Chalkface Recruitment Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

We undertook an announced inspection of Chalkface Recruitment Limited on 11 August 2015. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

Chalkface Recruitment Limited provides a range of services to people in their own home including personal care. At the time of our inspection four people were receiving personal care in their home. The care had either been funded by their local authority or people were paying for their own care.

Summary of findings

We attempted to contact two relatives to ask their feedback but we could only speak to one person. We also attempted to contact five care workers but were only able to speak to one care worker.

We last inspected the service on 31 January 2014. At the last inspection there were no breaches of the Regulations we were reviewing.

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.

There was a policy in place in relation to medicines but the medicine administration record (MAR) charts was not completed accurately and did not provide the care workers with appropriate guidance on how medicines should be administered.

The provider has a policy and training in place in relation to the Mental Capacity Act 2005 but they did not have procedures in place to ensure people using the service had been assessed as to whether they were able to make decisions about their lives.

The provider had limited systems in place to monitor the quality of the care provided and these did not provide appropriate information to identify issues with the quality of the service.

The relative we spoke with felt their family member was safe when they received care in their home. The provider had policies and procedures in place to respond to any concerns raised relating to the care provided.

The number of care workers required for each visit was identified through the assessment of the person's care needs and following a discussion with the person using the service and their relatives. There was an effective recruitment process in place.

Staff had received the necessary training and support to enable them to provide care safely and to an appropriate standard.

Assessments were carried out to identify each person's care needs before they started to receive care in their home. This information was used to develop the support plan for the person.

The relative we spoke with was happy with the care provided and felt the care workers treated their family member with dignity and respect. Support plans identified the person's cultural and religious needs. Care workers support people using the service to be involved in a range of activities.

The provider had processes in place for the recording and investigation of incidents and accidents. A range of risk assessments were in place in the support folders in relation to the care being provided.

Care workers completed a record of the care and support provided during each visit.

There was a complaints process in place and the relative told us they knew who to contact at the office if they had a concern. A feedback form was sent to the person's family twice a year and there were regular house meetings to discuss the care being provided.

We found breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to the management of medicines, Mental Capacity Act and quality assurance. You can see what action we told the provider to take at the back of the full version of this 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?

Some aspects of the service were not safe. The medicine administration record (MAR) charts were not completed accurately and did not provide the care workers with appropriate guidance on how medicines should be administered.

The provider had processes in place for the recording and investigation of incidents and accidents. A range of risk assessments were in place in the support folders in relation to the care being provided.

The provider had an effective recruitment process in place. The number of care workers required to provide appropriate care for a person was based on the assessment of the person's needs and following discussions with the person using the service and their relatives.

Requires improvement

Is the service effective?

Some aspects of the service were not effective. The provider had a policy in place in relation to the Mental Capacity Act 2005 but people using the service had not been assessed to see if they could make decisions about their lives.

Care workers had received the necessary training, supervision and appraisals they required to deliver care safely and to an appropriate standard.

Care workers informed the relatives by telephone if they were going to be late.

Requires improvement

Is the service caring?

The service was caring. The relative we spoke with felt the care workers were caring and treated the person using the service with dignity and respect while providing care.

Support plans identified how care workers could support the person in maintaining their independence when receiving care.

The support plan included a personal history of the person using the service identifying the activities they enjoyed, people who were important to them and any cultural or religious needs.

Good

Is the service responsive?

The service was responsive. Initial assessments were carried out before support began to ensure the service could provide appropriate care. Support plans were developed from the assessments and care workers completed a record of the care provided after each visit.

People using the service were sent feedback forms every six months and regular house meetings were held to discuss the care provided.

Good

Summary of findings

Is the service well-led?

Some aspects of the service were not well-led. The provider had limited systems in place to assess the quality of the service being provided. They did not provide adequate information to identify areas for improvement.

The relative we spoke with felt the service was well-led and that the staff were efficient. The care worker we spoke with felt they had appropriate support and that the service was well-led.

Care workers were given a handbook explaining policies and procedures as well as identifying expected standards of professional conduct and good practice.

Requires improvement

Chalkface Recruitment 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 11 August 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

One inspector undertook the inspection and carried out telephone interviews following the inspection. Before the inspection we looked at all the information we had about the service, including any notifications of significant events which had taken place since the last inspection.

During our inspection we went to the office of the service and spoke with the registered manager.

We reviewed the support plans for three people using the service, the employment folders with the training and supervision records for four care workers and records relating to the management of the service. After the inspection visit we attempted to contact two relatives but were only able to speak to one of them. We also attempted to contact five care workers but were only able to speak to one of them.

Requires improvement

Is the service safe?

Our findings

The provider had a policy and procedure for the administration of medicines but the medicine administration record (MAR) charts did not provide care workers with appropriate information as to how to administer medicines as prescribed. The registered manager explained that the care worker would sign the MAR chart but it was a family member of the person using the service that prepared and administered the medicines. We looked at the MAR chart for this person and saw there were gaps where the care worker had not recorded when the medicines were administered. We also saw the same medicine had been listed twice. One record was with set times twice a day and dosages for administration and the second record was for a specific dosage to be taken as and when required (PRN). We saw that the MAR chart indicated that the PRN medicine should be administered at the same time as the evening dosage in the other record. We also saw that the care workers had been administering the PRN medicine every day and there were no records to indicate that the person required this additional dose. This meant that the person could be receiving a higher dose of the medicine than originally prescribed by the general practitioner (GP).

We also saw there were duplicate MAR charts being completed for June 2015. The registered manager explained that a second MAR chart was started during the month as the prescribed medicines had been changed by the GP. We discussed these with the registered manager who confirmed she would contact the person's GP to confirm which medicines had been prescribed with the format of the MAR charts and the process for supporting relatives to administer medicines also be reviewed.

We saw care workers had received training in the administration of medicines but this was provided by senior members of staff who had not received training to provide this course. The senior staff had attended the same or a similar training course to the one provided for the care workers. This meant that the senior staff were unable to provide the care workers with appropriate support in relation to administering medicines.

The above paragraph demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relative we spoke with told us they felt their family member was safe when the care workers were providing care in their home. They said "I feel my relative is really safe from abuse when receiving care. We completely trust the care workers." We saw the service had effective policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. There was a safeguarding policy and care workers had completed training on safeguarding adults and children. Information on the whistleblowing policy was also included in the care worker's handbook.

The provider had a policy and procedure in place for recording and investigating incidents and accidents. We saw care workers completed an incident and accident recording form which included the details of the incident, who was involved and what action was taken by the care worker at the time. It also recorded if the event was witnessed and any witnesses were asked to comment on possible reasons for the incident or accident. The registered manager explained the completed form was then passed to them so they could complete an investigation record form. The form included the registered manager's notes from their investigation and their recommendations to reduce the risk of the incident or accident occurring again. The completed forms were kept in each person's support folder. During the inspection we looked at the incident and accident forms for two people and saw the forms were completed in full with detail relating to the event and any actions. We saw that where actions had been identified they had been completed (for example additional guidance in relation to responding to challenging behaviour had been obtained following an incident).

We saw that each person had a range of risk assessments in place which were detailed and up to date. There was a mental health assessment tool completed to assess the person's mood, if they had depression or demonstrated any challenging behaviour and if they were at risk of self-neglect or harm. The manager would make comments to identify any additional information or how this risk could be reduced. Other risk assessments included health and medicines and the person's ability to complete tasks related to everyday living such as washing, dressing, nutrition and continence, moving and handling and an environmental risk assessment. If the person had been identified through the moving and handling risk assessments, additional assessments relating to falls and

Is the service safe?

using a hoist were also completed. A behaviour assessment identified who might be at risk from possible challenging behaviour, the probability of such behaviour happening and any influencing factors. Preventative measures were identified to reduce the risk of the behaviour and reactive strategies for care workers to prevent escalation of a situation were recorded. We saw there were risk assessments in place if the person attended regular activities for example going to college or a day centre.

The registered manager explained that the number of care workers required for each visit was based upon the person's care needs which were identified during the initial assessments and in discussions with the person who would be receiving care and their relatives. They told us that before they would agree to provide a care package they would check to see which of their existing care workers had the appropriate skills and experience to meet the person's care needs as well as checking to see if they were willing to take on additional work. The registered manager said they would not start a care package until at least two existing care workers had agreed to provide support so they could ensure there was cover for annual leave and sickness. This ensured people using the service would be supported by a consistent.

We found that the provider had an effective recruitment process in place. The registered manager explained that when they were contacted by a person wishing to apply for a care worker's role they would check to see if the person could provide appropriate references and discuss their previous care experience. If the person completed the online application form they would be asked to complete another form in the office to check their handwriting and written English. We saw checks were carried out on the person's passport, visas and proof of identify. Following an interview, two references were requested and verified when received. The new staff member could not start their role until a Disclosure and Barring Service check (DBS) had been received to see if they had a criminal record. We looked at the recruitment records of two care workers and saw two references had been received, detailed notes were taken of their interviews and a DBS check had been carried out. This ensured that checks were carried out on new staff to ensure they had the appropriate skills to provide the care required by the people using the service.

Requires improvement

Is the service effective?

Our findings

The provider had a procedure in place in relation to the Mental Capacity Act 2005 (MCA). The MCA is law protecting people who are unable to make decisions for themselves to maintain their independence. The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty. This is a process to ensure people are only deprived of their liberty in a safe and correct way which is in their best interests and there is no other way to look after them.

The support plans had a capacity and consent section which identified if the person could make decisions about their care and day to day life. We saw that one support plan identified what type of decisions a person could make but stated their relatives were responsible for the majority of decisions. We also saw in all the support plans we looked at that the family were identified as being responsible for the person's finances and acting as the person's advocate in relation to voicing any concerns or complaints. The support plans were agreed and signed by the person's relatives if it was decided that the person was unable to sign their agreement. We asked the registered manager if they had any copies of mental capacity or best interest assessments that had been carried out in relation to the person's ability to make decisions relating to their life. We also asked if they had copies of Lasting Power of Attorney for any of the people using the service. A Lasting Power of Attorney legally enables a relative to make decisions in the person's best interest as well as sign documents such as the support plan on their family member's behalf. The registered manager told us that they had not been provided with any such records by the local authority and they did not carry out assessments of the person's ability to make decisions about their care. Following the inspection the registered manager contacted the local authority and arranged mental capacity assessments for two people using the service. This meant the people using the service were not protected from having decisions made relating to their care that were not in their best interest.

The above paragraph demonstrates a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The support plans we looked at indicated any choices the person had made in relation to how their care should be provided and things they enjoyed or activities they liked to do. We saw the care workers had received training in relation to the MCA. The care worker we spoke with understood the principles of the Act and the importance of supporting the person using the service to make choices and to be as independent as possible.

We saw people were being cared for by care workers who had received the necessary training and support to deliver care safely and to an appropriate standard. The registered manager explained that a number of training courses had been identified by the provider as mandatory. These included first aid, infection control, health and safety and safeguarding adults. The registered manager told us the expectation was that carer workers completed refresher courses annually. She also told us that specific courses were provided for care workers depending on the care needs of the person using the service. These included courses relating to challenging behaviour, dementia and epilepsy. We looked at the training records for four care workers and we saw copies of the certificates of completion for various courses were on file. The records we saw indicated that all care workers were up to date with their mandatory training. This meant that the care workers had received a range of training to support them in providing appropriate and safe care.

The registered manager explained that new care workers completed an induction programme. They told us that while the provider was waiting for the references and DBS check to be returned the new staff member started their induction training. New staff completed a workbook based upon the Skills for Care common induction standards for care workers and the training identified as mandatory by the provider. The registered manager told us that when the new care worker completed each section of the workbook it was reviewed by the manager. New staff were expected to complete the workbook at the office so additional support could be given as required and it had to be finished within 12 weeks of starting their role. Once suitable references and DBS checks were received the new staff member would start to shadow an experienced care worker for a minimum of two weeks and up to four weeks depending on their previous experience. The experienced care worker, the person using the service and their relatives were asked for feedback on the competency of the new staff member.

We saw records indicating that care workers had received regular supervision sessions with their manager. The

Requires improvement

Is the service effective?

registered manager told us they aimed for each care worker to have a supervision session every three months. We also saw completed appraisal paperwork for four care workers whose records we looked at.

We saw there was a good working relationship with health professionals who also supported the person using the service. The support plans identified which health professionals were providing support, with their contact details. We saw information from community mental health teams, consultants and the general practitioner (GP) were also kept in the support folder. Health professionals were contacted if the registered manager felt additional guidance was required to provide appropriate care and to respond to any changes in need.

The support plans identified if the person using the service had any allergies or food intolerances. The plans also included detailed information relating to any preferences in relation to food and drink. Care workers also received guidance in the support plan on how to ensure the person they were supporting ate healthy foods and to follow any advice given by the dietician. Care workers completed training on nutrition and fluid.

Relatives we spoke with said the carer workers usually arrived on time but called if they were going to be late as well as staying for the scheduled time. The care workers used timesheets to record their arrival and departure times for each session. These timesheets were signed by a relative of the person using the service and the care worker to confirm the information. Guidance on how to complete the timesheets and the importance of accurate recording was included in the care worker's handbook. The timesheets were checked each week by administration staff in the office. We saw examples of completed timesheets that had been checked for accuracy.

Good

Is the service caring?

Our findings

The relative we spoke with told us they were very happy with the care and support received by their family member. They told us "X has done more with these care workers that done with previous support. X would not still be in the community and living at home without them."

The relative we spoke with told us they felt the care workers treated their family member with dignity and respect. Care workers received a copy of the operational guidance which included information relating to ensuring people's dignity and privacy was maintained when providing care. We asked the care worker we spoke with how they maintained a person's privacy and dignity when providing personal care. They told us "I would make sure the curtains were closed and there was no one else in the room before I started personal care. I would also make sure the person was happy for me to help them with their personal care before we started." There was an equality and diversity policy in place and information was provided for care workers in their handbook.

The relative we spoke with confirmed they were involved in the care and support provided for their family member. They told us "We have regular meetings and we were involved in the support plan development." They told us the care workers carried out all the activities scheduled for each visit and the care workers clearly understood their relatives needs through discussion with them and reading the support plan. They said "We make sure the care worker knows what they need to do and often they do more than expected during the visit."

The importance of people's families was identified in the support plans with information on the person's family members and friends who visited them regularly. There was guidance for care workers on how they could support the person to keep in contact with their family and friends.

The relative told us "The care workers are amazing with X. They really promote independence. They always have a goal or target for my relative to work towards." The support plans we saw identified how the person maintained their independence by identifying when they required support and when they were able to complete tasks on their own. We saw there was a section of the support plan which identified key points for care workers in relation to how care was provided to ensure the person felt comfortable, cared for and enabled. These included prompting the person but not being persistent, maintaining the person's daily schedule and ensuring the person had enough time to do things. Each section of the support plan also included detailed personal aims and objectives which identified how the person's independence could be maintained while receiving care. There was also information on any support the person required in relation to developing and maintaining key life skills.

Care workers were provided with information about the personal history of the person they were supporting. We saw a section in each support plan we looked at which described who the person lived with, any previous care, any pets, activities they enjoyed and who they liked spending time with. The summary of the support plans identified the person's cultural and religious needs. This included the person's religion, their ethnicity, preferred language and if this had any impact on the way that care was provided. There was also a section in the main support plan relating to culture, identity and beliefs which provided the care workers with additional information.

Good

Is the service responsive?

Our findings

The registered manager explained that they carried out detailed assessments when a person was initially referred to the service. The service received referrals from the local authority as well as enquires from people wishing to fund their own care. The registered manager told us they would visit the person to complete an assessment of their care needs and carry out risk assessments. They would then develop the draft support plan and return to discuss it with the person and their relatives so it could be agreed. They would also contact the health professionals involved in the person's care.

We saw that each person using the service had a support plan in place. The registered manager explained the support plans were reviewed every six months or sooner if the person's care needs had changed. The support plans included contact information for the person's next of kin, their GP, if they had a social worker and/or other professional involved in their care. The support plan identified the individual activities carried out as part of providing the person's care and support as well as any associated issues. These included personal care, communication, safety, mobility and behaviour support. The plan described in detail the support required for each care activity and care workers were directed to the relevant risk assessment, guidance or communication tool to review additional information. We looked at three support plans and saw they were up to date and the relatives of each person using the service had signed the plan to confirm they agreed with it.

We saw that care workers recorded information following each visit to the person they provided care for. Depending on the support needs of the person the care workers would complete either a daily record or a challenging behaviour form. The daily records included information on the care provided and any activities. If the needs assessment of the person using the service identified they may demonstrate challenging behaviour, the care worker completed a form for each session which recorded the person's reaction to the care provided. The person's behaviour was assessed and if they became agitated or aggressive the care worker would record anything that could be a trigger for that behaviour and what they did to resolve any issues. We saw that detailed daily records for one person and challenging behaviour forms for another had been completed by care workers for each visit during the previous month.

We saw the care workers supported people to be involved in a range of activities. In the support folders we looked at there were daily activity programmes which described the various activities for each day including visiting a day centre, swimming, using a computer or spending time in the community supported by the care worker. The registered manager explained that some of the people using the service required a clear activity programme for the week that did not change to ensure they had regular structure to their day.

We saw the provider had a complaints policy and procedure in place. Information relating to the complaints process was included as part of the support folder in the person's home. There was also a supply of complaints forms included in the folder. The registered manager told us they had not received any formal complaints from people using the service or their relatives during the previous year. They explained they aimed to resolve any questions or concerns raised by relatives informally as they had regular contact with the families by telephone and during house meetings. Information on the complaints procedure was also included in the care worker's handbook

The provider had processes in place to obtain feedback from the people using the service and their relatives. The registered manager explained that a feedback form was sent to the families of the person using the service twice a year. The feedback form included questions relating to how they felt their relative was being treated by the care workers, if their care needs were being met and if the care workers were reliable, punctual and flexible. The relatives were also asked if they were happy with the service overall and there was a section for them to write any other comments. We looked at six family feedback forms and saw the responses were good or very good with positive comments. The registered manager told us the families of people using the service were called twice a week to check how the care was being provided but they did not make a record of when these calls were made or the feedback received. The registered manager explained that any issues were discussed with the family at the regular house meetings held with them. The house meetings were held every two months and included the person using the

Good

Is the service responsive?

service, their family, the care workers and the registered manager. The meetings were used to discuss if the care needs of the person were being met, if there were any changes to the daily schedule and what cover would be provided if the care worker was going on annual leave. We saw detailed notes of each house meeting were taken and these were given to the relatives, the care workers and a copy was kept in the support folder.

Requires improvement

Is the service well-led?

Our findings

The provider did not have a robust system of audits and checks in place to review the quality of the care and support provided. The registered manager told us they called the family of each person using the service twice a week to check the quality of care they were received but they did not record when these calls were made and any issues raised by the relatives. In addition, checks were not carried out on the MAR charts when they were returned to the office each month to ensure they were completed correctly and if any issues were identified

We asked the registered manager if any other audits were carried out in addition to the spot checks to monitor the quality of service and she informed us that any other checks were done informally and were not recorded. This meant that there were limited systems in place to monitor the quality of the care.

The above paragraph demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we looked at the support folders we saw that spot checks were carried out by the registered manager twice a year for each person using the service. The spot checks included a review of the records of daily care, timesheets and if the most up to date version of the support plan was available in the person's house. The registered manager would also ask the person's relative if they were happy with the care provided, if the care workers were on time and if they treated the person using the service with dignity and respect. There was also a section for the relative to write general comments. The form was then signed by the person's relative and the registered manager. We saw four completed spot check forms which had positive feedback and comments. The registered manager explained that if they received any negative comments they would discuss them with the relatives and the care workers to resolve any issues.

When asked if they felt the service was well-led and effective, the relative we spoke with told us "The agency is well-led. The manager and the staff are very efficient and get things done. The care workers who visit us are always happy working for the agency." The care worker told us "The service is definitely well-led. There is no problem with communication, getting paid and I have no issues with the service." The care worker we spoke with also said "I definitely get enough support from the manager and I feel confident to contact them if I have any concerns or questions."

Care workers were given a staff handbook and a copy of the operational guidance for the provision of care as part of their induction. The documents included information on the care worker's role and responsibilities in relation to the provision of care. The care worker's handbook included the general rules of behaviour for care workers which described the standards of professional conduct and good practice the provider expected from the care workers including promoting a person's independence, privacy, dignity and choice. There was also guidance in relation to standards of dress, use of appropriate protective clothing and confidentiality.

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 11 HSCA (RA) Regulations 2014 Need for consent **The registered person had not acted in accordance with the Mental Capacity Act 2005.** **Regulation 11 (3)**

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not assessed, monitored and improved the quality of the services provided.** **Regulation 17 (2) (a)**