The Care Partnership (UK) Limited

Waveney Office

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 June 2017. The service supports people in their own home in rural and coastal areas of Suffolk providing care on a visit or live in basis. At the time of our inspection they were supporting approximately 20 people.

The service did not have a registered manager. The previous registered manager had left the service. The provider had recruited a manager. This person had not yet applied to register but was in the process of obtaining legal checks before they put in a formal application to the Care Quality Commission. 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.

Care plans did not contain sufficient information to enable care to be delivered effectively. There was little detail as to people's likes, dislikes and preferences. Neither was there sufficient detail in the care plans to support staff to provide consistent care and support to people. In some cases, care plans did not contain information to ensure care staff met people's individual needs. Care staff's individual knowledge of people was relied upon for this information.

Care plans did not contain risk assessments to ensure that the care and support people received was carried out as safely as possible. There were no risk assessments in place for people's moving and handling needs. You can see what action we told the provider to take at the back of the full version of the report.

Staff received training to support people with their medicines. However, the service did not follow its own policy with regard to carrying out a full assessment before supporting people with their medicines.

There were systems in place to protect people from abuse. Staff could identify the different types of abuse and knew what actions to take to report abuse. The service had made appropriate safeguarding referrals.

Staff had a good understanding of the Mental Capacity Act 2005. The service had worked with the local authority to obtain a Court of Protection Order where this was necessary for one person. Staff gained people's consent and offered them choice when providing care and support.

People receiving support and care staff were complimentary about the management of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments were not always carried out to ensure risks to people from receiving care and support were managed appropriately.

The amount of support a people required with their medicines was not always fully recorded.

Staff had received safeguarding training and knew how to report abuse.

Is the service effective?

Good

The service was effective.

Staff had regular training and supervision which supported them to carry out their role effectively.

The Mental Capacity Act 2005 was understood and principles of the code of practice were being followed.

The service worked with other healthcare professionals to support people to maintain good health.

Is the service caring?

Good

The service was caring.

People's involvement in their care planning was not reflected in care plans.

People were treated in a kind and caring way.

People's privacy was respected and they were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not contain details of how people would like to receive their care and support.

People knew how to raise a complaint or a concern and felt that these were listened to and appropriate action taken.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service did not have a registered manager.

The provider of the service had not recognised deficiencies in the care plans.

There was a process for the service to obtain feedback on the quality of the service provided.

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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.

This inspection took place on 6 June 2017 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and staff are often out during the day; we needed to be sure that someone would be available to speak with us.

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

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury.

During the inspection we spoke with seven people who were being supported by the service or were relatives of people receiving support. We spoke with four members of care staff. We also spoke with the manager and the managing director of the provider company. We looked at records in relation to four people's care. We looked at records relating to the management of the service and systems for monitoring the quality of the service. We also received feedback from two healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when receiving care and support from the service. One person said, "Yes, I feel safe without exception. A relative said, "Most definitely [person] is safe, I wouldn't leave him otherwise. I now go away on holiday and leave [person] with them."

We found that people's care plans did not always contain appropriate risk assessments. For example one person's care plan recorded that the person should be assisted into their wheelchair using a 'banana board'. There was no risk assessment for this person transferring into their wheelchair by this method. There was no information which demonstrated that this method of transfer was the best for this person and that the risks of transferring by this method had been assessed and any appropriate actions put in place to mitigate the risk. We asked the manager and nominated individual if there were moving and handling risk assessments in place for people who required hoisting. They confirmed that no specific moving and handling risk assessments were carried out. This put people at risk of not having their moving and handling needs met by the safest and most appropriate method.

Where people were at risk of developing pressure ulcers this had been recognised and actions to prevent pressure ulcers were recorded in the care plan. However, these were generic and did not address the risk to the individual. For example two care plans contained the same instructions regarding the prevention of pressure ulcers. These were 'encourage and assist with regular position change' and 'check pressure areas daily and record any change on body map and inform manager.' There was no formal method of recording people's position changes or information as to how often their position should be changed. Staff told us that when they changed a person's position they recorded it in the daily notes. There was no information in the care plans as to what the current condition of the person's skin was so that the member of care staff would be able to recognise if any change had taken place and report it to the manager.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe Care and Treatment.

The service supported people to take their medicines. The service policy entitled 'Medication Management Policy' stated that 'Carers must not offer any assistance with medication unless an assessment has been carried out, the level of support required is clearly documented and a care plan is in place and accessible within the person's home.' The policy did not set out the different levels of support which may be required, for example, the difference between prompting a person to take their medicines and administering a person's medicines. The medicines care plan for one person recorded 'Care need – needs assistance with medication,' the actions and support to be provided was recorded as 'Prompt to take medication via MAR (Medicines Administration Record) chart as required.' This did not represent an assessment of the level of support required, nor was the level of support clearly documented. The level of support a person required with their medicines should be fully documented in the care plan, for example whether the person needs their medicines administered or needs prompting to take their medicines.

Care staff told us and records confirmed that staff had received training and competency checks on

medicines administration. Audits of MAR charts were carried out monthly to check people had been given their medicines.

Care staff we spoke with confirmed they had received training in safeguarding vulnerable adults from abuse. They were able to explain what constituted abuse and all said they would contact the manager if they had any concerns. They were also aware that there were other outside agencies they could contact if they did not wish to contact the manager. Our records confirmed that the staff had previously brought concerns to the attention of the manager when they had suspected abuse and the appropriate referrals had been made.

The manager told us that the service only took on new care packages when they had sufficient staff to cover the hours required to provide support. We saw this demonstrated during the inspection, when we saw manager discussing with the nominated individual whether they had the required staff to support a new care package that had been requested. They also told us that they were actively recruiting more staff. Care staff told us that they believed there were sufficient staff to meet people's needs. One member of staff demonstrated this by telling us that the service was not "Always chasing me to do extra hours," which had been their experience when working for another care provider.

Staff personnel files evidenced that the service followed robust recruitment procedures. Appropriate pre-employment checks had been completed and these included written references from previous employers and an enhanced disclosure and barring service (DBS) check. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. These measures supported in ensuring they did not employ unsuitable staff.

Good

Is the service effective?

Our findings

People and relatives told us they were happy with the care provided and that care staff had the skill and knowledge required. A relative said, "I make sure one hundred per cent they know what they're doing but an older person is always here with a new young person and that's ideal." Another person said, "Skills, yes they have been brilliant."

When they began working for the service new members of care staff went through an induction procedure. This included training in safeguarding, first aid and moving and handling. They also shadowed a more experienced member of staff until they were confident to provide care and support alone. New members of staff completed the Care Certificate which was introduced in April 2015 as the new minimum standard for induction for those commencing a career as an adult social care worker. Staff told us that the management team encouraged them to gain further qualifications in care to develop their knowledge and abilities.

Staff were complimentary about the support they received from the manager both during their induction and on an on-going basis. One member of care staff had written on their six monthly supervision record, 'I feel that if I have a problem that I need to talk about I can go to the manager who is very approachable and get the situation, whatever it is, dealt with in a professional manner.'

Training records showed that care staff had completed training in areas that supported them to meet people's needs. Mandatory training for all staff included; medicines, safeguarding, first aid, moving and handling and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Where staff needed training to support people with particular needs, such as monitoring their insulin levels, the service liaised with local professionals to provide this. The manager told us that the service was taking on more 'end of life' care packages. We noted that the service did not provide care staff with specific training in end of life care. The manager told us that they were planning sessions for staff on this subject but as yet these were not in place.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The service had recently worked with the local authority to obtain the required authorities to apply for a Court of Protection Order for one person and had received positive feedback from the mental health team.

People and their relatives told us that care staff gained people's consent before providing care and support.

A relative said, "Consent? I'm in the room and they do ask, and one or two in particular are very forthcoming as they will say, "May we do this?", "Thank you for being so patient."

People who required support with their meals told us staff reflected in their practices the importance of their individual meal choices. One person said, "The carers come at lunchtime and whatever I say I want to eat they'll do it. My carers cover for when my friends are away and cook my [retailer] meals for me. In the evening they always make me a hot drink."

People who used the service and relatives told us they made their own health appointments, but staff would support them with this if they needed it. Staff told us, when needed, they liaised with district nurses or doctors on behalf of people to arrange appointments or seek advice. The manager described how they had good working relationships with health professionals involved in people's care. We received positive feedback from a member of the community liaison nurse at the local hospital regarding working with the service around discharge planning.

Good

Is the service caring?

Our findings

People and their relatives were positive about how staff were caring and they were treated with respect. We gained positive feedback from people when speaking about how they were supported to feel cared for by staff who came into their homes. A relative said, "[Person] just appreciates them talking to them. [Carer name] talks about [person] interests for example speedway, she bought [person] a book on speedway and [person] just loves to chat."

Staff reflected in their conversations with us the caring relationships they had developed with the people who they supported and cared for. A staff member described how they knew people well and, that as they had provided care to the same people over a period of time, they had built up trusting relationships with these people and their relatives. One relative said, "They all bring something different, one goes out with [person], one does DIY, one talks and does the computer and [named carer] talks about hovercraft and cars."

In the PIR the provider gave us examples of situations where staff had taken practical action to support people. These included supporting a person being taken to hospital due to urgent mental health concerns and supporting a person who was moving house to settle into their new environment.

The manager told us that care plans were reviewed six monthly and that people were involved with their reviews. They went on to tell us that with end of life care they reviewed the care plan after one week to ensure the appropriate care and support was being provided. These reviews were not recorded in the care plan and care plans did not demonstrate people's involvement with the review.

People told us that they could contact the office and their views were respected and acted upon. One person said, "It's very good the communication." A relative said, "I've got no compunction with ringing the office about anything, anything I want changed they do it."

People told us that their privacy and dignity was respected. One person said, "There's privacy and dignity and confidentiality, yes every bit, its stable, it's perfect." People told us they were asked if they preferred a male or female member of care staff and their wishes were respected.

Staff understood the importance of respecting people's confidentiality and told us they would only share information about people on a need to know basis. We saw paper care records were secured in the office and only people with authorised access could look at computer records held by the provider.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not contain sufficient information to ensure that people received personalised care that was responsive to their needs. People and their relatives told us that care staff knew them well and were aware of their likes and dislikes. One relative said, "[Person's] likes and dislikes as a person they know fully well, as [person] gets regular carers and they chat away with [person]." However, people's likes and dislikes, and preferences as to how they wanted to receive their care and support were not recorded in the care plan document. This meant that should care staff change they would not be aware of the person's preferences regarding their care and support needs and relied upon staff's direct knowledge of the person.

Care plans did not contain details of what support was to be provided to people. We asked one member of care staff if the care plan provided them with sufficient information to provide care and support to people, particularly if they did not know the person. They replied, "I like to talk to the person when I start providing care and find out their background and what they like." We asked another member of care staff the same question and they replied, "It's common sense." Without effective care planning the service could not ensure that people received consistent care which was responsive to their needs.

We asked the manager and care staff how the details of people's care and support needs were communicated to staff. One member of staff told us that the care plans did not contain much information but that sometimes there was more information in the pre-assessment completed before care was commenced which was available in people's home. They went on to say that the manager "Goes through everything before we go in." These were verbal instructions and were not recorded in the care plan. We asked staff how they received updates or changes to people's care plans and they told us they received a text message from the manager. This method of communicating people's needs and any changes to their care plan did not ensure that all staff were aware of the care and support to be provided.

We asked one member of care staff how they knew what moving and handling requirements people had as these were not in the care plan. They told us that they worked with a senior member of staff and followed their lead. We asked a senior member of care staff how they knew what a person's moving and handling requirements were. They told us they were given this information verbally. The lack of a care plan for this type of support meant that care staff may not be aware of the support required by the individual. In particular when using a sling what type and size of sling should be used. If the wrong size of sling is used, or the adjustment of the sling is incorrect discomfort or injury could be caused to the person.

A health care professional we spoke with was complimentary about the commitment of individual members of staff to providing good quality care and stated that the service provided, "Good verbal handover." However they went on to say that care planning, "Was not quite there," explaining that they had written the care plans for people they were responsible for.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care.

The provider had a complaints policy which included details of how to make a complaint and how to escalate concerns if people were not happy with the response they received. The manager told us that a copy of the service complaints policy was available to people in the documentation which was left in their home. People told us they knew how to make complaints if they needed to. One person told us, "For complaints there's [named member of staff] in the office and they're lovely. I've never met them but I feel I know them. I would make a complaint if I had to, I don't need a leaflet." A relative said, "Yes, I've got information in the leaflet about the care and there's a complaints section."

The service had not received any formal complaints. People told us that if they raised concerns with the service these would be listened to and action taken. One person said, "I would say if anything was wrong, I definitely wouldn't hold back." A relative said, "I would say to the office if I had any concerns, and I have done. Things were very quickly sorted."

Requires Improvement

Is the service well-led?

Our findings

The registered manager for this service had left prior to this inspection. The provider had offered the managers post to a senior member of staff and they were now managing the service. They were in the process of obtaining a DBS check in preparation to applying to the Care Quality Commission to register as the manager. The application had not been made at the date of our inspection.

People we spoke with were complimentary about the management of the service. One person told us, "I feel it is very well run. I'm quite happy with it." A relative said, "Yes, I do think it's well run. I know [manager] and [name] is very nice. I've spoken to [manager] a few times." Staff were also complimentary about the manager and how the service was run. One member of care staff said, "This is a small company, we have a lot of contact with the office. Communication is very good, any concerns I know who to contact."

The manager told us that, as this was a small service, they regularly provided care to people. They told us this enabled them to monitor the quality of the care and support being provided by care staff. This included working with other staff where two care staff were required on a call and having informal conversations with people receiving care about the care they received.

We asked the managing director and the manager about the quality of the care plans. They told us that changes had been made to the content of the care plans by the previous registered manager. The changes to the care plans had not been pro-actively monitored by the provider which had resulted in them containing insufficient information for care staff to ensure they were meeting people's needs. We have spoken with the manager since the date of the inspection visit and they are working with the provider to improve the quality of the care plans.

The service had a rolling process for requesting client feedback. Where the service had provided end of life care feedback was sought from relatives as to the quality of the service provided. The feedback forms we saw were undated. The last time feedback was analysed was January 2017 by the previous registered manager. This showed a very high satisfaction rate. The managing director told us that following the resignation of the registered manager they would be looking at how they obtained and analysed data about the quality of the service people received.

The manager told us that when compliments and thank you cards were received these were displayed in the office, and if relevant to a particular member of staff, recorded in the staff file. Staff we spoke with confirmed this and appreciated the acknowledgement by the service when people complimented them.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans did not contain sufficient information to ensure care was delivered safely.