Nova Payroll Management Services Limited

Pinpoint Health & Homecare

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service responsive?	Requires improvement

Overall summary

We carried out an announced comprehensive inspection of this service in February 2015. After that inspection we received concerns in relation to possible breaches of the regulations regarding staff recruitment, supervision, training and care planning. As a result, we carried out this announced focused inspection on the 5, 13 and 17 November 2015. This report only covers our findings in relation to these regulations. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pinpoint Health & Homecare on our website at www.cqc.org.uk.

Pinpoint Health and Homecare is a domiciliary service based in Gateshead covering the North East. A registered manager has been in post since May 2014. 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.

Staff were recruited by a process that ensured that staff were safe to work with vulnerable people. The process of checking previous training and qualifications needed to be more robust.

People's medicines were not always managed well. Some medicines care plans and risk assessments had not been completed when required. Records of administration were not completed correctly and the care plans did not always contain details of how to use as and when required medicines.

Staff told us they had regular support from seniors, but senior staff did not keep written records of supervisions and appraisals of staff when these occurred.

Summary of findings

Care plans did not contain details of how best to support people, or reflect their preferences. There was no evidence to show how people had been involved in the creation of their care plans. Some risk assessments had been completed incorrectly and had not been identified in a recent review of plans.

Formal complaints were investigated and responded to by the registered manager. However, not all senior staff were aware of when to initiate the formal complaints process, so complaints may have been under reported.

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

Summary of findings

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. People's medicines were not always managed well. Some records did not show that people received their medicines as prescribed or that risk assessments had been completed when required.

Staff knew how to keep people safe and prevent harm from occurring. The staff were confident they could raise any concerns about poor practice in the service, and these would be addressed to ensure people were protected from harm. People in the service felt safe and able to raise any concerns.

Recruitment records demonstrated there were systems in place to employ staff who were suitable to work with vulnerable people. Checks on previous qualifications needed to be more robust.

Is the service effective?

Requires improvement

The service was not always effective. Staff received on-going support to ensure they carried out their role effectively. However, formal supervision and appraisal processes were not in place to enable staff to receive feedback on their performance and identify further training needs.

Is the service responsive?

Requires improvement

The service was not always responsive. People had their needs assessed by the registered manager and staff but care records did not contain details to support personalised care. Some risk assessment tools were used in an inconsistent way.

The registered manager investigated and responded to complaints, but their policy was not up to date with new regulations and not all staff knew when to initiate the complaints process.

Pinpoint Health & Homecare

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 was carried out as a result of concerns received about staff recruitment, supervision, training, and the quality of care planning.

This inspection took place on 5, 13 and 17 November 2015 and was announced. We gave the service 48 hours' notice as it is a domiciliary service and we needed to be sure people would be available.

The inspection visit was undertaken by one adult social care inspector and another adult social care inspector made the follow up phone calls. They telephoned people using the service, their families and care staff on the 13 and 17 November 2015.

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. There had been recent safeguarding alerts raised about the provider relating to staff recruitment, supervision and training and care planning. We contacted local commissioners who told us about concerns they held about the former Middlesbrough location office, which had recently merged with the Gateshead office. We also reviewed feedback the CQC received from families of people who used the service.

During the visit we spoke with nine staff including the registered manager, four people who used the service or their relatives if they were unable to communicate via phone.

Five people's care records were reviewed as were the staff training records. We reviewed complaints records for the last year, 24 staff recruitment/induction/supervision and training files. We also reviewed missed/late call records.

Requires improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe with the staff support they received. Some told us there had been changes in staff recently after a period of regular staffing, but they felt the staff were good overall. One relative told us how staff stayed later when an ambulance needed to be called, "They have stayed longer if something was wrong." A person using the service told us "I am very pleased with this company."

Staff we spoke with felt that safeguarding or other safety issues would be dealt with appropriately by their managers. All the staff we spoke with were aware of safeguarding adult's procedures and felt confident to use these. They also felt confident that the registered manager would respond quickly to any concerns they raised.

As concerns had been raised about the recruitment of staff without suitable checks being carried out, we looked at a number of staff recruitment records from both the Tyneside and Middlesbrough areas. We saw that staff went through a consistent process of application, interview and that previous employment and police checks were undertaken before they started work. We saw that some staff were recruited direct by the provider, others through the Pinpoint recruitment agency which was based in the same building. We found that some staff, recruited through the agency, did not have evidence of previous qualifications or training on file. This meant that the provider could not be certain their training was up to date and that they may have deployed staff whose training had lapsed. When we brought this to the registered manager's attention they agreed to put in place a process to check this when staff transferred across from the recruitment agency. Staff still undertook the provider's training as part of their induction.

We looked at medicines records for two people who used the service. We saw that one person had been identified as at risk due to a previous misuse of their medicines. We saw that the medicines care plan had not been completed, and that a risk assessment had not been carried out. This meant the service had not taken appropriate steps to identify and manage such risks. We saw that medicines administration records (MAR's) contained gaps in records which could not be accounted for. This meant we could not be assured the person was being assisted to take their medicine as prescribed. As and when required medicines did not have a separate care plan or details to tell staff when to use this. This meant staff did not have clear guidelines of how to manage this person's medicine.

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

We looked at the records of late or missed calls to people. We saw that the provider had staff available to make extra calls at short notice if staff were taken ill or were delayed at another visit. However, feedback from people using the service and commissioners was that some people were not contacted by the provider if a call was going to be delayed. One relative told us "(Name) needs two care staff and on one occasion only one person turned up and they had to wait some time before the second care staff turned up." We discussed this with the registered manager who agreed to review the process of contacting people when a call was going to be delayed.

Requires improvement

Is the service effective?

Our findings

People told us they felt the service was effective at meeting their needs. One person told us "I'm very happy. There is quite a nice mix of staff with some older and some younger ones." A relative told us "They have been absolutely great. They just get on and do what is needed." One relative told us, "Some of the care staff are more capable than others." When asked what they meant they told us that some staff have more initiative than others and do tasks without being asked.

As concerns had been raised with the CQC about the providers training and supervision of staff, we looked at staff records and found that some did not have written records in relation to induction, supervision and appraisal. We asked the registered manager and team leaders about this and they told us that staff received supervision when they carried out regular observations of staff. When we looked at observation records completed by the team leaders, these records did not reflect that a formal supervision had been carried out. Staff we spoke with told us they had regular contact with the team leaders and they felt supported, but we found that no formal records were kept of these conversations. Staff told us they attended the provider's induction training, which was a mix of e-learning and face to face training. However, not all staff files contained certificates or completed induction records signed off by the appropriate person.

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

We looked at the provider's electronic records in relation to moving and handling training. It was not always clear if staff had attended the practical training as well as the theory due to the method of recording used. The registered manager took immediate action to remedy this issue with their IT support.

Requires improvement

Is the service responsive?

Our findings

People told us they felt the service was responsive. One relative told us "(The registered manager) is very friendly. Whenever I have cause to raise a concern I don't feel inhibited." People and their relatives told us they had been involved in the creation of their care plans and in any reviews. People and relatives felt able to raise any concerns they had with the team leaders or the registered manager.

Following concerns raised about peoples care plans; we looked at five people's care records, including support plans about their care needs and choices. We saw the quality of recording was inconsistent and did not always provide clear information about each individual. We looked at some recently reviewed care plans and compared them to the previous plans. Some essential information about people had not been carried over into the new plans from the old plans, such as specific times of calls requested, or their full medical history. This meant people's needs and wishes regarding their care were not being fully addressed in their care plans. We also saw that some score-based risk/ safety assessments were completed inconsistently meaning the final scores were incorrect, and did not accurately reflect the level of risk to the individual. The new care plans lacked details about how best to support people in their preferred manner and could not evidence that people or their relatives had been involved in their review. We discussed this with the registered manager who agreed to review the process of care plan reviews the team leader had used.

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

We looked at the provider's complaints and compliments records and could see the registered manager had a process of investigating and responding to complaints. There were two complaints from people using the service in the last year. We could see these were responded to in a timely manner and gave feedback to the complainant. Team leaders we spoke with were less clear that when concerns were raised by people, these should be progressed through the formal complaints process. There were instances where people's concerns could have been managed as a formal complaint, but the full complaints process had not been followed. Senior staff had responded appropriately to these concerns, but not using the correct policy and procedure. The provider's complaints policy was out of date and made reference to regulations that were no longer in force. We brought these issues to the registered manager's attentions who advised they would take immediate action to update this policy and disseminate information about it to staff and people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not ensured that they designed care or treatment with a view to achieving service user's preferences and ensuring needs are met. Regulation 9 (3)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured the proper and safe management of medicines. Regulation 12 (2)(g)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured that persons employed by the service provider in the provision of regulated activity received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)