Blyth Valley Disabled Forum Ltd

Blyth Valley Disabled Forum

Inspection report

20 Stanley Street
Blyth
Northumberland
NE24 2BU

Tel: 01670360927
Website: www.blythdisabledforum.co.uk

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08 December 2020
09 December 2020
11 December 2020

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Blyth Valley Disabled Forum is a domiciliary care agency providing personal care to people living in their own homes. Services are provided to people with a wide range of needs, including people living with a dementia. At the time of the inspection there were 220 people receiving care and support.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People were not protected from the risk of infection because government guidance and safe infection prevention and control processes were not being followed. Risks had been identified, however, measures to minimise the risks to people had not always been documented. People did not receive their medicines in a safe manner due to documentation not being completed or kept up to date.

Quality assurance systems were not robust enough to assess monitor and improve the quality and safety of the service provided. The concerns noted during this inspection had not been identified by the provider.

There were enough staff to support people safely, and staff told us how supportive they were as a team and had pulled together to cover any staff absences.

People, and their relatives were very happy with the care and support they received. Comments included, "I feel very safe" and "They are very helpful, anything I ask for I get."

Staff told us they felt well supported and could contact the office at any time if they had any concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 9 January 2018).

Why we inspected
The inspection was prompted in part due to concerns received about a possible failure to notify the Commission of certain changes, events and incidents affecting the service or the people who use it. Subsequently, we also became aware of a specific incident involving a serious injury which is being dealt with outside of the inspection process.

This inspection was a focused inspection to review the key questions of safe and well-led only. As part of CQC's response to the coronavirus pandemic, we also included a review of infection control and prevention measures as part of this inspection under the Safe key question.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

You can see what action we have asked the provider to take at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Blyth Valley Disabled Forum on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and discharge our regulatory enforcement functions to keep people safe, and to hold providers to account, where it is necessary for us to do so.

We have identified breaches in relation to preventing and controlling infection, risk management, medicines, governance and notification of incidents.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Blyth Valley Disabled Forum

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection. This was because we needed consent from people to allow us to contact them and we requested some documentation be shared with us prior to the office visit.

Inspection activity started on 7 December 2020 and ended on 11 December 2020. We visited the office location on 9 December 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We telephoned seven people who used the service and six relatives to speak with them about their experience of the care provided. Five people and three relatives shared their views with us.
We spoke with the registered manager, the deputy manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also telephoned twelve staff and spoke with six of them about their experiences. This included care coordinators and care staff.

We reviewed a range of records including four people's care and medicine records and two staff recruitment files. We also looked at a range of records relating to the management of the service, some of which were shared with us electronically.

Feedback from the inspection was shared with the nominated individual, the registered manager and the deputy manager.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and requested copies of audits of care records. Audits of care plans were not received.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- People were not protected from the risk of infection.
- Training specific to Covid-19 and the donning and doffing of Personal Protective Equipment (PPE) had not been provided. Staff were unable to describe current guidance and the safe and correct order in which to put on (donning) and take off (doffing) PPE.
- Infection prevention and control training had not been provided for all staff within the provider's own timescale for refresher training.
- Policies in relation to infection prevention and control and infectious diseases were in place but did not reference the management of the Covid-19 virus. Contingency planning for Covid-19 was also in place but did not reference best practice guidance in relation to working safely during the pandemic.
- Quality assurance systems had not been adapted to provide governance and oversight to minimise the risks of the impact of Covid-19 on people and staff.

The above omissions and shortfalls exposed people and staff to a significant risk of harm. Systems and processes were not in place to assess, control and prevent the spread of infection. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives said staff always wore masks, gloves and aprons.
- Visitors to the office base for the service had their temperature taken on entry and were directed to use hand sanitiser.

Assessing risk, safety monitoring and management

- Risks had been identified, however, actions to minimise and manage these risks were not always documented.
- Some risk assessments had generic actions which were not specific to the individual person or circumstance.
- Monthly bed rail checks had not taken place as required by the provider's own documentation.

Steps had not been taken to mitigate risks to people leading to a potential hazard to their health and well-being. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Not all staff who administered medicines had attended training within the provider's own timeframe of annual refresher training. Some staff had not completed training since March 2018.

● 'As required' medicines were administered but one person's care plan did not contain information to guide staff on when and how to administer this medicine.

● Medicine administration records (MARs) were completed. One hand written entry had no application instructions for a prescribed cream meaning there were no clear instructions for staff to follow about the administration of this medicine and the person's needs.

● Audits identified issues, including gaps on MARs but there was no detail on the action taken to rectify the concern.

Oversight of medicine training, and medicine recording had not been maintained. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they were happy with how staff supported them to take their medicines.

Systems and processes to safeguard people from the risk of abuse

● Safeguarding training had not been completed in line with the provider's requirements.

● A safeguarding policy was in place and staff understood how to recognise if people may be at risk of harm.

● People and relatives felt safe and trusted the staff who supported them.

Learning lessons when things go wrong

● Incidents, such as falls and safeguarding concerns were recorded and the deputy manager explained how they were analysed on an individual basis for learning.

● The deputy manager shared an example which had led to improved communication between the staff and the family of someone who received care.

Staffing and recruitment

● There were enough staff to meet people's needs.

● People told us they were normally supported by the same staff, which they preferred as it meant they knew staff well.

● Recruitment practices were safe and included pre employment checks.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection we recommended the service sought guidance and advice regarding its quality assurance procedures to ensure improvement. At this inspection we found improvements had not been made.

- Quality assurance systems and governance arrangements were not robust.
- Audits were completed but they had failed to identify shortfalls and improve practice in relation to infection prevention and control, the use of PPE, risk management, medicines recording and gaps in training.
- Staff meetings, monitoring visits and spots checks had stopped in order to minimise the risk of transmission of Covid-19. However, alternate systems of assurance had not been developed and introduced to oversee the safe delivery of the regulated activity.

Systems to maintain quality and safety were not robust, potentially putting people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We identified one case where we had not been informed of a notifiable incident, and one case where there had been a delay of two weeks in completing the notification to the CQC.

There was a failure to notify the Commission, without delay of events the provider is required to do so by law. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. We have dealt with this matter outside of the inspection process and have written to the provider about their legal duty to inform the CQC of such events.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives told us they were included in developing care plans and were regularly contacted to see if they remained happy with the care they received.

● Annual surveys had been completed by people and staff to gain feedback. All comments were positive.
● People, relatives and staff said the coordinators and managers were approachable and any concerns or queries could be raised and responses were received in a timely manner.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager had an understanding of their responsibilities under duty of candour. However, they had failed to notify the Commission of events that they are required to do so by law.

Working in partnership with others
● Staff worked in partnership with healthcare providers to make sure people received appropriate care.
● There was evidence of partnership working. The registered manager and deputy manager attended regular meetings with the local authority and other providers.

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 The provider had failed to deliver care in a manner that was safe for people who used the service. Systems had not always ensured staff had the appropriate training to deliver care, including medicines and safeguarding. Not all that was reasonable had been done to mitigate risks. Regulation 12(1)(2)(b)(c)(h)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the safety and quality of the service were not robust and did not ensure the service was compliant with the requirements of the regulations. Records relating to medicines administration were not robust. There was no oversight to ensure compliance with training. Regulation 17(1)(2)(a)(b)(c)(d).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to submit notifications of incidents in line with regulations. Regulation 18(1) Notification of other incidents.

The enforcement action we took:

We did not proceed with enforcement action in respect of this breach.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Robust processes to manage the prevention and control of infections were not in place. Regulation 12(1)(2)(h)

The enforcement action we took:

We took enforcement action to impose urgent conditions on the providers registration in respect of infection prevention control.