed. Important areas such as dietary needs and medicines support needs had not been assessed.

We looked to see if the person's care plan gave staff clear and accurate guidance on how best to meet the person's assessed needs. The care plan was written in a narrative style which did not clearly define some specific needs. For example, we found no detailed guidance in the care plan with regard to certain assessed needs such as issues of continence and the person's exercise regime, despite the provider having been given written advice from relevant health professionals. The care plan gave workers guidance on nutritional and swallowing issues that was contrary to that given in the person's dysphagia risk assessment and risk management plan. We noted, in the daily care records, care workers were carrying out interventions not specified in the care plan. These included exercising the person's legs and checking urinary output.

We found no evidence that the person's care plan had been formally reviewed since the service provision had commenced, despite changes having been made in the person's care regime. The director told us she re-assessed people's needs informally every week.

We looked at the documents workers used to record certain care interventions such as fluid intake and positional turns. We saw significant discrepancies between the recorded fluid intake and output for the person. When we asked the care workers about these issues they told us they had no instructions about what level of fluid intake/ output would cause concern and therefore need reporting. We found no specific care plan on the person's care records regarding hydration.

The person's spouse told us the person had developed a pressure ulcer the previous day, which had required the attention of the person's GP. When we looked at the positional change record for the person over the previous week we noted no changes had been recorded on one day; one change, only, on a second day; and no changes between midnight and midday on a third day. This meant that care workers had not followed the care plan for maintaining the person's skin integrity and that an issue with the person's skin integrity had possibly arisen as a result.

We found fluid intake and output charts were in place for the person using the service. However, the absence of any recorded fluid intake targets, it was not possible to be assured the person was receiving adequate fluid intake to ensure their comfort. We noted some days where the person's fluid intake, as recorded, was very low and represented a risk to the person's health and well-being.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The complaints log showed two complaints had been recorded. Both had been investigated by the provider. One contained discrepancies regarding the chronology of events, in that it included references to events that had taken place after the date of the completion of the complaint record. The registered manager was unable to offer an explanation.

Is the service well-led?

Our findings

We spoke with the spouse of the person using the service. They told us they were very happy with the management of the service. They told us they felt well-supported and could contact the company at any time.

We asked the person's spouse if they felt their views were sought and acted upon. They told us they felt able to raise any issues directly with the registered manager and the director, who were responded appropriately. For example, we were told there had been some issues with the performance of one care worker. When this was raised with the registered manager and the director, they removed the care worker from the care package. The person's spouse told us the registered manager and the director visited every two weeks to discuss the person's care with them. The person's spouse told us they had been asked to complete a service user and advocate survey on behalf of the person.

We asked to see the company's policies and procedures files. The director told us she had purchased the company's policies from a reputable company and had them printed with the company's letterhead, and believed them to be appropriate. However, we found numerous examples of the registered manager and director not being aware of the service's own policies and/or stating the actual policy was different from the service's written policies. For example, the service's recruitment and selection policy and procedure stated the applicant must give previous employment information covering their full working life, whereas the provider's representative told us she only requested the last ten years employment history. A second example was a policy allowing for restraint to be used in certain circumstances, whereas the provider's representative told us the service would never use restraint under any circumstances. A third example was the differences in the expected frequency of staff supervision, where the stated policy was different to the written policy. This meant we could not be assured there were clear policies and procedures in place to guide staff, or that the management of the service was following its own policies and procedures. This demonstrated a lack of clarity and leadership in the management of the service.

We found that many records were not signed and/or dated, or were otherwise incomplete, making them inadequate for demonstrating appropriate care was being given. The registered manager and the director were unable to supply some records, including the staff training matrix and documentary evidence of induction training. Some records reportedly could not be found; other omissions in the records were said to be due to computer problems on the day of the inspection.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence of the provider having used information from complaints, whistle blowers or feedback from staff and people using the service as a means for improving the service, or of any meaningful reflection on the management of the service.

We found no evidence that care workers were involved in the development of the service. We asked two care workers if they had been asked to attend any staff meetings. They told us they had not, and were not aware that any such meetings had been planned. We found no evidence of any surveys of the views of care workers. However, the workers told us they felt well supported and were able to ring the registered manager or the director for advice at any time.

We identified multiple shortfalls which demonstrated a failure to operate effective systems to monitor the quality of service provision. Issues such as gaps in the medicines administration records, incomplete fluid intake and positional movement charts had not been identified by the registered manager or the director.

This in turn meant that some risks relating to the health, welfare and safety of people receiving a service had not been identified, assessed or managed.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not obtained the consent of the relevant person before providing care to the service user. Regulation 11.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems in place for assessing the risks to the health and safety of the service user of receiving their care. Regulation 12(2)(a).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place to ensure the proper and safe management of medicines. Regulation 12(2)(g).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have appropriate systems in place to monitor the quality of the service and risks to the service user; and did not have the necessary records in place in relation to persons employed and to the management of the regulated activity. Regulation 17(2)(a)(b)(c)(d)(e)(f).

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not carried out a full assessment of the needs and preferences of the service user, and had not designed their care in a way that ensured their needs were fully met. Regulation 9(3)(a)(b)(i).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have appropriate systems in place to support staff by means of training, supervision and appraisal. Regulation 18(2)(a)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have an effective recruitment procedure in place. Regulation 19(2)(a).