City of York Council

# Personal Support Service

## Inspection report

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27 February 2019
07 March 2019
11 March 2019

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service:  Personal Support Service is a domiciliary care agency providing personal care to people living in four separate independent living communities owned by York City Council. The service also provides personal care at night to people living within the city of York. At the time of the inspection there were 104 people using the service.

People's experience of using this service: This focused inspection was carried out to assess any current risks to people using the service. We therefore only looked at two domains where the key lines of enquiry are about risk and leadership of the service. No other concerns had been identified through our ongoing monitoring. Therefore, the other three domains of effective, caring or responsive were not assessed as part of this inspection. A full comprehensive inspection will be carried out at a later date.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The registered manager and the provider completed checks and audits to monitor the quality and safety of the service. However, the provider had not always identified when incidents affecting people's safety and welfare were not reported as safeguarding matters.

Overall, there were enough staff to meet the needs of people who used the service. There were mixed responses from people about regular and consistent staff. We have made a recommendation about the deployment of staff to ensure improved consistency.

Assessments of people's needs were completed before they began to use the service. Any changes in people's needs were followed up and acted upon.

Risks to people were assessed and most people said they felt safe and well looked after. One person said, "I feel safe, as soon as I came here I felt this is where I'm staying. I love it." One person told us they did not get on with one staff member and this was being addressed by the management team.

Staff knew how to respond to possible harm and how to reduce risks to people. People were seen to have good relationships with staff. Lessons were learnt from complaints, safeguarding and incidents to help prevent reoccurrence in the future.

Rating at last inspection: Good (published 12 November 2018)

Why we inspected: This focused inspection was brought forward due to information of risk or concern that had been raised about the safety and management of the service.

Enforcement: We found the provider failed to notify us of two incidents which had occurred at the service across a two month period which the provider is legally required to inform us of. More information is in detailed findings below. We are dealing with this outside of the inspection process and will publish a

supplementary report once we know the action we will be taking.

Follow up:  We will continue to monitor this service and inspect in line with our re-inspection schedule or sooner if we receive information of concern.

## 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 well-led?**

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

# Personal Support Service

**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 provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service is also a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a night care and support service to older adults.

Not everyone using Personal Support Service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had two managers 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 24 hours' notice of the inspection visit because we needed to be sure the registered manager and management team were available to assist with the inspection.

Inspection site visit activity started on 27 February 2019 and ended on 11 March 2019. We visited one of the extra care housing schemes to speak with the management team and staff. We also reviewed records there.

What we did: Before our inspection visit we reviewed the information we held about the service. This

included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service.

During the inspection, we spoke with one of the registered managers, the locality service manager, the head of service, one team leader, two staff members and an agency staff member. We also visited and spoke with three people who used the service and made telephone calls to two people who used the service. We looked at six people's care records and a selection of documentation about the management and running of the service. This included accident and incident management, staff training records, quality assurance records and staff rotas.

Requires Improvement

# Is the service safe?

## Our findings

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

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.

Staffing.
•People did not always receive care in a timely way. Some people said their care calls were later than expected and staff did not always have time to meet all their needs. One person said they had occasionally missed their shower because of this.
•People did not always have consistent staff attending their care calls. One person said, "They are always short-staffed; get lots of different ones, never know who is coming. I don't like that." Another person told us they didn't like having too many people assisting them with a shower and preferred a smaller team of staff to do this. They said there had been staff sickness recently and it couldn't be avoided.
•Staff confirmed they were sometimes short of staff due to sickness but said people's needs were met. One staff member told us they sometimes had to leave domestic tasks such as cleaning but always made sure people received their care.
•Rotas showed there were between 14 and 21 different staff attending people's calls over a period of a week if they received calls four times per day. The service locality manager had recognised this was not providing the consistency they wanted for people. They told us there were plans in place to deploy the staff in teams to ensure better consistency.

We recommend that the provider reviews the organisation of their rotas to ensure consistency of carers for people.

Systems and processes to safeguard people from the risk of abuse.
•Safeguarding and whistleblowing policies were in place. However, the provider had not always ensured they reported safeguarding incidents to the local authority. They had also failed to notify the CQC of two incidents which had occurred at the service across a two-month period. We are dealing with this outside of the inspection process and will publish a supplementary report once we know the action we will be taking.
•Staff were trained to identify and respond to safeguarding concerns. They could describe the different types of abuse and what to do if they had concerns.
•Staff told us they were confident the management team would act on any concerns reported to ensure people's safety.
•Overall, people told us they felt safe. Comments included; "I feel so safe, staff watch me with my equipment to make sure I stay safe", "They [staff] always make sure whatever I do, I'm safe" and "I love it here; nice staff. I've no complaints." One person said they did not like the approach of one of the staff. They said this had been reported and was being dealt with by the management team.

Assessing risk, safety monitoring and management.
•People's needs were assessed and risks identified. Risk assessments showed specific areas of risk, and the

measures put in place to minimise those risks. These included the risks of falls and malnutrition.
•Risks to people's safety when going out in the community were supported by the 'Herbert protocol'. The Herbert protocol is written information about people living with dementia who can become disorientated when out in the community. In the event of the person not returning to their home, this protocol information can help the person to be located.
•Staff understood where people required support and care plans contained explanations for staff to follow to keep people safe.
•Risk assessments were reviewed regularly and when people's needs changed.
•The environment staff worked in and equipment they used had been assessed for safety.
•Emergency plans were in place to ensure people were supported in the event of a fire.

Learning lessons when things go wrong.
•Accidents and incidents were monitored by the registered manager and provider for any patterns, trends or learning.
•Investigations and actions taken were recorded and lessons learnt were shared.
•Staff were aware of the reporting procedures for accidents and incidents. One incident that had affected a person's safety had not been recorded as an incident. This meant the incident was not included in the management oversight of accidents and incidents.

We did not inspect the key questions Recruitment, Using medicines safely and Preventing and controlling infection because ongoing monitoring did not raise any information about risks or concerns in these areas.

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.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
•Most notifications had been sent to the CQC. However, we found two incidents across a two-month period, relating to police incidents and safeguarding which had not been reported via a statutory notification in line with legal requirements. Statutory notifications contain information about changes, events or incidents that the registered provider is legally required to send us so that we can monitor services. This is a breach of regulation 18 of the CQC (Registration) regulation 2009. We are dealing with this outside of the inspection process and will publish a supplementary report once we know the action we will be taking.
•People and staff were positive about the management team. Comments included; "[Name] is a nice girl from the office", "I have a good relationship with all the managers" and "The service is well managed; I feel I can trust them with anything."
•Staff said they received good support from all members of the management team. One staff member said, "There is a good support network; always someone there for you at the end of a phone."
•The provider had a comprehensive quality assurance system in place. This enabled the management team to collate information to show how the service was performing and report this to the senior management team. Some records such as care plans, needed to be improved and the registered manager was aware of this. The systems in place had not identified the issues we found regarding the recording of incidents.

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 management team were committed to providing a person-centred service for people. People's support needs were recorded and updated in their care plans. Some care plans needed more detail on how specific care tasks were carried out. The registered manager said these records would be reviewed to improve them.
•People's abilities were kept under review and any change in independence was noted and investigated, with changes made to their care plan and support as necessary.
•Staff told us they felt listened to and that the management team were approachable. One staff member said, "There is an open culture and you feel able to own up to any mistakes."
•The provider reviewed and assessed people to determine whether they were deprived of their liberty. Records showed the relevant people were involved in this process to ensure people's rights were respected.

Continuous learning and improving care.
•Learning had taken place from previous events at the service in relation to how they had improved general safety and managed risk. For example, people referred to the falls prevention team after falls had occurred.
•Staff were kept informed of important issues that affected the service. For example, staff told us following

incidents, there was discussion and reflection at staff meetings and handovers.

We did not inspect the key questions Engaging and involving people using the service, the public and staff, fully considering their equality characteristics and Working in partnership with others because ongoing monitoring did not raise any information about risks or concerns in these areas.