Consistent Services Ltd

Consistent Care Services

Inspection report

Unit 1 Trent Walk
Joiner Square
Stoke On Trent
Staffordshire
ST1 3HE

Tel: 01782209111

Date of inspection visit:
14 August 2017
15 August 2017

Date of publication:
29 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We completed an unannounced inspection at Consistent Care Services on 14 August 2017 and 15 August 2017. This was the first ratings inspection since the provider registered with us (CQC) on the 30 March 2017.

Consistent Care Services are registered to provide personal care. People are supported with their personal care needs to enable them to live independently in their own homes. At the time of the inspection the service supported four people in their own homes in the Cheshire area.

There was a registered manager at the service. 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. However, after the inspection we were given information that the registered manager planned to leave the service and de-register from their role as registered manager.

We found that there were no systems in place to monitor and manage the quality of the service provided. This meant that areas of poor practice and ineffective training we found at our inspection had not been identified by the provider.

Systems in place to gain people's feedback about their care were not effective because there was no evidence that feedback had been acted upon to make improvements to the care provided.

Records did not always contain up to date information to ensure staff had the guidance to provide safe and individualised care.

Staff training was not effective. Some staff did not have sufficient knowledge of safeguarding and the Mental Capacity Act 2005. This meant that people were at risk of receiving unsafe and ineffective care.

Improvements were needed to ensure staff understood their responsibilities to keep people safe where abuse may be suspected.

Improvements were needed to ensure people's risks were consistently planned for to protect people from potential harm.

We found some improvements were needed to ensure that people's medicines were managed in a way that kept people safe from harm.

There were enough staff available to meet people's assessed needs. We saw that all staff had undergone police checks to ensure they were suitable to provide care. However, the provider had not ensured that all staff had employment references from previous employment.

We found that records were not clear whether people had consented to their care where they were able to. When people were unable to consent to their care it was not clear that representatives had the authority to make decisions in people's best interests.

Plans were not always in place to ensure that appropriate professionals were contacted to gain advice to ensure risks to people were lowered.

Some improvements were needed to ensure staff had the knowledge and skills to be as caring as possible when supporting people with their choices if they lacked the capacity to make informed choices.

People were involved in the planning of their care. However, some improvements were needed to ensure that people's preferences and assessed needs were detailed in care plans to ensure staff had sufficient guidance to provide individualised care.

People told us the staff were kind and caring and people's dignity was maintained when they received support from staff.

People were supported to eat and drink sufficient amounts and staff understood people's nutritional needs and preferences.

People told us they knew how to complain and the provider had a complaints system in place.

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 consistently safe.

Improvements were needed to ensure staff understood their responsibilities to keep people safe where abuse may be suspected.

Improvements were needed to ensure risks to people's health and welfare were consistently planned to protect people from potential harm.

Improvements were needed to ensure that people's medicines were managed in a way that kept people safe from harm.

There were enough staff available to meet people's assessed needs.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff training was not effective. Some staff did not have sufficient knowledge of safeguarding and the Mental Capacity Act 2005. This meant that people were at risk of receiving unsafe and ineffective care.

The provider was not meeting the legal requirements to ensure that people were supported to make decisions in their best interests.

Plans were not always in place to ensure that appropriate professionals were contacted to gain advice to ensure risks to people were lowered.

People were supported to eat and drink sufficient amounts and staff understood people's nutritional needs and preferences

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some improvements were needed to ensure staff had the knowledge and skills to be as caring as possible when supporting people with their choices if they lacked the capacity to make choices.

People told us the staff were kind and caring and people's dignity was maintained when they received support from staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were involved in the planning of their care. However, some improvements were needed to ensure that people's preferences and assessed needs were detailed in care plans to ensure staff had sufficient guidance to provide individualised care.

People told us they knew how to complain and the provider had a complaints system in place.

Is the service well-led?

Inadequate

The service was not well led.

We found that there were no systems in place to monitor and manage the quality of the service provided. This meant that areas of poor practice and ineffective training we found at our inspection had not been identified by the provider.

The provider failed to respond to people's feedback about their care because there was no evidence that feedback had been acted upon to make improvements to the care provided.

Consistent Care Services

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 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 14 August 2017 and 15 August 2017 and was unannounced. We carried out the inspection unannounced because we had been provided with information of concern about the management of the service.

The inspection team consisted of two inspectors.

We reviewed information that we held about the service. This included notifications we received about incidents and events that had occurred at the service, which the provider was required to send us by law. We also spoke with local authority stakeholders to gain their experiences of the service.

We spoke with two people who used the service and two relatives, four care staff, a senior care worker, the trainee manager, the registered manager and the provider. We viewed four records that showed how people's care needs and medicines were assessed and managed. We also viewed seven staff training and recruitment files and records that showed how the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the support they received from staff. One person said, "I feel safe when the staff help me". Another person said, "I feel very safe". However, we could not be assured that all staff knew how to protect people from the risk of abuse. Some staff we spoke with had a limited knowledge of how to recognise and report suspected abuse. One staff member said, "I would be friendly and use aprons and gloves". Another member of staff said, "I would make sure there is good communication. I would report it". The registered manager was aware of their responsibilities to report suspected abuse the local authority, but we could not be assured that all staff would know what needed to be reported due to their lack of knowledge. This meant that improvements were needed to ensure all staff understood how to recognise and report suspected abuse.

We found that some medicines were administered safely. One person required assistance and prompting with their medicine they told us that staff helped them to take their medicines when they needed them. However, we found that one person needed to be supported with topical creams. There was no information in the records that showed how staff needed to support this person. We asked the senior care about this and they printed off this person's topical Medicine Administration Records. However, the topical MARs did not give sufficient information for staff to support this person safely. For example; there was no indication of the frequency or the area that staff needed to apply the topical cream. Another person needed their medicine "as required" and we found that there was no protocol in place to ensure staff understood when this medicine was needed. This meant that medicines were not always managed in a safe way because staff did not have sufficient guidance available.

We found that there were inconsistencies in the way that people's risks were planned for and managed. We found that two of the four people's care records we looked at contained detailed assessments of their needs and how staff needed to support people to manage and lower their risks. However, one person's initial assessment when they started to use the service stated that they had fallen in the bathroom. We found that this person's risk of falling when they were in the bathroom had not been assessed and there was no guidance for staff to follow when they provided support. Staff we spoke with knew people well and were able to explain the support people needed. However, there was a risk that staff that did not regularly provide support to people would not have the information required to support people safely. This meant that some improvements were needed to ensure people's risks were consistently planned for.

We saw that the registered manager had undertaken some checks that ensured staff that were employed at the service were suitable to provide support to people. Checks were in place to ensure that staff had the right to work in the UK and criminal records checks had been sought. However, we found references from the most recent previous employer for some staff had not been sought. Without this information the registered manager and provider could not be assured of staff suitability to the role, which included whether the staff member had been reliable and trustworthy in their previous employment. This meant that improvements to the provider's recruitment procedures were required to ensure staff were suitable and of good character.

People and their relatives told us that there were enough staff available to meet their needs and they received support from consistent staff. One person said, "Staff always arrive on time and I get the same two staff". A relative said, "The staff are brilliant. They always arrive on time and it's always the same staff". At the time of the inspection there were only two staff that were actively providing support to the small number of people required support. We saw that there were staff that had been recruited so that if the two members of staff were unavailable or when more people started to use the service there would be enough staff available to support them. This meant that there were enough staff available to provide consistent support to people.

Requires Improvement

Is the service effective?

Our findings

We checked whether people received care in line with the Mental Capacity Act 2005 (MCA). The 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.

We found that records were not clear regarding people's ability to consent to their care. We saw that some people had signed to consent to their care. However; one person's relative had consented on their behalf and there was no evidence to show why this person was unable to consent to their own care and if the relative was the best person to make decisions in their best interests. The registered manager and senior carer told us that this person's relative had Power of Attorney (POA). POA gives a representative the authority to act for another person in specified matters. In these circumstances the relative would need to have authority to make decisions about the person's care and welfare. We asked the registered manager and senior care what the POA covered and if this gave the relative authority to make decisions about their care and welfare. We were told that they were unsure of what the POA covered and there was not a copy of the POA which meant that it was not clear whether the relative had the legal right to make decisions about the person's care and welfare. The registered manager said "I think there is a mix up between consent and next of kin and power of attorney. We will explain this to staff and ensure we document people who are able to consent and if not ensure we all understand what the POA covers" This meant we could not be assured that the provider was working in line with the principles of the MCA 2005.

This was a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us and we saw that they had received training. However, we found that this was not always effective. Staff we spoke with were not always able to show sufficient knowledge to ensure people were protected from the risk of abuse. For example; when we asked staff how they would protect people from abuse three of the staff were unable to explain what may be considered abuse and these staff did not always state that they would report abuse. One member of staff said, "I would be friendly with them and tell them it is my job not theirs to do things". We also found that staff lacked knowledge of how they needed to support people in line with the principles of the Mental Capacity Act 2005 (MCA). We spoke with the senior care worker who told us they had a good understanding of the MCA and they had provided this training to care staff. We found that the senior care worker did not have sufficient knowledge about the MCA and was unable to show their understanding of how to support people if they lacked the capacity to make informed decisions about their care. This meant people were at risk of receiving inappropriate and ineffective care because staff did not have sufficient skills and knowledge.

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

People and relatives we spoke with told us that they had not required support with accessing health professionals but they felt confident that staff would help them if they needed it. One relative said, "There hasn't been an occasion where the staff have needed to contact the G.P or any other professionals, but I feel confident they would if needed to". The records we viewed showed that two people had suffered falls in the bathroom/shower and we did not see from the evidence provided that there had been a referral to an occupational therapist to assess if there was any equipment available to lower the risk of harm for these two people. The trainee manager told us that they had plans to refer to the occupational therapist team, but this had not been carried out at the time of the inspection. This meant that improvements were needed to ensure that referrals to health professionals were made swiftly to ensure people's risks were lowered.

People told us that staff supported them with their nutritional needs. One person said, "The staff are very good they help with my meal preparation. They always ask what I feel like and make sure I have a drink when they leave". The senior carer and trainee manager who provided the support to people at the time of the inspection knew people's nutritional needs well and were able to tell us what support people needed. The records we viewed contained details of the support people needed to meet their nutritional needs and also contained their food preferences. This meant people were supported effectively with their nutritional needs.

Requires Improvement

Is the service caring?

Our findings

People told us that the support they received from staff was caring. One person said, "The staff treat me with care". Another person said, "They [the staff] are very caring". A relative told us that the care staff showed care and patience when supporting their relative. However, due to the staff members' lack of knowledge regarding abuse they were unable to show that they understood how to provide caring support to a person that maybe at risk of harm. For example; staff were unsure of how to recognise potential abuse which meant that staff would not be able to show care and support if a person was at risk of harm. This meant that improvements were needed to ensure that staff were able to show care in all aspects of the support provided.

People told us they were given choices in the care they received. One person said, "The staff always ask me what I want doing and listen to my choices". Another person said, "The staff listen to what I want and respect my wishes. They are very good with me". A relative said, "The staff are great with my relative, they are patient and give them time to choose what they want such as their choice of meals and the clothes they want to wear. The staff we spoke with knew how people liked to be supported and told us they gave them choices in their care. However, we found that the staff did not have sufficient knowledge of the Mental Capacity Act 2005. This meant that if people lost the capacity to consent to their care or had difficult making decisions staff would not always be able to support them with their choices in their best interests.

People we spoke with told us that they were always treated with respect. One person said, "The staff are very respectful and they make sure that I am comfortable when they help me to shower". Another person said, "The staff are great, they make me feel comfortable and respect my dignity in every way". A relative told us that the staff treated their relative with respect and their privacy was upheld as any personal care provided was carried out in privacy. Staff told us that they ensured people felt comfortable when they provided support. One staff member said, "It is important that I assist people in private to maintain their dignity and I promote independence where possible so that people are able to do some things for themselves and we don't take away their independence". This meant people's dignity and privacy was protected.

Requires Improvement

Is the service responsive?

Our findings

People told us that their preferences were taken into account when their consistent care staff provided support. One person said, "Staff know me well and know how I like things to be done". Another person said, "The regular staff know how I like my care providing". Staff we spoke with who provided care knew people's preferences and were able to describe how people liked to be supported to maintain their independence, such as food choices and how people liked their care providing. However, the records we viewed did not always contain details of how people preferred their support to be carried out. The provider had employed new staff who were available to work if the number of people who used the service increased or to cover any shortfalls in the current staff who provided support.This meant that improvements were needed to ensure that new staff were aware of how to support people in line with their preferences.

People and their relatives told us they had been involved in the planning of the care. One person said, "The manager came out to see me before I had any care provided. They involved me and my relative in the assessment". Another person said, "I was fully involved and I was able to say what I wanted from the service". However, we saw that people's needs were not always detailed in their care plans to ensure that staff had a clear view of the support required. For example; one person told us that they had grab rails in their shower to ensure they remained safe and this had been discussed at the initial assessment and staff ensured they used the rails when they were being supported. The records we viewed did not contain this important information, which meant there was a risk that new staff would not be aware of this important information to keep them safe. This meant that improvements were needed to the planning of people's care to ensure that all information required was detailed in people's care plans.

People told us that they were aware of how to complain and knew who they needed to contact if they had concerns. One person said, "I have no complaints at all I am happy, but I would call the office if I needed to complain". A relative said, "There is a folder at my relative's house with lots of information in about the service which includes complaints and how to contact the office if needed". We saw the provider had a complaints system in place which contained details of the how complaints would be dealt with and the timescales that needed to be followed to respond to any complaints received. At the time of the inspection the service had not received any complaints at the service.

Inadequate

Is the service well-led?

Our findings

We found there were no systems in place to ensure that staff training provided was effective. We saw that there were no competency assessments in place to ensure staff understood the training provided and staff lacked knowledge in important areas of care. We asked the registered manager how they could be assured that staff had understood the training provided and they had sufficient knowledge to support service users. The registered manager said "I take that on board. We haven't got anything in place to ensure we know staff are competent. We signed a checklist and had a discussion but there is nothing to evidence that staff are competent". The registered manager and the provider were unaware of these shortfalls in staff knowledge and that the training they had provided was not effective. This meant that people were at risk of unsafe care because there were no systems in place to ensure that staff were carrying out support in line with the training received.

We found that there were no systems in place to ensure that staff performance was monitored and managed. For example; we saw that one staff member had a positive DBS that gave details of concerns regarding their employment suitability. We saw that the registered manager had completed a risk assessment to ensure people were protected from possible harm. We were not shown evidence of how they ensured this staff member was competent in their role and how the registered manager and provider monitored their performance to ensure service users received safe and appropriate care. For example, the registered manager had not carried out a spot check of this staff member and they had not received a supervision session since they had started to work at the service. The registered manager told us they had started to complete supervisions but they were only rough notes in a book and they had plans to ensure a schedule of supervision was implemented for all staff employed at the service. This meant there were no systems in place to monitor staff performance to ensure risks to people were mitigated.

We saw that accurate records had not always been kept and did not always contain sufficient up to date information of how staff needed to support people. For example; two of the four records we viewed had information missing to give guidance to staff on how to support people with their risks. We saw from the initial assessment record that one person had suffered a fall in their bathroom before they received support from the service. However, there were no plans in place to give staff guidance on how to lower the risk of this service user falling whilst they were providing support in the bathroom. The senior care told us that this care plan and risk assessment was in person's home. They were unable to provide a copy of this at the time of the inspection so we were unable to assess whether this was appropriate. Another person required support with their catheter care. Details of how staff needed to support this person safely were not in the care plan and the senior care told us they had taken this to complete at home so it was not in the office file. We asked the registered manager how they monitored records to ensure that they contained accurate and up to date information. The registered manager told us that they did not currently have any systems in place and they needed to implement these systems to ensure the records were appropriate. This meant that there were no systems in place to monitor the information within people's records to ensure they contained accurate and up to date information.

We found that medicines were not always monitored and managed in a safe way. The initial assessment for

one person stated that they required support with the administration of creams. There was no information in the records that showed how staff needed to support this person. We asked the senior care about this and they printed off a topical Medicine Administration Record (MAR). However, the topical MAR did not give sufficient information for staff to support this person. For example; there was no indication of the frequency or the area that staff needed to supply the topical medicine. Another person needed "as required" medicine and we found that there was no protocol in place to ensure staff understood when this medicine was needed. We asked the registered manager how these people's MARs were monitored and we were told that there were no systems in place to monitor medicines at the time of the inspection. This meant that people were at risk of potential harm because the provider had not ensured that there were systems in place to make sure that medicines were managed safely.

We saw that feedback had been gained from people. However, there was not an effective system in place to ensure that concerns raised from feedback from people was responded to and acted on. For example; we saw that the feedback gained from one person stated that staff never wore a uniform; the person did not know how to make a complaint and were unaware of their care plan, which they hadn't signed. The trainee manager told us they had discussed this with the person, but there was no evidence of this and supervisions had not been carried out with staff to raise these issues. We were not given evidence to show how this feedback had been acted on to make improvements. This meant that we could not be assured that appropriate action had been taken to ensure that feedback gained from people was acted on to inform service delivery.

We found that the registered manager and provider did not have a clear overview of the service and the management was unstable. The registered manager was not available at the service on a full time basis as they worked elsewhere. The registered manager was unaware of the staff that had provided support to people. They told us that only the trainee manager and senior care staff members were providing support to people. However, we saw in the daily records that another member of staff had provided support. The registered manager told us that rota's were completed by the trainee manager and senior care worker. They said "It's a genuine mistake and I will be honest I wasn't aware of who had been out to people. I need to put a system in place so that I know who is providing care". The registered manager showed us a management action plan that they had devised after a meeting with the trainee manager, which contained details of the systems needed to ensure that the service was monitored and managed effectively. They said, "I'm just in the process of putting systems in place. In hindsight I should have had them in place before we started providing care". However, these systems had not been implemented at the time of the inspection. After the inspection the registered manager informed us that they had resigned from their role and they had given three weeks' notice. They told us that they would continue to implement the action plan before they left. We spoke with the provider who told us that they would need to recruit another registered manager and they would visit the office more regularly. This meant that although some of the shortfalls had been recognised we could not be assured that these systems would be effective and sustainable due to the instability of the management structure.

The above evidence shows that there were not effective systems in place to monitor and mitigate risks to people. This 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

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 11 HSCA RA Regulations 2014 Need for consent The provider was not meeting the requirements of the Mental Capacity Act 2005, which meant people were at risk of receiving care that was not in their best interests.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were at risk of receiving ineffective and unsafe care because the training provided was ineffective.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to manage and monitor the quality of the service, which meant unsafe and ineffective care practice had not been identified.

The enforcement action we took:

We served a warning notice.