McChristel Recruitment Limited

Stone House Business Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This announced inspection took place on 17 January 2017.

Stone House Business Centre is a domiciliary care agency providing personal care and support to people in their own homes in Oxfordshire. At the time of the inspection there were eight people using the service.

At the time of our inspection the service did not have 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.

The provider did not adequately assess risks for all people using the service. We found one instance where risk assessments had not been carried out for a person with identified risks clearly detailed in their hospital discharge files. Some of the risk assessments were in a lengthy tick box format and did not provide staff with enough guidance on how to recognise risks, what actions to take or how to mitigate the identified risks.

Medicines were not managed safely. Medicines were not always accurately recorded on the Medicine Administration Records (MAR).Staff did not receive medicines competency check. These factors increased the risk of that errors in medicine administration may occur

The service was not always safe. People's relatives told us the service did not ensure sufficient staffing levels, which caused staff to miss or be late for care visits. There were no systems in place to monitor missed visits.

Care planning varied. Some people had care plans which were well designed and comprehensive. Other care plans were less thorough. We found one person who did not have a care plan. This meant that there was no clear guidance for staff on the care needs of people who used the service.

Staff did not receive effective regular supervision or annual appraisals. Staff were not always appropriately trained to ensure they had the skills and knowledge to meet people's needs.

Systems to monitor the quality of the service were not effective. Audits of people's care files and MAR had not been carried out regularly and had failed to identify issues found at this inspection.

There were no contingency plans in place in case of an untoward event. People were at the risk of not having the service delivered in scenarios such as staff sickness or bad weather conditions.

People were not supported in line with the principles of The Mental Capacity Act 2005 (MCA) and people's consent to care. Most people had provided consent to their care and treatment in line with legislation and guidance. However, the provider did not follow the appropriate legislation and guidance, or maintain

appropriate records, when providing care to people who lacked capacity to consent to their care. Staff had not received training in MCA. The acting manager did not have a clear understanding of their responsibilities in relation to the Act.

People and their relatives told us they were treated with dignity and respect. Staff were able to give examples of how they promoted dignity. People were encouraged to be as independent as possible.

The provider had a complaints policy and procedure, and written complaints were investigated and responded to. However, verbal complaints were not always responded to. Feedback received from people was not analysed to identify trends and reported concerns were not followed up. This did not enable any learning to take place following concerns which may prevent reoccurrence and improve the service that was delivered.

People, their relatives and staff gave us mixed feedback about the approachability and availability of the acting manager. Some people and staff found the manager open and approachable while others told us the manager was difficult to get in touch with and was reluctant to listen to feedback.

The service was not operating with the name and location that had been registered with the CQC.

The acting manager demonstrated a lack of understanding of fundamental standards and their regulatory responsibilities. The acting manager had not sent in statutory notifications and had not submitted information requested by us within a set timeframe. There were no effective systems and processes in place to assess and monitor the quality of the services provided. This meant people's welfare, health and safety were put at risk as the service was not effectively managed.

Overall, we found significant shortfalls in the care provided to people. We identified breaches of regulations 9, 11, 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of the Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks were not always identified and care plans did not contain sufficient measures to mitigate risks where they were identified.

Medicines were not managed safely. Staff did not receive medicines training and were not assessed as competent before administering medicines.

People experienced late or missed calls and were not always kept informed by the office about the lateness or absence of staff.

None of the staff had up-to-date safeguarding training. The service had procedures for safeguarding people from abuse but had failed to notify the CQC of two safeguarding incidents, as legally required to do so.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive appropriate supervision, appraisal and training. This meant people received care from staff who were not effectively supported.

The service was not following their responsibilities in relation to the Mental Capacity Act 2005 and people's consent to care.

People told us their nutritional needs were met by the service provider.

Is the service caring?

Requires Improvement

The service was not always caring.

People's preferences concerning their care were not always appropriately documented.

People felt staff were caring, treated them with respect and provided them with care and support in a dignified manner.

People and their relatives told us most of the staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Initial referral assessments to the service were not always carried out and documented.

A complaints policy was in place and written complaints were investigated and responded to. However, verbal complaints were not always dealt with appropriately.

Feedback was obtained from people, however this was not analysed to drive improvement.

Is the service well-led?

Inadequate

The service was not well led.

The service was managed by an acting manager who did not have an understanding of the fundamental standards and their regulatory responsibilities. They failed to submit the notification of notifiable incidents as required by the regulations and did not respond to our request for information within the set deadline.

There were no effective systems and processes in place to assess and monitor the quality of the services provided. This meant people's welfare and safety was placed at risk because the service was not effectively managed.

People and staff gave us mixed feedback about the openness and availability of the acting manager.

Stone House Business Centre

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 17 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure the people staff we needed to speak with would be present at the office.

The inspection was carried out by two inspectors.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We sought feedback from the commissioners (who fund the care for some people) of the service and asked them for their views.

During the inspection we looked at the care files for four people including care plans, risk assessments, medicines records and records of care delivered. We looked at four staff files which included recruitment, supervision, appraisal and training records. We looked at other documents relating to the management of the service, including incident reports, safeguarding records, complaints, monitoring records and policies and procedures. We spoke with two people who used the service and three relatives of people who used the service. We also spoke with three members of staff and the acting manager.

Inadequate

Is the service safe?

Our findings

Risk management plans were not always in place to promote people's safety. Care plans showed people had identifiable risks, however there was not always information of how these risks were managed. Risk assessments were in a tick box format and did not provide staff with enough guidance on how to recognise risk, what actions to take or how to mitigate the identified risks. For example, one person was assessed as being at risk of falls. However, their risk assessment did not contain any information on how staff could reduce the risks associated with this person experiencing falls. In another example, one person's assessment highlighted that the person was at high risk of pressure damage. It also emphasized that staff needed to ensure the lifting equipment was in a good working order. However, the person's care records did not include this information regarding the care needs and identified risk. Another person had recently been discharged from hospital. Their hospital discharge summary highlighted that the person had allergies associated with their dietary requirements, care needs and medicines. This person also needed to be supported by two staff members when moving from one place to another. The discharge summary also emphasized that the person had specific continence needs, required a catheter and needed support with eating and drinking. However, this information was not documented by the service and the person did not have any care plan in place. As a result, staff were not provided with relevant guidance to effectively mitigate risks to the person. The person's health and well-being were therefore compromised as the carers were not provided with sufficient information on how to meet the person's needs.

Another person was using a standing hoist and two other people required assistance of two carers. One person was using a transfer hoist and also required assistance of two carers. However, no staff were suitably trained how to use the hoists. This means the people concerned were at risk of sustaining injuries as a result of unsafe moving and handling practice.

Medicines were not managed safely. We looked at medicine administration records (MAR). One person was not always given their medicines as prescribed. The person's MAR records were unclear and signed on two different sheets of paper. The acting manager told us another care provider was tending the person and denied that the Stone House Business Centre staff had been administering any medicines to the person. We asked the manager why she had taken another care provider's MAR sheets for the last few months and kept them in her office. They answered they had done it by mistake and were going to return those MAR sheets to the relevant care provider. We checked the person's care records and we found that all medicines were actually administrated by the Stone House Business Centre's staff.

We looked at four staff files. We saw no evidence of medicine training or of staff competency in relation to medicine administration being checked. This meant people were at risk of harm because staff had not received appropriate training on the proper and safe management of medicines.

People told us their care workers were sometimes late or missed their visits completely. One person told us, "Where a carer is providing 24 hour care another staff member does not attend so that they can have a break". The potential fatigue and stress and the associated decrease work performance of living-in staff could have negative impact on people's health and welfare. The service did not have any system in place to

monitor whether people received their care calls as required. The acting manager told us they were not aware of any missed visits. When asked how they would know if there had been any missed visits, the acting manager told us that people would call the service to complain about the missed visits.

The service did not have any business continuity plan. This meant that in case of an untoward event such as staff sickness or bad weather condition people were at risk of not having their care delivered to them. As some people relied on the service to administer their medicines and were dependent on carers, their health and well-being could potentially be compromised as a result of interrupted service.

The acting manager had not been submitting safeguarding notifications as required. This means that we were not able to take any action regarding the safeguarding incidents.

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

None of the staff had up-to-date safeguarding training. When asked about their safeguarding training, a staff member told us, "I had my safeguarding training a couple of years ago". However, staff were knowledgeable and they knew how to recognise and report signs of abuse. A member of staff told us, "I know how to recognise different types of abuse. For example, bruising, finger marks, the person being withdrawn and afraid of you". Staff told us they would report any safeguarding concerns to the acting manager and to the local authorities. The service did not have their own safeguarding policy but used Oxfordshire Safeguarding Adults Procedures instead. The service had failed to notify the CQC of two safeguarding incidents, as legally required to do so. This means that we were not able to learn about or act in case of any of the safeguarding incidents.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were recorded and staff were aware of the reporting processes they needed to follow if either occurred. For example, staff told us they had reported that one person had suffered from panic attacks. The instances of these attacks were examined by the acting manager to identify trends and develop learning points, however, there were no written records of such analysis.

Inadequate

Is the service effective?

Our findings

People received care from staff who were not always trained to ensure they and the skills and knowledge to meet people's needs safely. We noted that only one staff member's files contained some training certificates that were up to date. None of staff was trained in health and safety or safeguarding vulnerable adults. The service had no system in place to identify when staff were to attend refresher training. One person's relative told us, "I think they really need to be retrained. We had one carer who had no idea about hygiene or infection control". There was no system in place to assess staff's competency and check if they required additional training or supervision.

Staff were not adequately supported to carry out their roles. The acting manager told us staff were contacted regularly by telephone and email if they did not visit the office frequently. However, there was no record of this contact. No one-to-one supervisions were recorded for the last 12 months on any of the staff records we looked at. No staff appraisals had taken place within the last year. A member of staff told us, "I had my supervision four months ago and it was really useful. The previous acting manager was easy to talk to". We asked the acting manager to provide us with any supervision records from the last year; however, they were not able to find them during the inspection. We gave the provider 5 working days to send us the supervision records, these were not provided.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Training records showed that no staff had received training in the MCA. Some of the care plans contained the information on people's capacity. Where there were representatives with legal authority to make decisions on people's behalf this was not always evident in people's care plans. This information is essential to ensure that decisions made on behalf of people are lawful. Some care plans stated that people had limited ability to make decisions, however, there were no mental capacity assessments in relation to specific decisions. As a result, staff knew that some people's ability to make certain decisions was limited, but this information was not substantiated and corroborated by relevant capacity assessments. The acting manager had a limited understanding of the MCA and how it applied to the functioning of the service. The acting manager did not recognise the importance of mental capacity assessments or best interest meetings.

The above is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about the MCA and understood the need to assess people's capacity to make decisions. Care staff gave examples of how they asked for permission before doing anything for or with a person while providing care.

The acting manager told us that if a person required professional healthcare support, they ensured this was provided. However, there were no records of people's healthcare visits. We asked about any referral letters that would confirm that people were referred do specialists. The acting manager told us they contacted with specialists mostly by phone and they did not keep any logs of their calls.

People and their relatives told us that staff offered them a choice of food and drink and ensured people had balanced meals. This was supported by the care records, most of which detailed people's nutritional preferences. It was clearly noted for staff to offer people balanced meals, for example adding fruit to their breakfast. For instance, one person's care plan stated they need to have their lunch chopped in small pieces due to their difficulties with swallowing. However, there was no speech and language therapist (SALT) input recorded incorporated in the care plan. There was no information on the person's condition and how the condition may affect the person's well-being.

Requires Improvement

Is the service caring?

Our findings

We noted that some people required end-of-life care. However, the care plans did not provide any information on people's needs and preferences regarding the end-of-life care. We also noted there was no end-of-life care training provided to staff. We asked a member of staff on how they provided the end-of-life care to people. The member of staff said, "We would definitely benefit from more training in this area". This means that people who were nearing the end of their life were not supported to maintain the best quality of life possible and to minimize their suffering.

We noted that some care plans were person-centred. For example, one person was hearing-impaired and their care records gave staff guidance on how to support this person. This included information on where batteries were kept and how to change the hearing aids. It also included instruction for staff to face the person when talking to them. However, not all care plans were person-centred in that they did not always include people preferences relating to how they wished to have their care delivered. For example, the care plans did not note people's faith or if they required help maintaining their faith. One person did not have their care plan in place. Their care was based on the information that was received when they were discharged from a hospital. This information was almost two months old.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and their relatives told us that staff were caring and kind. One relative said, "Both carers visiting [person] are very nice". Another person's relative told us, "[Staff] is very good, my mum loves her". However, one person's relative pointed out, "Not all carers are good. One of them was really rude upsetting everybody here".

Staff members told us about the importance of treating people with dignity and respect. One staff member said, "I try to treat people with dignity and respect. When I enter a client's home, I call them by their preferred name and I make them aware that I'm there. I close the door and draw the curtain during our client's personal care". People and their relatives admitted that most of staff respected people and promoted their dignity. One person's relative told us, "They are very caring. The staff are treating [person] with real dignity and respect".

Staff were able to explain how they promoted people's independence. One member of staff told us, "I allow our clients to do as much as they are able to do and as long as it's safe for them to do so".

People told us that staff listened to them and were good at explaining things to them. One person told us, "Yes, they explain things to me". Staff told us how they knew the individual needs of the person they were supporting.

People and their relatives gave us mixed feedback on being involved in care planning. One person's relative told us, "We are always involved in care plans and care reviews". Another person's relative said, "We are not

involved in care planning at all".

We saw that records containing people's personal information were kept in the main office which was locked and no unauthorised person had access to the room. Some personal information was stored within a password protected computer.

Requires Improvement

Is the service responsive?

Our findings

We asked people and their relatives whether the service was responsive to their needs, whether they were listened to. We received mixed feedback from people and relatives. One person said, "They are quite timely in updating me about things. I ring them and they generally answer". Another person's relative told us, "It is very difficult to tell them to change something. I asked them not to assign one carer to come back to dad. I had to do this a number of times but finally they provided us with another carer".

Some people's needs had been assessed when they entered the service. However, these assessments were not incorporated into people's care records. Some of the care plans we checked showed people or, where appropriate, their relatives had been involved in planning for their care. However this was not consistent. We looked at care files for four people and each of the care plans had different format. Some of the care files were quite comprehensive while others lacked the information on how to meet people's needs. A member of staff told us, "I'm familiar with the care plans but they are a bit of a mess. They could provide us with more information". Some of the care plans were rather task-focused and not detailed.

The provider used two systems for monitoring people's satisfaction with the service and receiving feedback from people. These were monthly telephone calls to people and annual surveys. Records showed people had raised concerns about missed visits through these systems. We saw three survey questionnaires returned to the service for 2016. Two out of the three surveys indicated that there had been instances of missed visits. We asked the acting manager about the total number of the missed visits. They answered there had been no missed visits at all and that she would know about a missed call as people would call her. There was no system in place to monitor missed calls. We asked the acting manager if they had been able to spare some of her time to analyse the results of the survey. She answered she had not done this yet. The service failed to act on the issues raised in the survey and to crate appropriate action plan.

The provider had a complaints process and written complaints were investigated and responded to. However, verbal complaints were not always acted on. One person's relative told us, "I have complained loads over the phone. I phoned them in August and in December to complain". We looked at the complains records and we saw there were no complains logged for December. This means that the service was not logging and acting on complaints raised over the phone.

Inadequate

Is the service well-led?

Our findings

Statutory notifications had not always been sent by the provider to the CQC. A statutory notification is information regarding specific incidents that have occurred and is required by law to be shared with the commission. These include safeguarding alerts, serious incidents and deaths of people receiving a service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service was not operating with their name and location as originally registered. The service had moved a number of times since the registration without notifying us. We contacted the service in May 2016 and instructed them to change the registration. Since then we contacted the service a number of times, however, they failed to operate according to the condition of their registration. The last registered manager left in January 2016, but the notice of absence was submitted only during the inspection.

This was a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009.

Audits of the service were not conducted regularly. The last audits of the care plans and MAR records were conducted by the previous acting manager in July and August 2016. Completed audits had failed to identify any of the issues found at this inspection. There were no effective systems in place to monitor and improve the quality of the service.

Daily records were not always accurate. For example, one person's care records stated that the person had received a care visit prior to their care commencing. Daily records did not always demonstrate that care visits had been carried out. For example, one person who received three care visits daily had only two care visits recorded on two occasions. However, the other care records confirmed that staff attended the person as planned.

Records were not always available, accurate or complete. The acting manager was uncertain of where documents were located and if the documents still remained on site, therefore was unable to produce all the documentation requested at the inspection. The acting manager demonstrated a lack of understanding of fundamental standards and their regulatory responsibilities. They failed to notify us of safeguarding incidents that had occurred and submit information requested by us within a set time frame in line with the required regulation. There were no effective systems and processes in place to assess and monitor the quality of the services provided. This meant people's welfare, health and safety were put at risk because the service was not effectively managed.

There were no staff meetings organised by the service. A member of staff told us, "I think we would benefit from regular team meetings to put our word across in some matters". This means there was a lack of communication between the management and staff. Staff were given no opportunity to provide an input on the running of the service. They were also unable to be informed about new policies.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

We received mixed feedback on the management of the service from people and their relatives. One person's relative told us, "They are easy to contact, and easy to approach. This worked with us extremely well". However, another person's relative told us, "The management side is not good at all. They do not contact us at all".

Feedback from staff was also mixed. Some staff members told us the acting manager listened to them and was responsive to their suggestions. A member of staff told us, "The communication between me and the manager is OK". However, another member pointed out, "The communication is something we could definitely improve on".