Mrs Esther Roselline Anzeze-Makindu

C&S Makenston Special Care Service

Inspection report

1 Sycamore Grove
Trowbridge
Wiltshire
BA14 0JB

Tel: 01225762911

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

C&S Makenston Special Care Service provides domiciliary care and support services to people with individual needs in their own homes. At the time of our inspection four people were being supported.

This inspection took place on 8 July 2016. This was an announced inspection which meant the provider had prior knowledge that we would be visiting the service. This was because the location provides a domiciliary care service, and we wanted to make sure the manager, or someone who could act on their behalf, would be available to support our inspection. This was the provider's first inspection since they registered with CQC in 2014.

The service is registered as an individual provider which means it does not require a registered manager to be in post at the service. The individual provider is responsible for the day to day running of the location, and has the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The service did not follow the requirements set out in the Mental Capacity Act 2005 when people lacked the ability to give consent to their care within their own home. This meant it was not possible to say whether these people consented to the care and treatment they were receiving, or if they did not have capacity to consent to their care.

Staff had not received the appropriate training relevant to their role. We identified gaps in the training records. Where staff had received training some of this had been completed but dated as far back as 2004. This meant training had been from their previous employer and they had not received training relevant to their role since being registered with CQC in 2014.

Medicines were not managed safely and where people were self-administering medicines, associated risk assessments were not in place. Medicines administration records (MAR charts) were not completed.

Care plans did not provide enough information about a person, their health condition and care needs. Risks to people were not fully documented and action plans had not been put in place for staff to follow.

The service did not follow safe recruitment practices. The staff files we looked at did not have the relevant references and ID checks needed.

The manager of the service worked as part of the care team on a daily basis but this left little time for managerial duties. The service did not have fully effective systems in place to evaluate and improve the quality of the service.

Staff were aware of the types of abuse people may be at risk of and the actions to take if they suspected someone was at risk of harm. Staff were aware of their responsibility to report any concerns they had about

people's safety and welfare. However, the manager had not notified CQC about significant events, such alleged abuse.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

We found breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

Staff told us they had a good understanding of, and demonstrated a positive attitude relating to the prevention of abuse. However, we found relevant agencies had not been informed when alleged abuse had taken place.

The systems in place to manage risks related to the administration of medicines were not completed consistently.

The service didn't operate a safe system for recruitment. There was not sufficient staff to meet people's individual needs.

Risks to people's safety had not been identified and associated risk assessments were not in place.

Contingency plans were not written down for staff in case of an emergency.

Is the service effective?

Requires Improvement

The service was not fully effective.

The service did not have arrangements in place to act in accordance with the Mental Capacity Act 2005 when people lacked the ability to consent to the care provided.

Staff had not received all the required training relevant to their role in order to effectively meet people's needs.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Is the service caring?

Requires Improvement

This service was not consistently caring.

People told us staff treated them with dignity and respect, but relatives told us there were times that their family member's privacy had not been respected.

Care calls were not always punctual and some people felt rushed.

The manager had got to know people's likes and dislikes and showed an interest in people's life histories.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person centred and did not evidence peoples or their relatives involvement.

Where risks had been identified there was not a full assessment in place or a subsequent plan of action.

People were not always encouraged to provide feedback on the service they received.

People and their relatives told us some complaints and concerns had been raised with the manager, however this had not always been resolved in a timely way.

Is the service well-led?

Requires Improvement

The service was not well-led.

The manager provided hands on care to people on a daily basis, leaving little time for managerial duties.

The service did not have fully effective quality assurance and information processing systems in place.

The service did not have fully effective systems in place to promote improvement and development.

Policies and procedures were out of date and incomplete.

C&S Makenston Special Care Service

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 8 July 2016. This was an announced inspection which meant the provider had prior notice that we would be visiting. This was because the location provides a domiciliary care service to people in their own homes, and we wanted to make sure the provider, or someone who could act on their behalf, would be available to support our inspection. One inspector completed this inspection. This inspection was the service's first rated inspection.

Before the inspection we checked the information we held about the service and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also reviewed the provider information return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with two people being supported by the service, three relatives, one staff member and the manager. We reviewed two records relating to people's care and other records relating to the management of the service, such as staff training and recruitment files as well as the provider's policies and procedures. We also spoke to one social care professional.

Inadequate

Is the service safe?

Our findings

The systems in place to manage risks related to the administration of medicines, which were not completed consistently. Information on how to provide support to people with their medicines was not always available or clear. We looked at two care records of people receiving support from staff to self-administer their medicines. We found there were no medicines care plans or risk assessments completed. Staff did not consistently record when they had supported someone with their medicines, for example when they had prompted the person or had left it out for the person to take at a later time. The service had a medicines management policy in place, which stated "For self-medicating service users, the date and name of the care staff who gave the service user their supply of medicines, must be recorded in a MAR chart (medicines administration record) as well as in their care plan and must be accounted for by their signature." Staff did not follow this policy and MAR charts were not used for recording medicines to ensure people were taking their medicines as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not follow safe recruitment practices. Staff files showed that the provider's recruitment procedures had not been followed and staff had not been thoroughly checked before they started working at the service. The two staff files we looked at did not have the relevant reference and ID checks needed. The manager told us they had known the staff for many years from their previous role as a registered nurse, and had therefore not asked for any references or ID checks. From staff files we looked at, there was evidence of Disclosure and Barring Service (DBS) checks, however these checks were not completed by the service, but were checks from the staff members previous employment. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. The manager told us that staff had not been visiting people's homes or provided personal care, but only provided support in the office. The manager was in the process of recruiting new care staff and some care staff had recently left, therefore the manager was the only staff member providing support to people within their homes at time of the inspection.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient staff to support people and staff did not have the right skills and knowledge to meet their individual needs. For example one person needed support with hoisting, but the manager who was providing the support, had not received up to date training on how to move people safely.

People did not receive a copy of their weekly care schedule. This meant people were not aware when they would receive their call or who would be supporting them. Daily records we looked at showed timings of care visits were inconsistent. We found as the manager was the only person providing hands on care at time of the inspection, people's care calls were not provided at their chosen time. Some people whose morning call should be around 10.00am sometimes did not receive their call until lunchtime, for example daily

records indicated that the person had their breakfast at 12.00pm. We also noted gaps in the daily records, for example, for one person nothing was recorded for the period 28 June – 5 July 2016. One relative told us their family member had been assessed to have four care calls per day, however the provider was only providing two of these care calls. The relative said that they never knew which carer was coming or what time and that their family member sometimes were not got out of bed until 2pm in the afternoon. Another relative said care calls were rushed and the carer only stayed for 20 minutes, which should be an hour call visit. The relative told us they still got invoiced for the whole hour.

Most people and their relatives we spoke with said the care was not punctual and they would not always be informed if staff was going to be late. One relative told us their family member had a missed call and the person had to manage their own care, for example emptying their commode, which resulted in a muscular injury.

The manager explained that recruitment had been hard, and for this reason some care packages that had been referred to them had been declined. The manager said they would not take on care visits unless the staff were in place first and they could ensure that the service could meet people's needs.

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

People and relatives said they felt safe when the manager was providing the care, however with new carers they did not always get introduced before the care visit. Some people and relatives told us staff did not wear uniform or had any kind of identification on them, which left them feeling vulnerable. One person said "I especially feel vulnerable when they come at night time and they are in casual clothes."

Some relatives told us that there were times when they didn't feel their family member's privacy was respected. For example there was an incident where staff entered a property without the person knowing they were coming, which startled the person. Another time the manager had accessed a person's home to review the care records, however again did not inform the person they were coming. On other occasions staff had taken their own relatives with them on care visits and people told us this made them feel uncomfortable. During one visit a male was taken into a home where the person had clearly stated they only wanted female carers. The person said "The male was very big and I felt intimidated. I couldn't believe he was allowed into my home."

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training and records confirmed that staff had received training relating to safeguarding people from abuse. Staff had access to information and guidance about safeguarding to help them identify abuse but did not always respond appropriately if it occurred. For example one person told us that some items had gone missing from their home and the carers had been dismissed. This had not been referred to the local safeguarding team, or the police and CQC had not been notified of the alleged theft. This information was also not made available to us during our inspection and the manager told us that the carers had left due to demands from another service user.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Requires Improvement

Is the service effective?

Our findings

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 legally authorised under the MCA. For people receiving care in their own home, this is as an Order from the Court of Protection. The manager confirmed there were no Orders from the Court of Protection for anyone using the service at the time of this inspection.

The provider's systems for gaining and recording consent for care and treatment were not always followed by staff. This meant it was not possible to say whether these people consented to the care and treatment they were receiving, or if they did not have capacity to consent to their care that the MCA had been followed. The manager told us one person they were supporting had short term memory loss, but the person did not have any mental capacity assessments in place for consent to their care and treatment. Where people had a diagnoses of vascular dementia no consent or mental capacity assessments were in place. There was also no record if any relatives or other representatives of people had any legal rights to support them with decision making, for example regarding their finances or for health and welfare. The manager told us people had not signed to give consent for their care, however they were always asked for verbal consent. The manager said because people and their relatives were involved in the discussions about their care, consent was assumed.

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

Staff had not received all the required training relevant to their role in order to effectively meet people's needs. We looked at three staff files, including the manager's and saw each containing certificates of training. However some of these certificates were dated from as far back as 2004 and did not have relevance to the job. This meant training had been from their previous employer and they had not received training relevant to their role since being registered with CQC in 2014. The manager told us they and another member of staff had just completed Level 2 of the Health and Social care Certificate in Understanding dignity and safeguarding in adults. However, the manager told us they were supporting people for example who were living with dementia, who were terminally ill and who were at risk of skin breakdown. We found that specialist training was out of date, for example tissue viability training had not been updated since 2012 and manual handling of people had not been updated since 2011. One person said "I do not feel staff have the training and skills to do their job properly". The manager had informed us since our inspection that they had booked onto manual handling training for September 2016 and another staff member for October 2016.

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

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. We saw in one person's daily records staff had

recorded that they had noticed a skin tear and contacted the community nurses for a dressing. Another person had breathing difficulties and staff acted by calling for paramedics. One person told us they felt confident that the manager would recognise when they were unwell and call the GP when needed. A relative said that a carer had noticed a dry patch on their family member's skin and acted by applying cream as required.

The manager told us people were independent with eating and drinking, but some people needed encouraging with food and fluid intake to ensure they maintained a healthy diet. One person said "X (Manager) would show me a variety of microwave meals so I could make a choice". Another person said "I am always offered a drink. X (Manager) knows exactly how I like my milky coffee in the morning".

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback from people and their relatives about the care they received. Comments included "All of the care givers I have met so far are diligent, fun, polite, helpful and friendly and demonstrate a kindness towards not only the client, but also their respective family and friends too.", "X (Manager) is a nice lady. We have a laugh together. She is very good. She knows now how I like things to be done." and "My wife likes X (Manager). However other comments included "The care had not been terribly successful" and "I do not feel the care is reliable. I would not recommend this service to anyone at present."

People told us staff treated them with dignity and respect and will give them a choice for example what to eat and what they want to wear. One person said the manager was providing the majority of their care calls and were very caring. They said the service was flexible and when they had an early morning hospital appointment, the manager would ensure they had their care visit earlier. Another person said the manager had recently employed a new carer and felt she was excellent. The carer would spend time with her, for example noticing dry skin on her feet and offering to rub some cream in. However, some relatives felt the care was rushed and one relative said their family member was concerned about complaining, in case they lost their carers.

The manager told us they had got to know people's likes and dislikes and showed an interest in people's histories, for example one person used to play in a band and liked listening to music. The manager would talk to the person about music when they visited. The manager told us they were not supporting people to go out at present, but that was something they would like to develop further.

The manager said they would always involve people in making decisions about their care, for example sit down with them and talk about what they needed doing and how they wanted it done. The manager said it was important to listen to what people were saying and to give people freedom of choice. Most people told us they had a positive relationship with the manager.

Requires Improvement

Is the service responsive?

Our findings

The manager told us people or their relatives were involved in developing their care and support plans, however we did not see evidence of this as there was no signed consent. When a person started using the service an initial assessment was completed. The care plans were not person centred but task orientated for example "X likes to have lunch at 1pm, X likes to have tea at 6pm" and "Help X to dress, bring downstairs, have meals and drinks prepared for me". Care plans did not encourage people's independency and where people had a specific health need there was not always clear information in place. For example one person's care plan stated they had mobility problems due to vertigo, but did not state how to support the person with their mobility.

In another person's personal care section, the care plan stated 'requires full help with personal hygiene' but the plan did not specify what these needs were. One person needed support with their catheter care and the care plan stated "daily care of urinary catheter", however did not state in detail how the catheter care should be provided and how many times a day. This meant there was a risk that the catheter care would not be provided when needed.

We saw that risk assessments had not been completed appropriately. Home visiting risk assessments to ensure staff safety were completed, however where people had poor mobility or skin integrity, these risks were not reflected in their care plans and associated risk assessments were not completed. There was no end of life wishes documented in people's care plans. The manager told us they were supporting a person who was end of life, however this was not reflected in the person's care plan. The care plan identified areas for rehabilitation, however the manager told us the person was terminally ill.

One person's care plan stated their memory was poor but did not say if they were able to retain information in order to make a decision. The person's care plan stated "Y has bad short term memory loss so tends to forget what she is suppose to do". There was no information in the care plan on how to support this person with their decision making.

This was a breach of Regulation 9 (3) (a) Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us some complaints and concerns had been raised with the manager, however this had not always been resolved in a timely way. One relative said they recently had a review of their family member's care plan and identified that one of the tasks had not been completed by staff. This still had not been addressed since the review. Another relative said they complaint about a missed call, which the manager apologised for and offered to go out immediately. Some relatives felt that complaints about continuity of care calls had not been addressed by the manager. One relative said "X (Manager) has too much on their plate and forget things." A social care professional told us the manager had been part of a care review of a person, where there were concerns about the continuity of care. The manager had also cancelled calls without informing the person or their relative. The social care professional said "The manager was keen to improve and things have settled down since the review." We found where concerns

had been raised, this was not recorded and there was no evidence of the manager investigating the concerns further.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The service is registered as an individual provider, and does not have a condition in place stating a registered manager needs to be in post at the service. The manager managed the daily running of the service and the manager told us they had been providing the majority of care calls due to difficulty in recruiting staff. This meant the manager had very little time for managerial responsibilities.

The manager had not notified CQC about significant events, for example alleged abuse. We use this information to monitor the service and ensure they responded appropriately to keep people safe. We found the manager had not taken necessary action when needed to keep people safe.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Internal audits had not been completed, which meant shortfalls in the service delivery had not been identified and appropriate action had not been taken. The manager had been providing hands on care, which made it difficult to complete audits, such as medicines management and health and safety audits. The manager acknowledged that this was a shortfall and was planning to put audits in place as soon as more staff had been recruited.

The provider did not have effective systems in place to monitor the quality of care and support that people received. The manager told us the service had only been providing support to people within the last few months, therefore quality assurance surveys had not been sent out yet. This was planned for the near future to get people and their relatives feedback about the quality of care received.

Policies and procedures had not been updated since 2013 and the provider's practice was contradictory to their policies, for example end of life policy, stated "Effective documentation such as detailed individualised care planning and review are essential supports for effective delivery."; however this was not the case for people who were at end of life. The moving and handling policy stated "Staff must not carry out the moving and handling unless the operation has been assessed for risk." We found there was no risk assessment for moving and handling for the person who needed support with hoisting.

The manager told us there was an on-call system in place, however this system meant the manager would be on-call 24 hrs each day. There was no other contingency plans in place in case of an emergency or in case of sickness absence. The manager told us they would contact another care provider to cover care calls, however we found this was not a very effective system for an emergency cover. Relatives also told us that the manager had been unable to cover the care calls on the day of our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us the service was committed to supporting vulnerable people so they can continue their lives with dignity and independence and participating members of their own communities. The manager

was keen on developing the service, but did not want to compromise the quality by taking on more people, unless they had sufficient staff to cover the care calls. The manager said "My clients come first."

The manager had recognised the challenges of recruiting and retaining staff. At time of the inspection, the manager had been supported by two office members of staff. Staff meetings had taken place and the manager said these were opportunities to discuss professional development and vision for the future. Areas of improvement were also discussed, for example staff uniform and training needs.

The manager had made community links, for example with other local care providers and the local authority. The manager told us she had been in discussions with other care providers about ways of working on improving the service. The manager was also hoping to build further relationships with Wiltshire College, to be able to offer a student from the College an Apprenticeship.

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 The service did not notify CQC of significant events such as abuse or allegation of abuse in relation to a service user.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care plans were not person centred and where people had a specific health need or risk to their safety, there was not always clear information in place. Documents were not always completed appropriately. There was no end of life wishes documented in people's care plans.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Necessary records of assessments of capacity and best interest decisions were not in place for people who lacked capacity to decide on the care provided to them by the service. The provider did not have suitable arrangements in place to act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

	The systems in place to manage risks related to the administration of medicines were not completed consistently.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service provider did not have fully effective systems in place to assess, monitor and improve the quality and safety of the service. Nor were there fully effective systems in place to evaluate and improve practice and to keep records in relation to the management of the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service did not follow safe recruitment practices. Staff file did not have the relevant references and ID checks needed.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received all the required training relevant to their role in order to effectively meet people's needs. There were not sufficient numbers of staff to meet people's individual needs.