Carradice Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was announced and took place on 10 August 2016. We gave the provider 48 hours' of our intention to undertake the inspection. This was because the service provides domiciliary care to people in their own homes and we needed to make sure someone would be available at the office.

Carradice Care is registered to provide personal care to people living in their own homes. There was a registered manager in place who is also the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection 30 people received care and support services.

Where people's medicines were administered by staff records did not accurately record when medicines had been administered. The provider had procedures in place to check that people received their medicines but these were not robust enough to ensure action was taken when issues were identified.

People told us that they felt more care staff were needed as staff often arrived late to provide support without prior notification. Staff told us more care staff were required to cover periods of leave and sickness.

We found risks to people's health and safety had been assessed and suitable plans of care put in place. We checked staff records and saw that staff had been recruited following appropriate checks.

People told us that staff provided a choice when supporting them with the preparation of meals. However people said the support was inconsistent as some staff provided poor quality meals and required guidance on how to prepare food.

The care people received was inconsistent and dependant on which member of staff supported them. People felt some staff did not treat them, their home and belongings with dignity and respect. People said some staff were caring and kind and supported them to maintain their independence.

Staff sought people's consent before providing care and supported people to access healthcare professionals when required. Complaints were not logged, investigated or responded to and the provider had not learned from them to improve people's care experiences and reduce the likelihood of events happening again. People and staff were not confident that if they raised any concerns action would be taken.

People told us they were not listened to or involved in their care and in making decisions about their care, therefore the service could not always be sure it provided care in line with people preferences.

The provider checks and audits needed improving as they did not assess, monitor and drive improvement in

the quality and safety of the services provided. Staff told us they could approach the provider for advice and guidance but they would like more support through supervisions and team meetings.

The provider had identified some improvements needed to be made and had a new staff structure to take this forward including the appointment of a new manager and two new care supervisors. This was planned to enable them to concentrate on their provider role and take a lead on checks and audits to ensure the quality of care was monitored.

You can see what actions we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicine records did not accurately record when people had received their medicines.

People said although care calls were not missed they could not rely on staff turning up on time.

People felt safe with the staff coming into their homes and providing care.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received a choice of meals but some staff had limited knowledge in food preparation.

Staff sought people's consent before proving care and supported people to access healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care received was inconsistent and people and their homes were not always treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints were not logged, investigated and responded to and learning taken to reduce the likelihood of events happening again.

Reviews of people's care was not consistent therefore the service could not always be sure it provided care in line with people preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Provider checks and audits did not assess, monitor and drive improvement in the quality and safety of the services provided.

Staff told us they would like more support through supervisions and team meetings.

Carradice Care Ltd

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 10 August 2016 and was announced. The inspection team consisted of one inspector. The provider was given 48 hours' notice because the location provided a domiciliary care service. The provider can often be out of the office supporting staff and we needed to ensure that someone would be in.

We reviewed information we held about the service and looked at the notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We spoke with six people who used the service and four relatives. We also spoke with the registered manager and provider, two care supervisors and six members of care staff. We looked at the care records of five people to see how their care was planned. We also looked at three staff files, medication records, complaints and compliments, communication records and provider checks.

Requires Improvement

Is the service safe?

Our findings

Four people and four relatives told us although care calls were not missed they felt that staff often arrived late for provide support. People told us they could not rely on staff turning up on time. One person said, "They are always late, you just get used to it." Another person told us, "They [staff] are terrible on time." One person gave an example of how they had missed a meal due to staff arriving late. One relative said, "They are often late with no notice. It's not right because [relative's name] is left sat there worrying."

Five members of staff said they felt people were safe and stated calls not missed, however they advised that calls were late at times due to covering additional calls when other staff were off sick or on leave. Staff told us that more care staff were needed.

The provider said that there were sufficient numbers of staff available to meet people's needs and all calls were covered. They told us they used a planning system to ensure staff cover and would only accept further care packages where staff had capacity to provide the support. They told us the system did not highlight late calls but the majority of care calls involved two staff and staff would call into the office if the second member of staff was late. They advised where staff completed care calls on their own a text was sent to the staff ensuring the call had been completed. There was no record of late calls and any actions taken to address this. The provider acknowledged they would like more staff to cover periods of sickness and leave and advised that they were looking to recruit additional care staff and interviews were on-going. This was acknowledged by staff.

People told us staff supported them with their medication and staff told us they had received appropriate medicines training before providing support. However, we found medication records were not completed consistently. For example, there were gaps in the records indicating the medicine had not been administered; therefore we could not be confident that people had received their medicines as directed. We also found that management checks of the medicines records were inconsistent. For example, we found that the monthly medicines records for five people had been signed as checked and correct. The check had not identified any gaps in the records or incorrect recording.

When we spoke to the provider they told us if a medication was not administered a record should be made of the reason why. The provider acknowledged the record sheets had not been completed correctly. The provider and staff were unable to show us where they had regularly checked people's medicines and taken actions so that any errors could be picked up and resolved in a timely way. The provider said that immediately following the inspection they would give additional training to the staff checking medicine records to ensure procedures were followed and all gaps and incorrect recordings were identified and action taken.

All people we spoke with told us they felt safe with the staff coming into their homes and providing care. One person said "They [staff] do look after me, I feel safe; I've no worries." Another person told us they felt assured as, "Staff call out when they arrive so I know they are here."

All staff we spoke with demonstrated an understanding of the types of abuse people could be at risk from and confirmed that they had received training in safeguarding people. They were clear about the steps they would take if they had any concerns. Staff told us they were confident to report any concerns with people's safety or welfare to the provider and that action would be taken. One member of staff told us of a concern they had raised. They said that action had been taken and the situation resolved.

All staff we spoke with were able to describe the different risks to people and how they supported them. One member of told us a person they supported required equipment to aid their mobility. They said, "Two carers attend the call; we work as a team and follow the care plan." People's risks had been assessed when they first received care from the service and had then been reviewed. Staff said the assessments gave them the correct level of information to provide care and support.

We saw records of employment checks completed by the service to before staff started work. The provider had made reference checks with previous employers and with the Disclosure and Barring Service (DBS). The DBS is a national service that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

Some people were being supported by staff to eat and drink enough to keep them well. People told us staff would give a choice of meals but three people told us the food preparation was poor as staff had limited knowledge. One person said, "They [staff] have no cooking skills, therefore I no longer let them help." Two people gave examples of when staff had not been able to make them a snack without help and guidance.

Two people also told us staff had left food for use past its use by date. One relative told us they had spotted out of date food had been left and was concerned if eaten this could have affected their family member's health. Another person told us staff had prepared their meal but said, "It's unhygienic how they [staff] left my kitchen." One relative told us they felt they needed to keep reminding staff about the nutritional needs of their family member as new staff didn't always provide the support as required.

When we asked the provider they told us all staff received food hygiene training. They advised they had received feedback about out of date food and poor food preparation skills. They said this had been addressed with individual staff through supervision; however this had not been recorded.

Whilst people told us staff food skills needing improving, four people we spoke with told us staff knew how to support their care needs. One person said, "Staff know what they are doing. They know how to look after me." Staff we spoke with explained training helped them to do their job. All staff we spoke with confirmed training gave them the right skills for their role and were able to give an example of how training had impacted on the care they provided. For example, one member of staff explained how manual handling training helped use different mobility equipment and gave them the confidence they were supporting people correctly.

Four staff told us the majority of training they received was online training courses and they would prefer more practical training as they felt this was a more effective way of learning. We discussed this with the provider who told us they agreed with the staff feedback. They advised they were currently looking to source more practical training courses.

We asked staff about their induction training. One member of staff told us they were new to care and their induction training had been, "Very good." They said they had shadowed experienced staff until they were confident and then continued on calls with other staff. Another member of staff told us they too had shadowed staff when they started. They said, "It really helps. It gives you the chance to ask lots of questions and get hands on advice."

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

Staff we spoke with told us they were aware of their responsibilities to ensure people's consent to care and treatment was sought and recorded. This was confirmed by people we spoke with, one of whom commented, "Staff always check if I am ready and everything is okay before they start." We looked at the training records for staff and saw that training was not complete for all staff. Four staff said they would like more Mental Capacity Act training to improve their knowledge. The provider acknowledged this and said training would be sourced.

The provider was clear that all people using the service were able to make choices and said, "All our clients are able to provide their consent".

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. We checked whether the service was working within the principles of the MCA. Any applications to deprive someone of their liberty for this service must be made through the court of protection. The provider told us no one was being restricted and they were aware of this legislation and were happy to seek advice if they needed to.

People told us staff would help them access medical help if they needed and staff had recorded when they had contacted health professionals. One person said when they were unwell staff had contacted their GP for them. One relative told us when their family member was unwell, staff had called the GP and stayed with their family member until they arrived. We also saw examples of when staff had contacted the district nurse team who then visited and supported people.

Requires Improvement

Is the service caring?

Our findings

People told us the care they received was inconsistent and depended on which member of staff provided the care. One person said, "Some staff are great and really caring, others don't care at all." One relative told us, "Some staff do [care], they are really nice. Others don't." They gave an example of when a member of staff had complained to their family member about providing care, they said this showed their lack of caring and made their family member feel uncomfortable. Another relative commented, "Some [staff] are good but I've asked others not to come back." Two people told us they felt staff were caring, one person said, "I have the same carer all the time, she is great."

One person and two relatives gave examples of when they felt they had not been respected by staff. They told us that they found it disrespectful when staff talked amongst themselves in a way that excluded them. One relative told us their family member had been upset after one incident and said, "They [staff] should have more respect than that." We discussed these issues with the provider, they told us the incidents had been addressed with the staff concerned through supervision; however this had not been recorded.

People told us they did not feel that staff always respected their home and belongings. One person told us staff didn't clear up after themselves, they said, "They leave the washing up and things lying around." Three people told us they felt that staff did not respect their home and gave examples of where staff had damaged furniture. One person said, "They just don't take care." We spoke to the provider about these issues; they told us damage had been caused by staff when using equipment. They told us they had personally visited people and an apology had been given. They also paid to put right any damage caused and this was confirmed by one relative we spoke with. The provider told us any issues had been addressed with the staff involved through supervision; however this had not been recorded.

Two people told us that they were involved in their planning their care. One person said, "They [staff] ask what I want and I tell them". Another person commented that when staff arrived , "They ask what I want and then they get going." A relative also confirmed that staff involved their family member in planning their care. They said, "If you will ask they will do it for you."

Staff we spoke with said they enjoyed working with people and had developed good relationships. One member of staff told us, "I enjoy working, I like helping people". Another member of staff said, "I love the people, I enjoy helping them." Staff told us where they provided care to the people they over a period of time they could build up relationships and get to know them and their families. A member of staff said this helped people become more relaxed and said, "You get to know people, it makes it better for the people we support."

One person told how they stayed independent, they told us, "My girls [staff] encourage me to keep doing things myself." Staff told us how they respected people as individuals and how they involved people in their day to day care and which promoted their independence.

Staff we spoke with shared their understanding of caring for someone with dignity. They told us about

practical ways in which they maintained a person's dignity. One staff member listed things they did such as closing curtains when people were getting dressed as well as ensuring doors were closed when supporting people with personal care.

Requires Improvement

Is the service responsive?

Our findings

All people told us they were aware of how to make a complaint if they had a concern. Two people and two relatives told us they had made complaints but did not feel that they were taken seriously or that long term changes were made as a result. One person said, "I keep ringing, they say all the right things but nothing changes." Another person told us, "I have given up, things change for a little while but then it goes back to normal." People told us that the lack of response to their complaints meant that some concerns continued. One person said, "They just move the staff, they don't tackle the problem."

All staff we spoke with told us they knew how to raise concerns or complaints on behalf of people receiving care and support. One member of staff told us they had raised a concern but they felt it had not been dealt with by the provider. They said, "They [management] took no notice. There was no action taken."

The provider told us that one person had made a complaint; however the provider was not able to demonstrate that all aspects of the complaint had been addressed. The provider was unable to show us any records of where they had logged, investigated and responded to any other complaints.

The provider had not investigated and responded to complaints and looked for any learning to reduce the likelihood of events happening again. This was a breach of Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints.

People told us that communication systems could be improved. One person said, "You have to ring and ask, they don't tell you anything." Two people told us that when they had rung the out of office telephone number no one had been available to take the call. Two people told us they didn't receive any notification of which staff would be providing support which they had requested.

Two other people told us they had not had been involved in reviews. One person said, "No one comes out to review [my care]." We spoke to the provider, they told us reviews had been completed but there was no record of any reviews because the care manager provided care and during calls discussed informally with people their care and if things were okay. The provider told us they had recognised the need for more checks and reviews and had implemented a new staffing structure and two new care supervisors had been appointed. On the day of the inspection we were unable to determine how effective these changes were as they had not yet been fully embedded.

Staff said communication systems were in place to advise them of any changes in rota's or people care, for example a change in medication. One member of staff told us office staff were good in responding to any support required when calling people's doctor or their district nurse.

Staff we spoke with understood people's needs. Staff demonstrated a good knowledge of the people they cared for and gave examples of how they supported them in the way they liked. One person said, "We chat during my calls, it works for me."

Requires Improvement

Is the service well-led?

Our findings

The provider had failed to identify many of the concerns people had raised with us during the inspection. People were unhappy with many areas of their care and support. Where people had raised concerns or comments these had not been used to improve people's experiences. The systems the provider had in place were not effective and were not meeting their regulatory requirements. When the provider had sought feedback it had not been used to drive improvement of the service.

We looked to see how regular checks and audits led to improvements in people's care. Effective systems were not in place to enable the provider to assess, monitor and improve the quality of the service. For example, audit records of daily care notes and medicines records had not been consistently completed and recorded; therefore we could not be assured that any learning was taken to improve the service.

People could not rely on staff turning up on time and were not notified that the staff were running late. We found the provider did not have a record of late calls to monitor and assess were actions were needed and improvements made.

People we spoke with gave mixed comments on the service they received. One person told us, "I am happy with the care." Another person commented, "It's very good I have no complaints." Two other people and two relatives told us the service needed to improve. One person told us they felt the care was good but that the management and communication within the service need to be improved.

Staff also gave mixed comments about the management of the service. Two members of staff told us they felt the service was well managed and they felt supported. One member of staff, "I think they are good, they try their best." Other staff told us they felt managers did not support them effectively. One person said, "You are just left to get on with it, there's no point in telling them anything, they don't want to know."

Three staff told us they did not receive supervision as often as they would like. One member of staff said, "I have not had supervision for over nine months. I would like the chance to discuss things." Staff confirmed that there were staff meetings but they would like them more frequently. One member of staff said, "We need to get the team together and discuss what works best and how to improve communication." They told us the last staff meeting was in December 2015. When we asked the provider they confirmed this and they told us they had identified the need for more regular meetings and planned to have these now that new staff were in place.

When we spoke with staff they were able to provide us with examples of their understanding of accidents and incidents. However the provider could not show us was how they monitored accidents and incidents. For example, they could not show us evidence of how they looked for any trends which may indicate a change or deterioration in people's abilities or reduce the likelihood of events happening again.

The registered manager and provider checks and audits did not assess, monitor and drive improvement in the quality and safety of the services provided. This was a breach of Regulation 17 HSCA 2008 (Regulated

Activities) Regulations 2014 Good Governance.

The provider advised that management meetings were held every three months to discuss any issues. They advised that they had recognised that checks and audits had not been consistently completed for a period but they had identified this prior to the inspection and newly appointed care supervisors were now working through records to bring the checks up-to-date.

The provider told us they had identified some improvements needed to be made and that a new staff structure was in place to take this forward. This included the appointment of a new manager so the provider would lead on checks and audits to ensure the quality of care was monitored.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not investigated and responded to complaints and looked for any learning to reduce the likelihood of events happening again.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and provider checks and audits did not assess, monitor and drive improvement in the quality and safety of the services provided.