Miss Petronella Manners

Sheldon Community Centre

Inspection report

Sheldon Community Centre
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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 24 August 2016 and was announced. This is the first time we have inspected this service since it was registered in June 2016. However the registered provider was continuing to support the one person who used the service and had supported this person for six years from a previous location.

The service is a domiciliary care service that provides personal care to people in their own homes. At the time of our inspection, one person was using the service. The registered provider had registered with the Care Quality Commission. The registered provider was not required to have a registered manager in place and they had chosen to manage the service as a 'registered person'. 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 one person using the service and their relative told us they felt safe. Staff had not received safeguarding training and clear guidance for reporting concerns were not available to staff or people using the service.

Processes did not ensure that people's risks would always be managed effectively. Risk assessments were not always updated and completed to reflect the needs of the person using the service. The registered provider had completed some checks to help keep people safe.

The person and their relative were satisfied that they received their calls on time and that they were notified if staff were going to be late.

The registered provider could not demonstrate that safe recruitment practice was always followed.

Although the person using the service did not receive support with taking their medicines, guidance in place for staff was unclear as to whether this support was required. The registered provider told us that they planned to improve their medicines management processes so that where required people would be supported to take their medicines safely.

The person and their relative felt that staff understood the care needs of the person using the service. Staff had not received any updated basic training to ensure they had the skills and knowledge they needed for their roles. The registered provider had failed to arrange the required staff training for a long period of time.

Staff received supervision from the registered provider and the staff member informed us that supervisions were helpful. The staff member told us that the registered provider sometimes conducted spot checks and observed practice for which they received feedback to aid their development.

The person using the service told us that staff supported them to make their own choices and decisions. However the registered provider was unclear of their responsibilities in relation to the Mental Capacity Act (2005) and staff had not received training in this area.

Staff provided some support to help the person to prepare and eat meals, however records did not clearly reflect how they provided this support and whether it met the person's specific needs.

Staff provided support when needed to help people using the service to access healthcare support.

The person and their relative told us that staff were caring and that staff had established a positive relationship with them. A relative told us that they valued the consistency of staff and that one member of staff had supported a person over a long period of time.

The person using the service and their relative were asked for their feedback and views on the service.

The person received care that was responsive to their needs. Their daily care records were not always maintained and the registered provider did not demonstrate that they had oversight of the records.

The person and their relative were involved in care reviews and said they received the care and support they wanted.

The person and their relative felt comfortable raising concerns about the service and told us that their feedback had been responded to appropriately.

The registered provider had failed to ensure that effective systems and processes were in place to assess and monitor the quality and safety of the service to ensure that people's care needs would always be met. Some improvements had been planned for the service and the registered provider told us they wanted to develop robust systems so that they could expand the service.

You can see what action we told the provider to take at the back of the full version of the 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 always safe.

Processes did not ensure that the person's risks would always be managed effectively.

Staff had not received safeguarding training, they told us they would inform the registered provider of any concerns to help protect people from abuse.

The person using the service and their relative told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received refresher training to support them in their role.

The registered provider and staff were not aware of their responsibilities in relation to the MCA. The person who used the service was supported to make their own decisions.

The person using the service was supported to access healthcare support as required.

The person's food and fluid intake was not always monitored to ensure they received sufficient nutrition to maintain their health.

Is the service caring?

Good

The service was caring.

Staff had developed a positive relationship with the person using the service and their relative.

The person was treated with respect and dignity.

The person and their relative were involved in their care planning.

Is the service responsive?

Good

The service was responsive.

The person received care that met their needs and wishes.

The person and their relative knew how to complain and a concern they had raised had been addressed.

Staff demonstrated a good understanding of the person's needs and preferences.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered provider had failed to ensure that effective systems and processes were in place to ensure the quality and safety of the service.

The registered provider had not maintained a full oversight of the service or their own responsibilities to comply with the regulations.

The person and their relative were satisfied with the service provided. Staff felt supported in their role.

Sheldon Community 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 24 August 2016 and was announced. The provider was given 48 hours' notice so we could ensure that care records and staff were available to help inform our inspection. The inspection was conducted by one inspector.

As part of our inspection, we reviewed the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

During our inspection, we spoke with one person who used the service and one relative. We spoke one staff member, the deputy manager and the registered provider. We also reviewed one person's care records, two staff files and records maintained by the service about risk management, staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

The person using the service told us they felt the service kept them safe. The relative told us that the person felt safe using the service and had done so for many years. Service user guides from the registered provider did not contain guidance for the person who used the service or their relative about safeguarding and how to raise such concerns, however the relative told us that they would be comfortable raising any concerns they had.

Although the registered provider could demonstrate that they knew about some signs and types of abuse and the appropriate authorities to raise concerns with, they had not shared this information formally through refresher training with staff or ensured that people and staff were aware of how to identify and report abuse. The staff member told us that the person would tell them if something was wrong and that they would report any concerns to the manager, they were unable to describe the types of abuse that the person using the service could be at risk of. The registered provider told us that they had intended to send staff some clear guidance about how to recognise and report abuse but had not yet done so.

The registered provider did not always manage risks effectively. We found that the person's care plan did not provide clear guidance to staff about the person's support needs and risks associated with this or other conditions they had. The registered provider told us about some of the risks to the person who used the service. The registered provider told us that they preferred to share information about a person's needs verbally with new staff members, rather than referring to the person's care plan. We noted however that the registered provider did not have a full awareness of the person's needs which indicated that there was not always a robust system in place for sharing key details of their needs and risks with staff supporting them.

There was not a process in place to ensure that the person's care plan provided specific and consistent information to guide staff on their support needs. Risk assessments we reviewed did not always reflect the person's current needs and were not always recorded in a timely way. One risk assessment had not been reviewed for over four years and did not reflect the person's current needs or the abilities of staff. The registered provider confirmed that they liaised with the relative as necessary to help keep the person safe.

A risk assessment had been completed in relation to the person's home and had not identified any hazards within the environment. There was a records book for accidents and incidents records in place and the registered provider told us that no accidents or incidents had occurred. The person's care plan instructed staff as to who they should contact in the event of an emergency. An emergency and out-of-hours number was available to the person using the service and their relative if they required this.

One person told us, "The carer stays for the full [call] time." A relative told us, "The carer is not always on time, they make up for it by staying longer and let me know [if they are going to be late]." The registered provider told us that there was one staff member who consistently provided care to the person using the service and they provided care in the staff's member absence or sought the support of a casual staff member or agency staff. The person's care plan contained outdated and unclear information about when they needed to receive their calls and differed from the information provided by the registered provider. Not

all records of calls were available and the registered provider had not maintained oversight of whether the person received their calls on time and for the required duration. The deputy manager told us that a system was due to be implemented to resolve this.

The registered provider showed us that they had an application and interview process in place. Although records showed that reference checks had been completed in advance of the current staff member commencing employment, there was not a clear or consistent process in place for receiving and requesting references. Although the registered provider told us they had completed staff pre-employment checks through the Disclosure and Barring Service (DBS) before staff commenced employment, they advised that they were unable to demonstrate this as the documentation had been archived and was unavailable to view. The registered provider informed us that they would supply this evidence within an agreed timeframe following our inspection, however they failed to do so. The registered provider told us that they were beginning the process of refreshing the staff member's DBS check and that they intended to do this every three years.

We were advised that the person who used the service was supported to take their medicines by a relative. We found however that the person's care plan provided conflicting information for staff about this. There were outdated medicines prescriptions in the person's care plan and generic guidance had been added to the person's care plan which did not apply to or reflect their needs. The deputy manager agreed that this information was unclear and outdated and assured us that the records would be clarified to reflect the person's current needs. The registered provider told us that they intended to develop clear medicines management processes and arrange staff training to ensure that they could safely meet these support needs for people using the service in future.

Requires Improvement

Is the service effective?

Our findings

One relative told us, "The carer knows my relative's needs and their likes and dislikes… They know their needs enough to look after [my relative], definitely." The person using the service had been supported by the same staff member over a long period of time and their relative confirmed that they had got to know their needs during this time. Records showed that the staff member had attained a health and social care qualification in 2012 while they worked at the service. The staff member told us that they had previously received a lot of training although this was not recent. Records showed that they had not received refresher safeguarding training or other training updates to ensure that they were working in line with current legislation since they had completed their qualification training.

The registered provider confirmed that they had failed to arrange such training for staff despite their intention to refresh staff training every two years. The registered provider told us they had plans to develop staff knowledge and records showed they had discussed their intention with staff to support them to complete the next level of their health and social care qualification. We saw that some staff training had been booked and the deputy manager had commenced their health and social care management training. The registered provider had developed a detailed outline of the induction process that would be in place for new staff members. We noted however that this did not demonstrate that the service's induction would meet the minimum care standards that new care staff must cover, as part of their induction process as outlined to meet the Care Certificate standards.

The person using the service told us, "[Staff] look after me really good." Although it is positive that this person's needs were met, the details of their care plan did not contain clear guidance of their support needs, in the event of absence of the main staff member the lack of detail would fail to ensure that the person's care needs were known by relief staff. We found that care plan instructions were generic and did not include sufficient details about the person's needs and preferences.

The staff member received supervisions and spot checks to aid their development. The staff member told us that supervision was helpful and added, "I can sit down and discuss anything… we do sit down and have a good talk." The deputy manager told us that they had improved some of their processes around staff supervision. Records confirmed that the staff member had begun to receive more regular supervision to discuss staff training and how best to meet the needs of the person who used the service. The staff member confirmed that they sometimes had spot checks for which they received feedback and added, "If there's any feedback we can discuss it". We saw that a direct observation of the person's care had recently been conducted, which had checked and confirmed that care tasks had been completed in line with the person's needs and wishes.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this

is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. The registered provider and staff did not demonstrate a clear awareness or understanding of the MCA and staff had not received training in this area. The registered provider told us that the person who used the service had mental capacity and that they were able to make their own decisions. The person using the service told us, "They always ask me what I want and always give me choices." The person's care plan provided guidance for staff about how the person preferred to express themselves and records showed that their consent to their care and treatment had previously been sought. The person was supported in line with the MCA.

A relative told us that they were satisfied with how staff supported the person with preparing meals and added, "The carer helps my relative with breakfast, and prepares a sandwich before they leave which they put in the fridge." The person using the service required staff to prompt them to eat. The staff member described the person's dietary requirements and told us, "I know what [person] can and can't have [in their diet] and I work from that." A record reflecting that the registered provider had recently conducted an observation of the staff member providing this care showed that staff had considered the person's nutritional needs when offering support.

The registered provider told us that staff completed daily care notes of the food and drink that the person had been supported to have. A relative told us that these records were not always clear and added, "They give [my relative] something to eat, [the records] don't say what it is… they cook enough for my relative." Records sampled confirmed that it was not always possible to identify if the person had received suitable food and drinks to keep them well and we found that not all records were available. This lack of information meant that the registered provider did not have oversight as to whether people's nutritional needs had been met.

A relative told us that staff helped their relative to access healthcare support when necessary. They told us, "If the carer comes and finds that [my relative] is not well, they will ring me so I can call the doctor." The registered provider told us that the person who used the service had regular healthcare appointments to help keep them well and that the person's relative supported them to access further support as required. We saw the person's care plan provided contact details of a healthcare professional so that staff were able to access additional information and guidance if required.

Good

Is the service caring?

Our findings

The person who used the service told us that they had a good relationship with their carer and that they found them kind and caring. They said, "The carer even stays with me longer than they should and we talk." A relative of the person told us that staff were very caring and added, "The carer has been with us for a long time now. The carer is good, she provides really good care for my relative. We often say they've become a part of the family, they've been with us such a long time." The staff member told us, "If [person] wants anything doing, they'll tell me," and provided us with examples of how they suggested activities to the person that they knew they would enjoy.

The relative said they valued receiving support from consistent staff who knew and understood the person's specific care needs. They told us, "It's good to have a consistent carer and [the service has] a backup carer, that's the main reason we stick with them." The staff member told us that they always informed the person if they were going to be unavailable, for example, due to annual leave and which carer was supporting them. The staff member told us, "I inform [person] of who's coming and tell [person], 'They're very nice and lovely' and [person] is happy."

The person using the service and their relative told us they were involved in care reviews and told us they felt listened to. Records reflected that care reviews took place and the relative told us, "We had a review and we shared what we do and don't like." Feedback from a review meeting showed that the person had expressed that they were satisfied with the overall standard of their care.

Although the registered provider and deputy manager demonstrated a consideration for the person's needs and preferences; processes were not in place at the service to ensure that the person received a consistent service that met their needs. The deputy manager had begun to contact the person using the service on a regular basis and told us that they had implemented this to check that they remained satisfied with the support they received. Although it was positive that the person was enabled to express their views and be involved in how their care was provided, the deputy manager had not maintained the frequency of these calls as intended.

The staff member told us that the person tried to be as independent as possible and explained that while there were some activities the person was not able to do alone, they encouraged them to do other household tasks that they were able to do. The staff member added that they would tell the person, "[Let's] sort it, you and me, we'll do it together."

The staff member provided examples of how they helped the person to maintain their dignity and the person using the service and their relative confirmed that they were treated with respect and dignity. The registered provider told us that they encouraged caring practice in staff and notes of a recent observation of staff practice confirmed that the person was treated with dignity and respect.

Good

Is the service responsive?

Our findings

A person using the service told us, "The routines are alright, they look after me really good." A relative told us, "I just think the carer is excellent, I can't fault them, they do exactly what we want them to do." The person's care plan outlined agreed objectives for their care so staff could support them in line with their expressed preferences. Records showed that the registered provider had checked whether the person received support to vote if they chose to.

The staff member demonstrated that they had a good understanding of the person's needs and preferences and demonstrated that they felt confident in the service they provided. They told us, "[Person] likes to read the paper, do crosswords, watch television," and described other interests they had. A small sample of daily care records that were available showed that the carer had responded to the person's needs and supported them with daily tasks and to maintain a clean home environment. We found that the registered provider did not have a formal process for regularly reviewing and monitoring daily records to check that staff had supported the person in line with their needs and wishes.

The registered provider conducted reviews with the person about their care plans, although the person's care plan was not updated following these reviews. The person's care plan did not contain sufficient or clear detail for staff about their support needs such as medication or when they required their care calls.
The staff member told us, "I'm kept informed with all changes. [The registered provider] will phone and tell us or call us in for a staff meeting", and added that there was good communication between the person, their relative and the service. Although the registered provider told us that they sometimes verbally informed staff of a person's needs as they considered this to be more useful than staff referring to the care plan, we found that they were not aware of all details relating to the person's care.
We found that aspects of the care plan considered the needs and perspective of the person using the service, but did not reflect the person-centred care that the person advised was provided. Some of the documents and statements with the care plan were generic. The registered provider had failed to identify where instructions and details within a person's care plan did not reflect their needs.

A person using the service told us that staff always responded to their concerns appropriately and their relative told us, "I've raised concerns and they were dealt with properly." The registered provider told us that they had a positive relationship with the person who used the service and their relative and that they tried to be transparent and approachable. We saw that the registered provider had taken appropriate action in response to a specific concern however this had not been done within the timeframe outlined in their own complaints policy. Some records incorrectly reflected that this complaint had been resolved within a shorter time scale.

Although the complaints policy contained some useful detail to guide and assure the person using the service and their relative, the policy did not include some basic details to provide them with clear information about how to raise concerns and how these would be addressed. The registered provider told us it was important to have a system in place so that they could be made aware of and resolve concerns and they assured us that they would amend their complaints policy.

Requires Improvement

Is the service well-led?

Our findings

The registered provider did not demonstrate a full understanding of their responsibility to comply with the applicable regulations. They did not demonstrate an awareness of where regulations were not being met and were unable to monitor and assess if the service was operating in line with current legislation including the Mental Capacity Act (2005). The registered provider was not aware of their responsibilities in accordance with the duty of candour.

The registered provider did not have effective systems for maintaining oversight of the service. There were no effective auditing processes in place and the registered provider had not maintained complete records to demonstrate compliance with the regulations.

The registered provider had failed to identify and address the issue that staff had worked for a number of years without receiving basic updated or refresher training to support them in their role. When an issue had arisen there was no record of action the provider had taken to address the failure and they were unable to recall what action had been taken, no appropriate records had been maintained.

The registered provider told us that they intended to improve the service by developing systems and processes so that there was a stronger structure and foundation for them to expand the service. Although the registered provider had started to devise a quality assurance tool which outlined goals for the service, it had not identified additional concerns we found during our inspection. When concerns about the service had been brought to their attention, the registered provider did not have an effective system to ensure they would be addressed promptly.

Failure to maintain the quality of the service and develop effective systems and processes, including the assessment of risks and accuracy of records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff member told us, "There are no problems, we all work together well, we're a good team. Although we're a small team, we're alright… we help each other out." The staff member told us that they felt listened to and supported in their role and added, "If there are any problems, I just ring [the registered provider]." We saw that the registered provider had recently ensured that staff received supervision more regularly and they told us they had booked some staff training.

A relative told us that the person using the service and staff had a "Very good relationship." The registered provider felt that the person using the service for a long time indicated that they were happy with the service and feedback we received confirmed this. The registered provider told us that they wanted to improve the service and we found that they had begun to take some steps to do so. Records showed that the registered provider had discussed development plans with a staff member and the deputy manager told us that they were completing the management level of their health and social care qualification. The deputy manager advised us that they were introducing an electronic monitoring system so that they would be able to check whether people received their calls on time and for the required duration.

The registered provider told us that the service did not have a set of vision or values and that they wanted to implement these. The deputy manager explained the value of staff supervision for clear and open discussions and we saw that they had begun to improve this process. The registered provider told us that they had improved their quality assurance process and that they had recently sent a questionnaire for feedback to the person using the service. The registered provider told us that they tried to distribute questionnaires every year and that they generally received positive feedback. They told us that they were continuing this process as they wanted more feedback to improve the service.

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 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to maintain the quality of the service and develop effective systems and processes, including the assessment of risks and accuracy of records.