I & S Care

# I & S Care

## 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? | **Good** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

The inspection took place on 23rd September and was announced. The provider was given 48 hours' notice because the location provided a domiciliary care service and we needed to be sure that someone would be in. I&S Care is a domiciliary care agency that provides personal care and domestic support to people in their own homes. At the time of inspection there were nineteen people using the service.

The service has a registered manager 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.

At this inspection we found the service to be in breach of Regulations 12, 17 & 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Improvements were required in the safe management of medicines to ensure people received their medicines as prescribed and any errors were identified and addressed.

There was a system in place for the safe recruitment of staff but this was not always adhered to. This meant that the necessary checks were not always completed for all staff.

The provision of formal training was patchy and inconsistent with no structured training programme in place. The registered manager did not have systems to monitor gaps in staff training.

Staff received informal supervision and appraisals on an ad hoc basis. There was no formal systems and processes in place to ensure that staff were supported with their professional development and monitored to ensure their competency so that they could meet people's needs safely and effectively.

There was a lack of quality assurance mechanisms in place to monitor the safety and quality of the service and to drive improvements.

People were protected from abuse as staff knew what constituted abuse and who to report it to if they suspected it had taken place.

There were sufficient numbers of staff to meet peoples care and support needs and keep them safe.

The service understood how to manage risk in a way that kept people safe whilst respecting people's rights and freedom to exercise choice and control.

The Mental Capacity Act 2005 (MCA) is designed to protect people who cannot make decisions for

themselves or lack the mental capacity to do so. The provider followed the principles of the MCA by ensuring that people consented to their care or were supported by representatives to make decisions.

People were supported to have enough to eat and drink and to access health care services to maintain their health and wellbeing.  When people became unwell staff responded quickly and sought the appropriate support.

Care workers had very positive relationships with people who used the services and were valued and held in high regard by people and the families they supported. The care delivered was personalised and met people's individual needs and preferences.

People, or their representatives, where appropriate, were involved in how their care and support was delivered so felt listened to and included. Care workers treated people with dignity and respect and promoted people's independence.

The provider had a complaints procedure in place and people who used the service knew how to use it.

Staff told us that they were well supported by the management team and felt confident that any concerns they raised would be listened to and dealt with fairly.

## 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.

Improvements were required in managing people's medicines.

Systems were in place for the safe recruitment of staff but these were not always adhered to.

Risk was assessed and managed safely.

Staff knew how to safeguarding people from potential abuse.

There were sufficient staff employed to meet their needs safely.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Improvements were required in how staff were trained, supervised and appraised to ensure they had the necessary knowledge and skills to support people effectively.

People were supported with decision-making and their consent was obtained.

People were supported to have enough to eat and drink to maintain their health and wellbeing.

### Is the service caring?

**Good**

The service was caring.

People were treated with dignity and respect.

People's privacy was upheld and their independence promoted.

The service listened to people and knew them well.

### Is the service responsive?

**Good**

The service was responsive.

People were included in the care planning process.

The care delivered reflected people's preferences.

There were systems in place to deal appropriately with any complaints.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

There were a lack of systems and processes in place to monitor the safety and quality of the service and drive improvements.

The service promoted a culture that valued people as individuals and treated people with compassion and respect and these values were shared by staff.

Staff and people felt well supported by the management team and felt listened to.

There was a whistle-blowing policy in place and staff felt confident that if they raised a concern it would be dealt with appropriately and fairly

# I & S Care

**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 23rd September 2016, was completed by one inspector and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

Prior to the inspection we reviewed information we held about the service We reviewed information we held about the provider including statutory notifications. A statutory notification is information about important events which the service is required to send us by law. We also looked at the provider information return (PIR) which we ask provider's to complete to tell us about their service.

We met with the registered manager, the nominated individual and a senior member of staff. We also observed two home visits by care staff and spoke with three people and two members of staff. After the inspection we telephoned and spoke with four people who used the service, one relative, one friend and four staff. We reviewed a range of documents including the care records for five people who used the service, recruitment and training records of seven staff and records relating to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe with the staff that supported them. One person said, "I feel very safe around them and with them in my home."

The service had a policy in place regarding medicines management; however in practice this was not being adhered to. Only two out of ten of the staff files that we looked at had certificates showing the staff had completed medicine training since joining the service. Some staff had joined the service having had previous experience in medicine management. However, in these cases there were no written competency assessments in place to evidence that they were competent to manage people's medicines. In addition, there were no written records of any observations of staff practice, which the policy stated should be done during staff's first medicine handling and then again at three months and yearly at which times practice should be reviewed during formal supervision. We discussed this with the management team who advised that training in medicines and competency checks were carried out in practice on an ad hoc basis but that they kept no written records to evidence this.

People had medicine administration records (MAR) sheets for topical creams or when they were on antibiotics or controlled drugs so that staff could record when they had been administered. We looked at four people's MAR sheets and found that there were unexplained gaps so we could not be sure people had received their medicines as prescribed. The provider was unaware of the gaps as audits of people's MAR sheets had not been completed.

Where people required assistance or prompting with their medicines which were dispensed in blister packs, staff recorded that the contents of the blister pack had been given to people in their daily record book rather than using a MAR sheet. This system of recording meant that it would be very difficult to audit to ensure people received their medicines as prescribed. We discussed this with the provider who advised that they would implement a new system using individual MAR sheets and listing what medicines people were being supported to take to ensure that medicine management systems were more robust.

The registered manager had failed to ensure there were appropriate systems in place for the proper and safe management of medicines. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place for the safe recruitment of staff but these were not consistently adhered to. Some checks had been completed on all staff, for example, a Disclosure and Barring Service (DBS) check, to ensure that employees were not prohibited from working with people who required care and support. Also, application forms for new staff had been completed with any gaps in employment accounted for and identification and a photograph confirming the person's identity has been provided. However, references were not always taken up prior to a person commencing employment or at all.

We discussed this with the provider who told us that in some instances verbal references had been taken over the phone; however they could provide no written evidence. In another case, they were still waiting for

references to be returned despite the person starting work and in another instance references had not been taken up at all.

The registered manager had failed to operate effective recruitment procedures to minimise risks to people's safety. This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was a lack of formal, up to date training in the safeguarding of vulnerable adults from abuse (SOVA) by the provider. We spoke with the provider about this and they advised that they were in the process of organising a more structured E-learning training programme which would include safeguarding. They told us that the majority of their staff were experienced carers with previous training in SOVA. Where staff were new to care, they had received training on safeguarding during their induction.

Despite the lack of formal training, all of the staff we spoke with understood their responsibilities to protect people and to look out for their wellbeing and safety. Staff knew the signs to look for that might indicate a person was being abused and were clear on the actions that they should take if they suspected abuse had occurred. Staff told us they would report any concerns to the management team or if required to an external authority such as the police or Care Quality Commission.

The registered manager reported that as an additional safeguarding measure and to help people to feel safe, the service provided all new people with a laminated sheet that had photos of all of the staff so that they could identify who was coming into their home. A person told us, "I have a photo card with everyone's name and telephone number so I know all of the carers." The sheet also had all workers' contact numbers listed underneath the photos to make it easier for people to contact the relevant staff member should they need to.

Whilst none of the staff we spoke with had ever had to report suspected abuse, staff told us about different ways they protected people from risk of harm. For example, one staff member told us about a time when they had noticed a bruise on a person's face which the person could not explain. They told the management team who arranged for a GP to attend and also put in extra visits to monitor the person's safety until their family returned home. We spoke with this person's relative who told us how pleased they were with the level of service their family member had received to keep them safe. They told us, "One notable example of their excellence, which I would say typifies the level of service they provide, occurred earlier this year whilst I was away on holiday. They kept me fully informed of [person's] progress and were happy to visit on non-scheduled days, until I returned."

Risks to people's health and wellbeing were assessed and recorded when people joined the service and updated every three months or sooner of if something changed. Risks assessed included whether people were prone to falls, risks around their skin care, and any medical condition or behaviour which called for specific action to be taken by the staff. For example, where a person was identified at high risk of falls, staff were instructed to ensure that equipment such as the person's commode was placed next to the person to minimise the risk.

We found that risk assessments lacked detail on how to manage risks to people, particularly with regard to people's behaviour, which meant there was a lack of written guidance for staff. For example, where a person displayed behaviour perceived as challenging, the management team told us how they had tried various techniques to manage the behaviour including trying different lighting, music and the use of a toy doll which they found calmed the person. Whilst this demonstrated an excellent level of understanding and commitment to providing good dementia care by supporting the person to alleviate their anxiety, this

information was not recorded in the person's risk assessment and management plan.

However, despite failings with regard to written records staff told us that because they were a small service they communicated with each other regularly and they knew people very well. They were able to demonstrate that they were very familiar with the risks to people and could tell us how they managed these. One staff member told us, "[Person] doesn't like being moved so I use distraction, I chat with them about their family and I find this helps." Another worker told us, "[Person] is very frail and cannot pick things up; we make sure there is nothing on the floor and no trip hazards in the home.

Environmental risks had also been assessed and risk management guidance produced where required. This highlighted the external and internal areas of a person's home that staff would visit. It ensured that staff were working in a safe environment and any risks to people or the staff member were identified. For example, the assessment ensured that access to the home was clear and safe and free of potential risks, such as trip hazards. This demonstrated the provider had ensured that staff were working in safe conditions.

There were sufficient staff working at the service to meet people's needs. Staff told us that they had enough time to get from one person to another and were not rushed. People told us that staff came on time and stayed their allotted time and they had never experienced a missed call. The management team also provided additional cover to ensure there were always enough staff to meet people's needs.

Requires Improvement

# Is the service effective?

## Our findings

People said that the service met their needs effectively and did everything they asked them to do. One person told us, "They do what I ask." Another said, "They are absolutely great and do whatever I say."

When new staff joined the service they received an induction. This involved shadowing senior members of staff to observe what was required of them until they felt confident to take on their role independently. One staff member told us, "The shadowing experience was very supportive, we were not on our own or practicing until we felt we were ready." Another worker said, "I had an induction with [senior] going round to people's houses, going through their care plans, we met all the clients so they knew us and we knew them."

Staff told us that once they were working independently if they were unsure about something or needed additional help they could request further support and guidance, which was always made available. A worker told us, "When I had to use a slide sheet and show someone else how to use it I realised I wasn't sure and didn't feel confident so I contacted [senior] and they came out and went through it all with me again." Staff told us they were never asked to do anything they did not feel confident and competent to do and felt extremely well supported by the management team.

Staff also told us they thought the training was good. One worker said, "They provided training in everything, manual handling, hoisting, safeguarding, and the different roles of everyone at the company." However, training records we looked at were patchy and inconsistent and showed that not all staff had received certified training in the mandatory areas required. There were no appropriate systems in place to monitor who had received what training, whether staff training was up to date and identify any gaps in staff knowledge and skills.

We were advised that a member of the management team was primarily responsible for training staff. However they had no formal qualifications in training and the training provided was ad hoc and informal. This meant that staff had not obtained any recognised qualifications and there was no formal means in place to appraise and monitor the effectiveness of the training.

The majority of staff employed already held formal qualifications in social care. Where staff were new to care they were being supported with completing the Care Certificate which represents a set of minimum standards that social care and health workers should stick to in their daily working life. In addition, staff told us they were encouraged to develop their skills and were being supported by the management team to take more advanced qualifications in health and social care, if they wished to develop professionally.

We discussed our concerns with the registered manager regarding a lack of a formal training programme which included a means for systematically monitoring staff competencies. They told us that training was their biggest challenge and they were working on improving their systems and processes in this area. E-learning training had been sourced to supplement staff learning but this system was not yet embedded in practice.

There were no systems in place to provide formal supervisions and yearly appraisals to staff to ensure they felt supported and were assisted to develop professionally. Nonetheless, staff told us they felt well supported as they worked alongside the management team on a daily basis and received continuous informal supervision and appraisal of their practice. One staff member told us, "We are in contact with each other all the time, I speak with the team every day, we are a small close knit group, they give me continuous feedback." Whilst the registered manager was unable to provide us with any evidence of completing observations of staff during our inspection they later provided us with some written notes for one member of staff. These demonstrated that the worker had received good quality feedback to help them to improve their practice.

The registered manager told us that they had set up a group chat system on the company mobile phones and this was how they stayed in contact with each other and shared information and supported each other. Staff confirmed that the group chat was used on a daily basis and they found it a valuable means of staying in touch with each other. We saw this system in use on the day of inspection and found that it was used effectively to support staff and share important information about people to ensure they received the care and support they required.

We found that whilst the current informal system of supervision was working as the staff team was small and consistent, the management team advised us that there were plans to expand and take on more people and staff. Therefore, the lack of a structured supervision and appraisal process would become more significant as the company expanded.

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.

Staff had not received formal training in the MCA through the provider. However, many staff had prior knowledge of the legislation and were able to demonstrate how they applied the principles of the Act in their daily practice. Others told us that they had informal discussions around the MCA during their induction and through their daily practice.

Staff supported people who had difficulty making decisions by giving them choices and communicating in ways that helped people to understand what was being asked of them. One staff member said, "We know our clients well so we know what they like, we show them things, encourage them, we can give them ideas and then let them choose." Another told us, "We help people make decisions. With clothing choices I would encourage people, I would open the wardrobe and say come on lets pick, you choose what you want, people don't like feeling like they are being told what to do." The people we spoke with said that staff always asked permission before providing any care or support and we observed this in practice.

Where required, people were supported to have enough to eat to maintain their health. We observed a lunch time visit and saw that the staff prepared a person's meal of their choosing that looked appetising. The person told us they enjoyed all of the meals that were cooked for them. People said they were given the choice about what they would like to eat and the level of support they wanted to prepare meals and drinks.

Where people experienced difficulty remembering if they had eaten staff found ways to help them with their nutrition. A staff member told us, "We say come on lets share a meal and then they will then sit down and eat, we sit with them while they eat and share a cup of tea, this person is sociable and us sitting with them

helps them to eat."

We reviewed people's daily care records and saw that staff were vigilant in ensuring people remained hydrated. We saw one person's daily entry which stated, "Worried [person] isn't drinking enough so challenged [person] to drink two glasses of juice by lunch time." We observed that people had plenty to drink which was left within reach after staff had visited them.

Relatives we spoke with said that the service was very good at supporting their family members to access health care services. We were provided with several examples where staff had responded when someone seemed unwell and had called for medical assistance to ensure the person got the treatment they needed in a timely fashion. A person told us, "If I have an appointment with the doctors they come and get me ready, they support me."

Good

# Is the service caring?

## Our findings

People told us the staff were kind and caring. One person said, "[Carer] is very good, I don't know what I would do without them." Another said, "They are all kind and caring, a nice little team, they are all really nice girls."

Staff knew the people they cared for well and talked about them in a kind and caring way. A friend of a person who received support told us, "they [staff] are compassionate and dedicated."

People and relatives told us they felt included in the planning of care and support and felt that they were listened to. A person said, "They help me with my personal care, they do it how I want it to be."

Care plans included a care summary which listed the care and support tasks that they needed. Daily records evidenced that care had been provided in accordance with the care plan. The daily notes were written kindly and sensitively and indicated that staff had time to spend with people to enjoy a chat and a cup of tea.

Staff understood how to promote and respect people's privacy and dignity, and why this was important. Their responses to our questions demonstrated positive values such as knocking on doors before entering and providing any personal support in private. One staff member told us, "I make sure people are covered up with a towel, make sure the curtains and door are closed, I do the same things I would do to protect my own privacy."

People told us they were treated with dignity and respect and spoken to in a courteous manner. A person told us, "They're very respectful when I have a shower, they wash my hair, I feel all lovely, they scrub my back and powder me on the back I couldn't wish for better carers."

Staff promoted people's independence as far as possible by allowing people to do things for themselves when they were able. A person told us, "I'm an independent person and they let me be independent."

Using a group chat system on their company phones, staff communicated with each other on a daily basis to feedback information on the wellbeing of the people they cared for. On the day of inspection we saw a text come through from a worker which advised that a person was low in mood and that staff should be vigilant and monitor how the person was feeling. They had also shared the information with family and asked if they could visit to cheer the person up.

Good

# Is the service responsive?

## Our findings

People and relatives told us that they received care and support that met their needs. One relative told us, "The management team came out to meet my mother and me at home initially in order to assess her needs and draw up a care plan. This fitted exactly her needs." When people joined the service they had an initial assessment which included a compatibility assessment to match people with suitable staff that reflected their preferences, for example, whether they wanted to be supported by male or female staff.

The information gathered during the initial assessment formed was used to develop people's care records which set out how people would like to receive their care and support. We looked at five people's written care records and found that they lacked detail and were not personalised to each individual. For example, the service completed a support needs assessment which looked at what people could do for themselves and what they needed help with. This was a tick box form which meant that there was a lack of detail to enable new staff who may not be familiar with people to provide care and support that was tailored to each person.

That said, because people were supported by a very small, stable and consistent workforce, we found them to be very knowledgeable about the people they supported. All of the staff we spoke to were able to provide very detailed information about people's needs and how they liked their care and support to be delivered. For example, one staff member told us, "[Person] has a very set routine, on Tuesdays we do their washing; we set up on the airer. We have an hour so we always have time to sit and have a chat, they love catching up on the outside world, we bring the outside world in."

Staff told us that they used people's daily record books to communicate with each other and people's families or representatives to ensure people's needs were met responsively. For example, where a person's care plan stated that they required assistance of one or two members of staff to mobilise. Staff would use the record book to document the person's variability so that everyone was aware how much help a person needed on any given day.

Despite the lack of written person-centred information held in people's care plans, staff were able to demonstrate that they had a good knowledge about people and their life histories. Life histories can provide valuable information about a person's life experience, including their relationships, past work experience, hobbies and interests, routines and aspirations. Staff used this knowledge constructively to build a rapport with people. For example, one staff member told us, "I look after [person] and [person], they have been together for sixty years, she likes things done a certain way, he loves motorbikes, they like it when we talk about their grandchildren."

People and their relatives told us that they were included in the development of the care & support plans. One person told us, "When we joined the service we sat down and discussed our needs and agreed a plan, we chose what we want and how we want it." The service reviewed peoples care plans every three months or sooner if there was a change in a person's circumstances for example if a person's abilities improved or deteriorated.

The service had a complaints policy in place and a system to deal appropriately with any complaints. When people joined the service they were given a service user guide which included information on how to make a complaint. People and relatives we spoke with said they knew who to complain to and felt confident that if they needed to do that their concerns would be listened to and addressed. However, everyone we spoke with told us they had never needed to make a complaint. One person told us, "I have never had to make a complaint; if I did I would ring [registered manager]."

Requires Improvement

# Is the service well-led?

## Our findings

There was a registered manager in post who understood their registration requirements including notifying us of any significant events to help us monitor how the service keeps people safe.

The registered manager was supported by a small management team which included the nominated individual and two senior members of staff. Between them, they possessed a range of professional qualifications and experience to draw upon including social work, teaching and nursing. Staff told us they valued the diverse knowledge and skills of the management team which meant there was always someone to answer any questions they may have to assist them to provide effective care and support.

Because of the small size of the service the management team were often hands-on, going out on visits with staff to provide care and support to people. This was of benefit to staff who told us they valued the accessibility and daily support of the management team. However, the involvement by the management team in daily care tasks had resulted in a lack of managerial oversight leading to failings in terms of systems and processes. For example, there was a lack of quality assurance systems in place which meant the registered manager was unable to reliably monitor the quality and safety of service being delivered. In addition, there were no formal mechanisms in place to ask staff or people who used the service and their family members for their feedback. As a result the registered manager was not able to assure themselves people were receiving a quality service and could not use effectively use feedback to drive improvements.

The registered manager confirmed that they had not regularly checked the quality of the service and was unable to provide evidence of consistent or robust audits to monitor aspects such as complaints, medicine administration, reviews of care plans and staff competencies. Because of this deficit, the service had not identified any issues of concern nor taken action to rectify them. For example, because there was no medicine audit in place the service had not picked up on gaps in people's medicine administration records (MAR) and therefore had not taken any action to rectify mistakes and make the necessary improvements to the service.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was evident during our observations of practice and discussions with staff and people who used the service that the organisation promoted a culture that valued people as individuals and treated people with dignity, compassion and respect. One staff member told us, "[management team] said to us to be a good carer, treat your clients like they are your nan and grandad." Another worker said, "I'm so positive about everything the service does, I have let them care for my relatives."

The management team was held in high regard by staff who told us they felt valued and well supported despite the lack of formal mechanisms in place to provide consistent and documented supervisions, appraisals and training. One staff member said, "We have a very supportive management team, we couldn't ask for more. They have supported me with my career and also with coping with losing people we work

with; they have really helped me with this."

Staff felt that the management team was approachable and listened to them. One staff member told us, "The communication is really good between us, best bosses I have ever had, I can talk to them about everything, they are so supportive." This meant that staff felt confident that if they needed to whistle-blow, their concerns would be listened to and actioned without recrimination. Whistle-blowing is when a person raises a concern about a wrongdoing in their workplace.

People and relatives we spoke with also provided positive feedback about the management team. A relative told us, "I cannot speak highly enough of them." Another said, "They are so helpful and always there for me."

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered manager had failed to ensure there were appropriate systems in place for the proper and safe management of medicines. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered manager had failed to assess, monitor and improve the quality and safety of the service. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The registered manager had failed to operate effective recruitment procedures to minimise risks to people's safety. |