Reedsfield Care 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Reedsfield Care Limited is a domiciliary care service that was providing personal and nursing care to 26 people within their own homes. The service supported older people, people with physical disabilities, learning disabilities and mental health conditions.

People's experience of using this service:
People told us they felt safe but we found continued shortfalls in relation to medicines, risks and care planning. Records relating to medicines were not accurate and where risks were identified the plans to keep people safe were not robust. Care plans were inconsistent and we found instances where important information about people's needs and preferences was lacking. We also found a lack of information about people's food preferences.

The provider had not always completed assessments in a timely manner which meant important information about needs and risks had not been gathered and planned for. People told us they were not always sure what time to expect staff and we found instances where the provider was not following their policy regarding call times. People had consented to their care but we found one instance where records relating to this needed improving. Records were not always up to date or complete. The provider's auditing and governance processes were not proactively identifying and addressing the issues that we found. The provider had not always notified CQC of incidents they were required by law to.

People told us that the staff who supported them were caring and we heard examples of people being supported to develop skills and independence. People told us that staff were respectful when providing care in their homes and were competent in their roles. Staff had received training and regular checks and supervision to assess their practice. There were regular staff meetings and staff told us important information was passed to them each day through handovers. Records showed regular work with other organisations and referrals to healthcare professionals when required.

Rating at last inspection: Requires Improvement (Published 18 May 2018).

Why we inspected: This was a planned comprehensive inspection based on the previous rating.

Enforcement: Action we told provider to take (refer to end of full report)

Follow up: We will request an action plan from the provider and continue to monitor the service. We will return to the service to inspect it again in line with our policy.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-led findings below.

Reedsfield Care Ltd

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one inspector.

Service and service type:
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing. It provides a service to older adults and younger disabled adults.

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

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:
Before inspection: We requested feedback from commissioners and the local authority. We reviewed statutory notifications and feedback sent to CQC. Statutory notifications are notifications of important events that providers are required by law to submit to CQC. We also reviewed information sent to us in the Provider Information Return (PIR). Providers are required to send us a PIR which contains key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During inspection: We visited the office and spoke with the registered manager, the deputy manager and an administrator. We reviewed care plans for five people, including records relating to risks, medicines and

personalised care planning. We checked records of accidents and incidents, complaints, audits and meeting minutes.

After inspection: We spoke with three people, two relatives and three care staff over the telephone between 22 March 2019 and 02 April 2019.

Requires Improvement

Is the service safe?

Our findings

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

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

At our inspection in March 2018, we identified shortfalls relating to medicines and risk assessments and planning. Records of medicine administration lacked accuracy and records of plans to reduce risks that people faced were not robust. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found continued shortfalls in these areas.

Using medicines safely

- People told us that they received their medicines as planned. However, we found continued concerns with the way medicines were administered.
- Medicines records did not clearly show people received their medicines as prescribed. The electronic medicines records had been completed in a way that caused duplication and it was not always possible to tell which staff member had administered medicines at what time. Medicines were recorded as completed at the same time as care tasks and in some cases two staff had recorded that they had administered the same medicine.
- These findings showed that medicines records were not being completed accurately and at the time that medicines were administered to people. These entries were flagged up as double entries on the electronic system and a recent audit had identified a lack of accuracy. In response to the audit, the provider introduced paper medicines records in people's homes but these created a duplication which made medicines difficult to monitor.
- Staff had been trained to administer medicines and the provider carried out competency assessments. However, the medicines records errors detailed above were regularly attributed to senior staff and the registered manager who carried out these assessments. This meant that staff were being assessed by senior staff who were not following best practice. Two staff files showed they had not had a full competency assessment for over 12 months. Staff received spot check observations each month which covered medicines, but the inaccurate medicines records show these were not identifying these issues and ensuring best practice was followed.
- Information about how people liked to receive their medicines was not always clear. The registered manager told us one person liked to take their medicines with a fizzy drink but this was not in their medicines care plan to inform staff and any risks around how their medicines may interact with this drink had not been raised with the pharmacist. Where people received medicines on an 'as needed' basis, there was limited information about when to offer and administer them.

Assessing risk, safety monitoring and management

- People told us they felt safe when being supported by staff. One person said, "Yes I feel safe." Another person told us, "Its safe, I have no concerns about that. "A relative said, "[Person] uses a lift in the bath and they [staff] use it safely."

● Despite this feedback, we found that recorded responses to risks were not always robust. We were told about risks which were not detailed within people's care plans. One person had started using the service following a safeguarding concern that meant staff had to be observant when visiting them. Information about this risk was not detailed within their care plan. After the inspection we received an updated care plan which now contained this information.
● The provider kept a record of any incidents and falls but these did not always show a prompt review of plans to manage risk. One person had suffered a fall in February 2019 and there was no record of their care plan having been reviewed. The registered manager told us they had considered the risk but there was no record of a formal review. The person's care plan also recorded other factors that could increase the risk of falls but there was no record of these having been assessed before or after they suffered a fall.
● Another person's records showed they had fallen in March 2019. The person did not have a mobility care plan in place and there was no record of this risk having been reviewed since the fall.
● Guidance for staff about risk was inconsistent. We looked at two care plans for people living with diabetes and one of them contained detailed information about the signs of high or low blood sugar but the other one did not contain this level of detail to inform staff about when and how to respond to this risk. Staff had received training in nutrition which covered these risks, but the lack of information increased the likelihood that staff may not know how to respond if the person became unwell.
● Delays in initial assessments meant that staff were attending calls with people before environmental risks had been assessed. In one instance, a person had been receiving care for over three weeks before a risk assessment had been carried out of their home environment. This assessment showed that the person was at risk when using the stairs, which showed known risks had no plans in place to manage them for this period.

The shortfalls in relation to medicines and risk management were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People told us that they were happy with the punctuality of staff, but they did not always know when to expect their calls. One person said, "The call isn't a fixed time which I don't mind, I don't always get a phone call." A relative also said staff could arrive between 6 and 9 am each day and this was their request but they did not always receive an update call if staff were running late.
● The provider's policy stated calls should be within 30 minutes of the specified time, but our findings showed this policy was not being followed because two people told us they did not have specified times and delays often exceeded 30 minutes. We also found that records did not always specify when people wanted their visits.
● There had been two complaints in the last three months about the times of calls and before the inspection the local authority shared concerns with CQC about calls not always being on time. Records showed there had also been one missed call in the previous month.
● The provider split calls across three geographical areas and the registered manager told us that in one area they had difficulty meeting call times. They said this was due to staff leave over Christmas, which meant the registered manager had been completing care calls. People and relatives told us the registered manager regularly completed calls and records confirmed this. This showed there were not sufficient numbers of staff to ensure the service could run effectively because the registered manager was often delivering care.
● There was not a robust system in place to monitor punctuality. The electronic care records system gave oversight to office staff of when calls had been completed so any missed calls could be flagged up and fulfilled. However, the provider had found that this system was not always sufficient for monitoring call times. The registered manager told us they had a plan to address this and showed us a system that was due to be implemented in the weeks following our inspection. We will require an action plan to state when and

how these shortfalls will be addressed.

The failure to ensure staff were deployed in a way that ensured care was provided at the expected times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider carried out checks on new staff to ensure they were suitable for their roles. These included references, work histories and a check with the Disclosure and Barring Service (DBS). The DBS carries out criminal records checks and holds a list of potential staff who would not be suitable to work in social care.

Systems and processes to safeguard people from the risk of abuse
● Staff were knowledgeable about the safeguarding process and how to escalate concerns. One staff member told us they had contact details for CQC, social services or the police which they would use if they escalated concerns and did not receive a satisfactory response.
● Records showed that the provider was working with the local authority to follow up on recent concerns that had been raised. We did identify one safeguarding concern which had not been reported to CQC which we have reported on in the Well-led domain.

Preventing and controlling infection
● People told us that staff washed their hands and used personal protective equipment when required during personal care. We also received positive feedback about how staff ensured the cleanliness of people's home environments before finishing calls.
● Staff had received training in infection control and records showed their practice was monitored as a part of monthly spot checks.
● Staff told us the provider always ensured they had a stock of personal protective equipment (PPE), such as gloves and aprons, to use when required.

Learning lessons when things go wrong
● Systems were in place to track and monitor incidents and complaints in order to learn lessons from them. Whilst we did identify an insufficient response to falls and risks, the registered manager completed a monthly analysis of incidents and complaints and documented any learning from them.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet

- Assessments were not always robust and did not take place in a timely manner. In all examples seen, care delivery had started before a robust assessment of people's needs had taken place. The registered manager told us they used the referral assessments from the local authority in the first instance and staff did tell us they had enough information when visiting people new to the service. However, as reported on in Safe we identified examples where needs and risks had not been assessed before care started.
- One person was living with dementia and the registered manager told us about known risks related to this and that they may decline support. Records showed staff had been visiting the person for four days before an assessment took place and a care plan was drawn up to provide guidance to staff.
- Important information about people's health needs were not planned for proactively. One person had regular visits from community nurses. The reason for this was recorded in their care plan but there was a lack of information for staff about when they may need to contact the community nurse if things had changed. After the inspection, we received an updated care plan that included this information. However, our findings showed these needs were not being updated and planned for in a proactive manner.
- People's care plan contained limited information about their dietary needs. One person was living with dementia and their care plan said they were diabetic. It recorded that 'meals should be diabetic controlled' but did not explain what that meant. The registered manager said this person lived with a relative who usually prepared their meals. However, due to their dementia the risk of staff providing inappropriate meals or snacks if the person requested them was heightened by lack of information.
- Care plans lacked detail on foods that people liked. Whilst the impact of this was reduced because people lived with relatives or prepared meals themselves, a lack of personalised information meant people were at risk of receiving foods they did not like if relatives were not present.

The lack of prompt assessments and planning for healthcare and nutritional needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

- People told us they had consented to their care and records showed people had been asked to agree to their care plans and this was documented electronically.
- 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.

● We checked whether the service was working within the principles of the MCA and found that consent had been sought but records were not always clear. In most cases, people were able to consent to their care and had done so. For one person, staff told us a relative had legal authority to consent on their behalf. The provider sent us evidence of this but it was unclear if the document was genuine due to the poor quality photograph. We have reported further on record keeping in the Well-led domain.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Aside from the example above, we saw evidence of staff referring to health and social care professionals where they had concerns. For example, where one person's mobility was seen to have changed records showed staff had made a referral to an occupational therapist.

● In another instance where staff had noted a person was showing signs of being unwell, records showed this had prompted a referral to their GP for investigation.

Staff support: induction, training, skills and experience

● Staff told us they found training useful to their roles. Training provided was a mix between e-learning and face to face training, staff said they were given enough time to carry this out and the registered manager reminded them when training was due to be refreshed.

● Staff told us they completed an induction which included training courses and shadowing to get to know people's needs. Records showed all staff had completed the Care Certificate. The Care Certificate is an agreed set of training standards in social care.

● The provider kept a record of staff training which tracked when it was due to be refreshed. Records showed training was up to date in areas such as fire safety, infection control and health and safety.

● Staff told us that they received one to one supervision meetings once a month and records supported this. We saw evidence of monthly spot checks where practice was observed in order to identify any learning needs.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

● We received positive feedback about the caring nature of staff. One person said, "Everything is fine, I like them all [staff]." Another person said, "They are all well-presented, cheerful and jolly." A relative said, "They all seem lovely staff."

● Despite this positive feedback about individual staff, the shortfalls in call punctuality meant that people were not always treated well by the service. This was because staff did not always arrive when expected and people did not always receive a call to update them. Until this issue is addressed the service will not meet the characteristics of a 'Good' rating in Caring.

● More work was required to ensure people's equality and diversity was captured in assessment and care planning, so these needs could be met. Records of care plans and assessments did not record people's first language, culture or religion. We also saw information about people's sexuality and gender identity had not been explored. This meant there was a risk that people would not feel comfortable talking about this which may affect their care choices.

● The information about people's preferences within care plans was limited. Care plans did not record people's routines or when they would prefer their calls attended. We have reported further on personalisation in the Responsive domain.

● People were contacted by telephone on a monthly basis to be asked about their care. The registered manager also supported with care delivery and people told us they saw them regularly and could make requests.

Respecting and promoting people's privacy, dignity and independence

● People told us that staff provided care in a way that encouraged independence. One person said, "I am still mobile and they work around me, if I have a bad day they always work around that."

● Care plans recorded tasks people could do themselves, such as washing their face or attending to oral care. People told us staff allowed them to do tasks themselves where they could. One staff member said, "Even if someone is bed bound, they can sit up and I will encourage them to do what they can like wash their face or have a drink."

● People told us staff were respectful when entering their homes. Staff told us they were mindful of people's privacy and dignity and gave examples such as ensuring curtains were drawn and doors were closed. We noted care plans also provided a reminder to staff to ensure people's privacy was maintained.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

At our inspection in March 2018, we found instances where people's care plans lacked detail about their preferences so made a recommendation about care planning. At this inspection, we found the level of detail within care plans had not improved and they no longer met the legal requirements of the regulation.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

● Care was not always planned in a person-centred way. Care plans sometimes lacked detail which meant care had not always been planned robustly around people's individual needs. For example, one person's care plan stated they had a learning disability. Their care plan recorded they were 'reluctant' to engage with some aspects of care but there were no further details on the nature of the person's learning disability or how staff may engage them in their care. The person had input from a local learning disability service as well as support from a voluntary organisation to manage finances, but there was limited information about this within their care plan.

● Staff also described how this person had made progress which had reduced their support needs. However, their care plan had not been updated to reflect that they no longer needed the same level of support.

● Information about mental health care needs was inconsistent. One person was receiving treatment for mental health conditions which had caused them to spend time in hospital in the past. Their care plan had detailed guidance for staff about how to respond to potential changes in their mental health. However, another person's care plan showed they were being treated for a mental health condition and there was no information for staff about how to identify and respond to changes in mood. The person was supported regularly by the same staff who had received mental health training, but the lack of detail meant staff may not respond appropriately when required. After the inspection, we received updated care plans that had an improved level of detail. We will require further action to ensure this is implemented consistently.

● Another person's care plan for managing incontinence referred to them wearing knickers, despite the registered manager confirming this person did not choose to wear this type of underwear. The registered manager also told us that the person was only incontinent at certain times but their care plan lacked detail on when this was.

● Care plans lacked detail on people's advanced wishes. The provider supported people who may require end of life care in the near future. All care plans seen lacked detail of advanced wishes to inform staff about people's wishes at this stage of their lives.

The shortfalls in personalised care planning were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Whilst we identified issues with care planning, people's feedback on staff practice and the care they

received was positive. One person with a long-term condition described how their needs were regularly reviewed and action was taken when things changed which gave them confidence in the service.

● Care plans showed regular reviews took place to identify any changes. People told us they received a monthly phone call to check they were happy with their care as well as visits each month to check their care needs. Records showed regular reviews of care but as we reported in Safe, we found instances where changes in risks did not prompt reviews.

Improving care quality in response to complaints or concerns

● There had been 20 complaints in the last year which was a high number for a service of this size, but records showed they were monitored and responded to. For example, where someone had complained about the conduct of a staff member an apology was issued and action was taken with the staff member to improve their practice. At our next inspection we will follow up on if the improvements made in relation to staffing, risks and governance have caused a reduction in the numbers of complaints.

Requires Improvement

Is the service well-led?

Our findings

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

RI:Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

At our inspection in March 2018 we found that the provider's systems to check and audit the care that people received were not sufficient to address the areas of concerns found during that inspection. We also found records were incomplete and not up to date. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that audits were still not robust and records were not accurate and complete.

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

- The provider had failed to robustly implement improvements following our last inspection. After our last inspection the provider submitted an action plan to CQC which stated how they would meet the legal requirements of the regulations. Our findings showed that all the legal requirements that had been breached had not been met through these actions. We also found a deterioration in other areas which meant further legal requirements were now not met. This showed a failure to robustly address areas of concern and sustain improvements.
- Audits were not sufficient to identify and address the shortfalls identified at this inspection. For example, audits of medicines were identifying the numerous areas we identified but there was no action to address these. We also found senior staff lacked knowledge of best practice in relation to medicines which meant audits were not based on up to date knowledge. Where we identified insufficient information within care records, there was no internal audit of documentation to identify and address these.
- Actions taken in response to audits were not timely or robust. The provider had an external audit three weeks before our visit which had identified concerns that we found in areas such as risk assessments and medicines. The audit had recommended a review of content of risk assessments but this had not been addressed by the time of our visit. Issues with medicines errors were highlighted in the audit but our finding showed these had not been addressed.
- Records were not always accurate and up to date. Information that the provider was aware of was not always documented within care plans. We also found inconsistencies in the detail staff recorded within daily notes. Some entries contained a detailed description of the call whilst others provided basic details of tasks completed, which were automatically generated by the electronic system. The registered manager told us this was something they had identified and were addressing with staff, we will require further action to ensure the legal requirements are met in this area.

The shortfalls in governance and audit and the inconsistencies within records were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● The provider had not notified CQC of incidents that they were legally required to do so. Providers are required by law to notify CQC of important events such as injuries, deaths and allegations of abuse. We identified a safeguarding concern related to an allegation that a staff member had committed theft. This had been investigated by the safeguarding team and the police but the provider had not submitted a statutory notification to CQC. The registered manager told us they were not aware that they were required to notify CQC of this type of incident, which showed a lack of understanding of the responsibilities of their registration.

The failure to notify CQC of an allegation of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and relatives gave positive feedback of the registered manager and said they visited them regularly. One person described how they got on well with the registered manager and discussed football with them, a relative praised how responsive the registered manager was to a request to change call times.

● The registered manager was regularly involved in care delivery. Whilst this may have impacted upon some of the issues with governance that we found, it had meant people and relatives had got to know the registered manager and gave us positive feedback on this.

● People received a monthly call from office staff and spot checks took place around once a month so people had regular visits from the registered manager or the deputy. These provided people and relatives with regular opportunities to provide feedback. People and relatives told us they felt confident to raise any issues they may have with them.

● Staff told us they had regular meetings where they could raise concerns or share good practice. One staff member said, "It's a really nice place to work, it is all about the management." Another staff member said, "I can't complain, the communication is good and we all work well together."

● Within care plans we saw evidence of liaison with other agencies and voluntary organisations involved in people's care. However, as we reported on in other domains, there was a lack of recorded detail about the nature of their involvement.

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 18 Registration Regulations 2009 Notifications of other incidents CQC had not been notified of a safeguarding allegation.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The system for assessing people's needs was not robust. Information about people was missing from care plans.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were frequent medicines errors which had not been addressed. Risks had not been assessed in a timely manner and plans to manage risk lacked detail.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems to audit the service had not identified and addressed all the concerns that we found. Records were not always accurate and up to date.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff were not always deployed in a way that call times were punctual. Staffing numbers meant management often completed care calls.