Hertsmere Valley Care Services Limited

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Inspection report

9 Bell Lane
Hendon
London
NW4 2BP

Tel: 02034173536
Website: www.hertsmerevalleycare.co.uk

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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 inspection took place on 19 January 2017 and was unannounced due to concerns we had about the service. As part of the inspection process we contacted people and staff for feedback on the 19, 20 and 24th January 2017. Hertsmere Valley Care Limited is a domiciliary care service which provides personal care and support to people in their own homes. The service was supporting 17 people at the time of our inspection. People had various needs including age related fragility and chronic medical conditions.

There was a registered manager in place who was also the provider. 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 and associated Regulations about how the service is run.

People and their relatives were not always positive about the service they received. Staff did not arrive on time and people told us they had experienced missed visits. People told us staff did not always stay the prescribed time and sometimes provided very little support to people. There were no systems in place to monitor staff arrival or departure. People told us they had concerns about some of the staff and visits were often provided later or earlier than the expected time. Three of the five people we spoke with gave positive feedback in relation to one member of staff who had recently stated to provide their care.
People told us the staff were not always very kind or caring. The provider was not able to give us any evidence that people were involved in the development or review of their care plans and times of visits. People's likes and dislikes and personal information were not included in care records.

Staff did not always understand their responsibility to protect people from harm and abuse. Although the provider told us they had received training in how to safeguard people from harm they were not able to demonstrate they understood what constituted abuse or how potential referral should be managed. There was a policy in place in relation to safeguarding people but staff were not aware of its existence.

People had a pre service assessment in place completed by commissioners but there was no provider assessment undertaken. We saw that risk assessments were basic and lacked the level of details to inform staff how to manage risks effectively. The provider told us care plans were on the system however did not show us these when requested as part of the inspection. Consent was not obtained or recorded on people's care records and staff did not understand when we asked them about the arrangements for obtaining consent and also did not understand how this related to MCA legislation.

We could not be assured that there was a process in place to monitor the process to check that people received their medicines appropriately and safely. Audits had not been completed in respect of people's medicines.

People were supported by a small team of staff. However we found that the recruitment process was inadequate and checks were not completed before staff started working. We could not be assured that the

staff were suited to work with people in their own homes.

Staff received some training. However, the provider was only able to give us a certificate covering up to 12 topics on one day. Staff were unable to demonstrate that they understood the learning and the provider was not able to provide evidence of any competency checks. There were no systems were in place to monitor and check the training and skills of staff. Staff's abilities and care practices were observed by new staff who had not had their own competency checked. We found that staff had not received training in some subjects such as end of life care and mental capacity. The provider told us staff received some supervision although they were unable to provide any evidence of this at the inspection and staff were not aware that they had supervision.

We could not assess if people were supported to eat and drink sufficient amounts due to the provider not making any care plans available during the inspection. We also could not check if people were supported to maintain their health as this information was not made available to inspectors. People were not supported with social interaction and engagement and staff did not understand when asked about 'engagement' with people.

The provider was not able to show us any completed audits in place to ensure the service was operating effectively and safely. We could not be assured that complaints were acted upon or that when feedback was received that it was acted upon. We found the provider had a limited understanding of how they should be meeting the regulations and also in relation to our regulatory role.

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.

Information provided to staff about risks to people was insufficient and did not provide specific guidance about how to keep people safe.

The recruitment process was inadequate and pre-employment checks were not completed in accordance with the provider's recruitment process.

There were insufficient trained and competent staff deployed to meet people's needs.

Staff did not understand their responsibility to ensure people in their care were safeguarded from abuse.

Medicines were not managed safely. There were no medicine administration records in use and no Audits had been completed to monitor the safe administration of medicines.

Is the service effective?

Inadequate

The service was not consistently effective.

Staff did not understand they needed to obtain people's consent before supporting them and were not aware of the principles of the Mental Capacity Act 2005

Staff did not receive regular support to help identify their learning and development needs, or an opportunity to discuss the people they supported.

Staff were not assessed by the provider to ensure that they were competent to deliver care to people.

Is the service caring?

Requires Improvement

People were not consistently treated with dignity and respect.

People gave mixed feedback about staff being kind, and caring.

People were not involved in the development or review of their care plans.

People told us they had not always felt listened to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records and risk assessments did not give staff sufficient information and were not personalised.

Care plans had not been reviewed, so we could not be assured people received the care and support that they needed.

There was a complaints process in place. However complaints had not been recorded at the time of the inspection.

People had not been asked for feedback. So were unable to say whether they felt they were listened to when they raised concerns.

Is the service well-led?

Inadequate

The service was not well-led.

We found the provider was not open and transparent throughout the inspection process.

There were mixed views about whether the organisation was well led.

There was a lack of management oversight in relation to meeting the regulations.

There were no audits or systems in place to monitor the quality of care people received.

Records were not well managed and we were unable to review care plans as they were not made available to inspectors.

There was an out of hour's process in place however records had not been completed for two months.

Hertsmere Valley Care Services Limited

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook a comprehensive inspection of Hertsmere Valley Care Limited on the 19, 20 and 24 January 2017. We did not give the provider notice of the inspection due to concerns. Before our inspection we reviewed information we held about the service. We had limited information as no PIR provider information return had been completed and we had not been notified about events that are reportable under the Health and Social Care Act 2014.

The inspection was undertaken by two inspectors. We inspected the office location and contacted people who used the service and staff to obtain feedback about their experiences of the service.

During the inspection we spoke with five people who used the service and or their relatives, we spoke with three care staff the manager who was also the provider and one member of the office staff team. We also received feedback from professionals involved in supporting people who used the service. We viewed eight people's care records, four staff recruitment files. Other records systems or process relating to the overall management of the service were not made available to inspectors.

Inadequate

Is the service safe?

Our findings

People did not always receive care in accordance with their assessed needs. Risks were not assessed and managed effectively. We found that risk assessments were only partially completed and were of a tick box nature. They did not explain individual risks to people or inform staff how to mitigate or manage the risks.

We found that the risk assessment for one person stated 'Standing/sitting requires assistance'. However there was no guidance on how staff should support this person safely with their mobility or how to reduce the risk of them falling. This put the person at risk of not being assisted safely.

We saw the risk assessment record for a person who required specialist equipment to assist them with moving and handling. The record stated that they required a 'Banana board' to transfer. However there were no guidelines or control measures in place for care staff on how to use this equipment safely.

The provider told us staff had received training in moving and handling. The person who provided the training told us that training consisted of staff watching videos and doing a quiz to test their knowledge. There was no evidence that staff had completed any practical moving and handling training or that their knowledge had been assessed or their competency checked. Staff told us they 'practiced moving and handling' but the provider was unable to demonstrate this through any records. This and the lack of information recorded in risk assessments put people at risk.

We reviewed four current staff files for staff members and found that the recruitment process had not been followed. In all four we found that application forms were incomplete. There were gaps in staff employment history and dates of employment were not recorded. There was no evidence that gaps in employment history had been explored.

References were not taken up in accordance with the provider's recruitment policy. We found each recruitment file checked contained only one reference and in the case of two staff members the reference had been provided by the training company used to provide training to Hertsmere Valley care staff rather than a previous employer. References were recorded as having being validated by the provider but we found the information within the reference did not correspond with information contained in the reference section of people's application forms.

Staff did not always have a CRB or DBS check completed before they started working with people using the service. We asked the provider for staff rotas to enable us to check the actual start date staff commenced work however they told us these were not available. However we found that staff had been delivering personal care prior to the issue of their CRB or DBS as this was evidenced in care records. A senior member of staff who also provided personal care to people did not have a current DBS or CRB. We could not be assured that staff providing personal care to people were safe or suitable to do so.

The provider was unable to give us any assurances that staff had been appropriately assessed as suitable to provide care to people. This was a breach of Regulation 19 (1) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014

Staff did not fully understand their responsibility to protect people from harm. One staff member told us "I would check them for muck before I leave them" when asked about their responsibilities to safeguard people from abuse. Another staff member told us that safeguarding meant not neglecting people, this staff member could not describe what they looked for or how they identified potential abuse. This meant that staff did not have the understanding or knowledge required to keep people safe.

People and their relatives told us they did not always get their visits at the expected time. One relative told us "there were a couple of times when the carer did not turn up between October and November 2016". They went on to tell us "Our relatives main cause of anxiety over the past four months has been without a doubt the issues with timekeeping. Despite times being allocated for carers there was rarely a day when 'person' wouldn't complain to me that they had turned up either earlier or later than agreed. In the early days this was absolutely dire because the care was 'non time specific' which was quoted to me every time I called to query".

The provider was unable to demonstrate that people received their visits at the agreed times. There was no call monitoring system in place at the time of our inspection. The provider was unable to demonstrate that people received their visits in accordance with their assessed needs. The provider told us they called people to check that their visit has been provided however there were no records available to support this. We could not be assured people received visits at the expected times. Three of the five people told us staff were regularly late for visits and two people told us they had recently had missed visits. The provider told us that there had been no missed visits but was not able to demonstrate how they were assured of this.

The insufficient arrangements to deploy staff was a breach of Regulation 18 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The process for the safe administration of medicines was inadequate. The provider told us "we do not support people with the administration of medicines we just prompt them". However staff told us they had received training in the administration of medicines. We reviewed a medicine log for one person. On one date staff had recorded that medicines had been offered, but not seen taken. There was no follow up to this to ensure the person received the support they required. The provider was unable to explain what had happened. We saw information recorded in another person's care plan that stated person was visually impaired but independent with their medicines. It went on to say that "since their return from Hospital care staff have been assisting with medicines from the original packs. The provider had recorded "I have advised customer to request a blister pack to make it easier and safer for the care staff to prompt". However during the interim period which was not specified on the record care staff were supporting the person to take their medicines with no medication administration record in place and no monitoring to check that the person was receiving their medicines correctly.

The risk assessment for one person stated that they required assistance with medicines. However there was no information recorded or any details available of the medicines prescribed or the times it should be taken. The risk assessment recorded only contained a tick. Staff told us they assisted people to take their medicines and recorded it on the medicine log. No audits or checks were in place to demonstrate that people were receiving their medicines safely.

Inadequate

Is the service effective?

Our findings

Peoples consent was not obtained before staff supported them. The provider and care staff were unable to demonstrate an understanding of consent in relation to people who may have fluctuating capacity or in relation to the Mental Capacity Act (MCA) 2005. Staff spoken to did not understand when asked about the process for obtaining consent. We noted that consent was not recorded in people's care records. For example we found that in the case of one person they had a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) in place. However Cardio Pulmonary Resuscitation was administered when the person was found 'unresponsive'. This was not in being with the person's consent or wishes.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where 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. We checked whether the service was working in line with the principles of the MCA and found that they were not aware of MCA requirements.

People or their relatives had not been involved with making decisions about their care. The provider told us that they had only been supporting people for a few months and people had not yet had their care reviewed so there was no evidence of people's involvement.

We asked the provider about the MCA but they were unable to demonstrate that they had any understanding of their responsibilities. We could not be assured that people that people's rights in relation to making decisions and giving consent were being protected.

This was a breach of: Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We could not be assured that staff were competent to deliver care to people. Induction training was not recorded to demonstrate what had been covered or how staff learning or understanding had been checked. The provider was unable to provide evidence of any competency checks to ensure that staff were competent to carry out their roles safely and effectively. The provider was unable to provide details to demonstrate that staff had any practical training in moving and handling or any competency checks so we could not be assured that people were being supported safely with moving and handling. Staff told us they were asked questions to test their knowledge, but there was no records provided to confirm this.

The provider showed us an online training matrix which contained the names of 13 care staff, eight of which were no longer employed at the service. The matrix contained the name address and date of birth of staff. However no training was recorded on the matrix. The provider told us they were updating the training matrix but were unable to provide us with details of the training staff had received. We could not be assured that staff had received the training and had the competency to care for people effectively. Staff told us they had received some training but were vague about what the training covered. People who used the service were

unable to say if the staff that supported them had the skills and abilities as they told us they had been supported by several staff members and said that some were better than others.

Staff did not receive formal supervision. The provider told us that the office coordinator 'supervised' the care workers. We asked to see records to demonstrate this but the provider was unable to provide these. The provider told us they had not completed one to one supervision with the office coordinator and were unable to demonstrate how they had determined the office coordinator had the skills to manage care staff effectively. When we spoke with the office coordinator they told us they did the filing, answered the phone and provided secretarial support but did not say they were responsible for managing or supervising care staff.

Requires Improvement

Is the service caring?

Our findings

People's preferences and choices were not always taken into account. People were not consulted about the times of their visits and calls were scheduled by morning, lunch tea time or evening irrespective of people's preferences or routines.

People told us when they had raised concerns about the times of the visits they were told "visits are not time specific". Care records were not personalised and did not contain details of people's likes, dislikes or how they wished to have their care provided. There was no system in place to ensure that when there were changes to times or staff people were notified of changes.

People told us they often did not know who was coming to provide their care until they arrived to provide the support. Three people we spoke with told us they were satisfied with the care they received when it was provided by regular care staff, however they did not always have support from their regular staff.

People told us they did not remember being involved in a discussion about their care and support. They also told us they had not had recent contact with senior office staff or the manager. People also told us that on occasions care staff spoke to them in an abrupt and rude manner. For example, one person told us that they woke one day to find the care staff standing over their bed. The explained to us that the care staff told them to get up and get showered, without giving them time to wake up properly.

Three people told us that one particular care worker was kind and caring and did treat people with dignity and respect. However the other two people both felt that staff were disrespectful and made comments that were inappropriate. For example we found that people were not addressed by their preferred name. One person was address by a shortened version of their name. A family member told us that they had requested that their relative be addressed by their full name but the care worker continued to use the shortened version.

Staff were unable to describe how they maintained people's dignity other than to say "I cover them up". In addition two staff told us if they were unsure about how to support a person they would speak to the relatives. However this may have been a conflict of interest and many not be in accordance with the person's wishes.
Staff were unable to demonstrate that they had an understanding of people's needs.. One staff member told us they supported four people and when asked to describe their support needs and routine the staff member could not remember the names of two of the people.

People told us that generally, when they had regular staff they felt they understood their needs and knew how to support them. However much of the feedback we received from people was about the lack of continuity of staff and continuous changes of staff which resulted in people receiving care from people who were not familiar with their needs and preferences.

People told us they did not feel they had developed meaningful relationships with the care staff that

supported them because they were always 'rushed' in and out as quickly as they could. Staff spoken with were indifferent when speaking about the people they cared for example one staff member told us "it is my job to clean people up". We also found that people used language that was inappropriate when completing records. The records we viewed also did not always have the person's name on them and mostly referred to people as he or she and not by their name. We spoke to the provider about this who agreed that daily log notes needed to be monitored to make sure staff were consistent in what was recorded and used language that was appropriate and respectful.

Requires Improvement

Is the service responsive?

Our findings

There was limited information both verbal and written to help us determine if the service was responsive to people's needs due to the provider not making available requested information during the inspection.

We found that where staff identified concerns about people these were not always escalated or responded to in order to make sure people's needs were being met. We saw records detailing that a person had a pressure area, however staff had not reported this to senior staff for any action to be taken to manage the pressure area. Another person had refused their medicines and although this had been recorded in the daily log notes there was no evidence that this had been reported or explored to consider any possible risk to the person having missed their medicines. We requested to look at people's care plans as part of the inspection but these were not made available by the provider. The provider was not able to show us any evidence to demonstrate that people's requests were considered or that people or their relatives were involved in the development or review of their care. People were not supported or offered the opportunity to share their views.

People's preferred visit times were not recorded, and people told us that if they requested specific times they were told "Visit times are non-specific". There was no evidence that the provider tried to accommodate people's requests. One relative told us that sometimes the morning and lunchtime visits were only an hour apart which meant that the person's needs were not being met. We could not be assured that where people were supported by staff to take their medicines these were taken with adequate time in between doses because of call times being non -specific.

One person told us that sometimes staff arrived and did not assist the person but stayed only a few minutes completed the daily log notes and then left. People told us that weekends were the most difficult time in terms of staff consistency. We spoke to the provider about this who told us that the office staff were available to support at weekends and was unaware of any problems.

The provider had a complaints policy and procedure in place. However the complaints log did not have any complaints recorded. Following the inspection the provider sent us details of three complaints that had been made with a brief outline of what was done. Two people we spoke to told us they did not have a copy of the complaints process but told us they called the office and complained but nothing had been done to address their concerns. The other three people we spoke with told us they were not sure if they had been given details of who to contact if they were unhappy about the care they received. One relative told us In December 2016 the care staff had entered the family member's home and proceeded to fall asleep in the chair without providing any care to the person and then left. This meant that the person did not receive care in accordance with their assessed needs. A complaint was made by the relative however this had not been recorded in the complaints log provided to us after the inspection. Another relative told us that when they had contacted the office to raise a concern it was not addressed. For example one person said "I have raised the issue of the timing of visits but care staff continued to arrive at all different times".

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Inadequate

Is the service well-led?

Our findings

People told us that they had not had much to do with the management of the service so could not say whether the service was well managed or not. People told us they had not been asked to give feedback on the service and told us that they felt they were not listened to. One person told us they could not always get through to the office and sometimes only got an answering service. A relative told us that the staff in the office could be "curt and abrupt with them which deterred them from having on-going dialogue".

We found during the course of our inspection that the provider did not have adequate governance and monitoring systems in place that ensured that people received the care they needed when they needed it. When we asked the provider to show us there audits and quality monitoring that were only able to show us blank copies of their quality monitoring checks. The lack of quality monitoring meant that the provider was not identifying and addressing areas of concern or where actions were needed to ensure people received safe, effective care.

Staff told us they were told which people they needed to visit by messages sent to their phone rather than having a schedule of planned visits. The provider was not able to demonstrate how staff rotas were planned or details of peoples preferred times being considered when planning visits. Feedback from staff demonstrated a disconnection between office staff, and the management of the service. For example one staff member told us "I am well supported by the manager" and when asked how that support was provided they told us "I visit the office whenever I need gloves and can always ask for advice". However this did not reconcile with what the provider described as staff support arrangements for staff. Staff were not able to demonstrate they fully understood their roles and responsibilities. For example one staff member told us "It's my job to clean people up" but was not able to elaborate on this or explain how they considered people's individual needs.

During our inspection the provider did not provide us documents we requested to be able to demonstrate compliance with regulations. For example one area of concern was in relation to the monitoring of missed or late visits. The provider was unable to show us how this was monitored. Without appropriate systems to identify missed calls the provider was unable to take the necessary action to make sure people received their care.

We found that staffing arrangements were not managed in a way that ensured sufficient staff were deployed to meet people's needs. During our inspection the provider told us and showed us documentation relating to four staff members who they told us delivered personal care. However two days after the inspection they sent us information stating they had six staff delivering personal care.

There was no information available to demonstrate how the organisation obtained the views of the people who used the service. None of the people we spoke with were able to confirm if they had been consulted or sent a satisfaction questionnaire about the service they received. This showed a lack of commitment by management to obtain feedback to enable them to put actions in place to improve the standards of care and improvements across all aspects of the service.

We found that there were gaps in the recruitment records of people employed by Hertsmere Valley care Limited which placed people at risk of harm from staff who may not be suitable to provide care to people. This included a lack of disclosure and barring checks for people, inadequate references in place for care staff and staff files that contained inconsistent records. The provider had failed to identify as an area of concern or to take any action to address this shortfall.

During our inspection we requested details of all staff training. This was not made available. However following the inspection we received this information from the provider. We found there were discrepancies about when the training was provided. Staff accounts of when they had received training would have resulted in insufficient staff to provide care to people.

We found that the training records did not confirm that all care staff had received the necessary training to carry out their role effectively and safely. For example not all staff had received up to date safeguarding training, or end of life training and they had little knowledge regarding the Mental Capacity Act.
There was no evidence that people had consented to the care being delivered or that people's capacity had been assessed. This placed people at risk of receiving care that they had not consented to. The provider was not aware of their responsibilities under the Mental Capacity Act 2005.

There were no audits or work based observations to checks to ensure that people were receiving care in accordance with their assessment of need or that staff had the required competence to provide care to people.

The lack of management oversight, governance of the organisation and lack of systems and processes was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure consent was consistently obtained.

The enforcement action we took:

NOD to restrict.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that people were receiving safe care to meet their assessed needs

The enforcement action we took:

NOD- to restrict admissions

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an adequate system in place to record, investigate and respond to complaints.

The enforcement action we took:

NOD to restrict

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate governance systems in place to monitor the safety and quality of the service.

The enforcement action we took:

NOD to restrict

Regulated activity	Regulation

Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider was unable to give us any assurances that staff had been appropriately assessed as suitable to provide care to people.

The enforcement action we took:

The provider was unable to give us any assurances that staff had been appropriately assessed as suitable to provide care to people.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had insufficient arrangements to deploy staff appropriately.

The enforcement action we took:

NOD to restrict