St Cathrines Care Ltd

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Inspection report

Swatchways
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Paglesham, Rochford
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Tel: 07926943347

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The Inspection took place on the 01 December 2015.

St Cathrines Care Ltd provides personal care for people within their own homes. There were six people using the service on the day of our inspection.

The service did have a registered manager. 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. The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare. Risk assessments and care plans had not been completed for people.
Medication was dispensed by staff who had not received training to do so. Staff had not been recruited or employed in a way that had ensured people's safety.

People were not always safeguarded from the potential of harm and their freedoms were protected. Staff were not provided with training in Safeguarding Adults from abuse, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

The service did not have any systems or processes in place to gathering people's views. There were no systems or processes in place to monitor or access the effectiveness of the service.

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.

The service did not have a robust and effective recruitment procedure in place. Appropriate checks had not been completed before staff were recruited and employed.

People were not protected from the risk of harm because staff had not received training and did not always know how to respond to any concerns.

Medication was being administered by staff who had not received appropriate training.

Is the service effective?

Inadequate

The service was not effective.

People had not had their needs, preferences and choices assessed and recorded.

Staff had not received an induction when they came to work at the service. Staff had not received training to support them to deliver care and fulfil their role.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff knew people well and what their preferred routines were. Staff showed compassion towards people.

People were not always given the information they required.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have care plans or records to show how they would need to be supported.
There were no arrangements in place for people's needs to be assessed and recorded.

People were not given information on how to make a complaint to the service.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager did not understand their role in running the service.

Staff were not provided with the support and guidance to provide a high standard of care and support.

There were no systems in place to seek the views of people who used the service and others and to use their feedback to make improvements.

The service did not have any quality monitoring processes in place to ensure the service maintained its standards.

St Cathrines Care Ltd

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 01 December 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 at the location at the time of our inspection.

The inspection team consisted of one inspector. Before the inspection we reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law.

During our inspection we spoke with two relatives of people, we also spoke with the registered manager, provider and three care staff. We reviewed four care files, three staff recruitment files and their support records.

Inadequate

Is the service safe?

Our findings

Although relatives of people who used the service told us they felt their family members were safe we found that the service was were not doing what was expected to keep people safe. One relative told us, "The staff are good, that come to visit [name]. They do everything they are supposed to." Another relative said, "They [staff] are excellent and I have no worries about [name] being safe."

Staff did not always know how to keep people safe and how to recognise safeguarding concerns. Staff had not been given the appropriate training to recognise or identify how people may be at risk of harm or abuse and what they would do to protect them. Staff we spoke with did not have a clear understanding of the process or procedure to raise any safeguarding concerns for people. This meant people were at risk of not being protected from safeguarding concerns, as staff were unaware of the correct procedures to follow.

The provider could not be assured staff were safely providing care and treatment for people.
They confirmed that they had not been completing assessments of risks to people's safety. Therefore there was no detailed information for staff on how to support the person's needs to keep them safe. People did not have plans in place for staff to follow should there be an emergency. In addition the service had not provided people with any information or contact details should they need to contact them outside of office hours.

People were at risk of harm because the provider did not have processes in place for staff to report or record accidents or incidents and therefore could not monitor, respond to issues and reduce the risk of reoccurance. We asked the provider what staff would do to inform them of any incidents or accidents, the provider told us that staff would record it in the 'daily record book' which is kept in the person's home. Staff we spoke with told us that they supported people with their medication. This could be by way of prompting and also administering medication. There were no training records to indicate that staff had undertaken training regarding the safe handling of medication. Staff we spoke with confirmed they had not received any training regarding medication. The provider also confirmed this. Therefore people were placed a t risk as they could not be assured that they were receiving support safely from staff who had been trained to provide people with support with their medications.

These issues were a breach of Regulation 12 (1) (2) (a-c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection we received concerns regarding staff being employed without appropriate checks being completed. The service did not have a safe recruitment practice in place. Staff had been recruited and employed without having appropriate checks completed. There were no application forms completed by staff and the service did not have any records of staff's previous employment history. No references had been requested for staff prior to their employment. The service had undertaken a criminal record check with the Disclosure and Barring Service (DBS) for one member of staff prior to them starting their employment. Two members of staff had DBS certificates on file although these were from previous employers. The provider had not checked these certificates with the DBS to ensure they were portable and suitable for the

positions they were employing people to. Therefore the provider had not completed robust checks and could not be assured that staff were safe to work with people in their own homes.

These issues were a breach of Regulation 19 (1) (a-c) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Before our inspection we received concerns regarding staff not having appropriate training. Staff were not provided with the skills, support and knowledge they needed to provide effective care to people.
Staff told us that they had not completed a formal induction when commencing their employment with the service. One member of staff said, "I was shown what to do by another carer, as she knew what the people needed done." Another staff member told us, "I shadowed another carer for a few shifts and they said how things should be done and then I carried on myself." The provider told us that although there was no formal induction process; staff would shadow and learn skills from a more experienced member of staff.

Although the provider told us that staff should be completing mandatory training via e learning, which consisted of safeguarding, food safety and hygiene and manual handling, most staff had not received any training from the provider since starting their employment. We did find that one member of staff had received training in safeguarding, food safety and hygiene for catering and manual handling for parents. However, the certificates for these courses were dated 8 October 2015, but the member of staff had been working unsupervised in people's homes prior to this date.

Staff told us they felt supported at the service, but we found that they had not had any formal supervisions or observations of their practice. Staff confirmed this. The provider told us that they would call the staff and had conversations over the telephone. Supervision is important for staff to discuss any issues they had around their practice or training needs and how they can add value to the service.

These issues were a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005. The Mental Capacity Act 2005 (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. Staff had no knowledge of the MCA and had not received any training which related to this. The provider was unable to demonstrate that they understood their responsibilities with regards to MCA. The provider did not have clear knowledge on the processes or procedures if a person required an assessment of their ability to consent to making specific decisions. There were no records to indicate that people had given consent to care and treatment.

These issues were a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Although relatives of people told us that the staff were caring towards their family members the service were not able to assure themselves that they were able to provide an appropriate service that met people's needs. One relative said, "They are excellent and very caring towards [name]." Another told us, "Staff are caring and [relative] gets on with them well."

The service had not obtained people's preferences or life histories. The provider confirmed that they had not recorded any information for people, this included assessment of needs. This is important information as it will ensure people are receiving care and treatment how they would like it to be delivered. The staff could not be assured that they held the current information about people's assessed needs and support required.

Staff we spoke with demonstrated they had good knowledge about people's individual needs and spoke in a kind and caring way about each person. Relatives of people who used the service told us that staff treated people with dignity and respect at all times.

Inadequate

Is the service responsive?

Our findings

Although relatives of people told us that the staff were caring towards their family members the service were not able to assure themselves that they were able to provide an appropriate service that met people's needs. One relative said, "They are excellent and very caring towards [name]." Another told us, "Staff are caring and [relative] gets on with them well."

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Inadequate

Is the service well-led?

Our findings

The service was not responsive to people's needs. Although the provider told us that when people are new to the service, a meeting was arranged with the person and their relatives to discuss what support was required, there were no records of these meeting and planning of care and support that then became plans of care for people that staff could use to provide care that people needed.

Relatives of people who used the service told us that they were involved in the initial meeting with the service but no further meetings had been held and they had not seen any care plans with regards to the support required. People did not have care plans that reflected how they would like their care and support to be provided. People could not be certain they would receive person centred care and support. One relative told us, "Yes, we had a meeting with St Cathrines, they introduced the carer that would be coming into [relative], but we don't have any documents to say what the carer will be doing, they just know what they have to do."

Staff had a good understanding of people's care needs and routines. They were able to describe how people liked to be supported and what their preferred routines were, however the staff we spoke with confirmed that there are no care plans for people. One member of staff we spoke with told us, "I was part of the meeting with the person, and I knew what I needed to do to support them from the discussions at the meeting." Although the staff member knew this information about the person, we could not be assured that the information would be shared by other members of staff that might have to support the person when that staff member was absent.

These issues were a breach of Regulation 9 (3) (a, b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although service had a complaints process in place, this information had not been given to people who used the service. The provider told us, "I am in the process of devising booklets for people to ensure they have all information they require, although people know they can call us if they have any problems." This meant that people might not be aware on how to share their experiences or how to raise a concern or complaint.

The provider also told us that no formal complaints had been made about the service. Relatives of people we spoke with told us that they had not had any complaints about the service and that they did not know the procedure but would call the manager or provider if they had any concerns.