Palmerstone Homecare Ltd

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Inspection report

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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

This was an announced inspection carried out on the 12 and 13 July 2016. At the last comprehensive inspection in September 2015, we rated the service as requires improvement. At that inspection we found two breaches of regulation; people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines and people who use the service were not protected from the risks of unsafe care because the recruitment procedures were not adequate.

After the inspection in September 2015, the provider wrote to us to say what they would do to meet the regulations in relation to each breach. They told us they would complete all actions by the end of January 2016. At this inspection, in July 2016, we found that the provider had not completed their plan of action and legal requirements were still not met. We also found additional breaches.

You can see what actions we told the provider to take at the back of the full version of the report

Palmerstone homecare provides personal care and support to adults who live in their own homes. At the time of inspection up to 197 people were using the service and some people were vulnerable due to their age and frailty, and in some cases had specific and complex health care needs.

We completed this inspection after receiving concerns about missed and late visits and people being left without care and support. Concerns included people's personal care needs not being met and people not receiving their medicines at the prescribed times. We found the local authority had temporarily suspended new placements to the service because they had concerns about the service being provided.

The service has a registered manager in post. 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.

Medicines were not managed safely. Safe medicine administration practices were not followed so people were not protected against the risks of unsafe management of medicines. Although some staff had received training in managing medicines, this had not given staff the required competency to manage medicines safely.

Sufficient recruitment checks had not been carried out before staff started work to ensure that they were suitable to work in a care setting. Staff were not always supported to carry out their work and had not received regular support and training.

The provider's systems to monitor and assess the quality of service provision were not effective. Actions that had been identified to improve the service were not always implemented and the provider's quality

monitoring systems had failed to identify significant concerns. People did not always receive their care and support as planned as staff had missed some people's calls and did not always spend the agreed time on the calls.

There were not always effective systems in place to respond appropriately to complaints and comments made by people who used the service or people acting on their behalf. People who used the service were not confident that their comments and complaints were always listened to and dealt with effectively.

People were receiving the support they needed to eat and drink sufficient amounts to help meet their nutritional needs. Staff knew who to speak with if they had any concerns around people's nutrition.

Risk assessments identified specific risks to people and hazards in their home environment.

Staff had a good knowledge of safeguarding procedures and were clear about the actions they would take to help protect people. Risk assessments had been completed to help staff to support people with everyday risks and help to keep them safe.

People were supported by staff to maintain good healthcare and were assisted to gain access to healthcare providers where possible.

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.

We found that insufficient action had been taken to improve safety.

Staff had not been recruited safely with the necessary checks in place.

Systems were not in place to protect people from harm.

The safe management of medicines was not in place and therefore people could be at risk of not getting medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive the support and training they needed to carry out their role effectively.

People were supported by staff to eat and drink sufficient amounts according to their preferences.

Staff took prompt action to contact other health care professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People commented positively about their regular care workers caring attitude however felt replacement care workers were less reliable and did not provide the same levels of care.

People were consulted about their care needs.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were overall involved in contributing to the planning and review of their care and support.

There was not an effective system in place to deal with people's complaints and information was not used as an opportunity to learn and improve the service

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered provider had failed in their duties to ensure they met their legal obligations in reporting to the Care Quality Commission all safeguarding incidents which had occurred at the home

The provider's systems to monitor and assess the quality of service provision were not effective

Staff felt able to approach the manager with any concerns and felt that they were listened to and valued.

Palmerstone Homecare

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.

The inspection took place between 12 July and 20 July 2016 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 in.

The inspection team consisted of one inspector. We reviewed information we held about the provider including concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

We accompanied staff from the agency on visits to one person who was in receipt of care. We also spoke on the telephone to 16 people, which included people who received care and their relatives. We spoke with 13 staff including the head office team and the registered provider who was also the manager of the service

We reviewed a range of documents and records including care records for people who used the service, records of staff employed, complaints records, and incident records We looked a range of quality audits and management records

Inadequate

Is the service safe?

Our findings

At the previous inspection in September 2015 we found the provider did not have systems for the proper and safe management of medicines. At this inspection we found similar concerns. We found concerns about safe handling of medicines for some people whose records we looked at.

We found some improvements in the standard of record keeping had been made since our last inspection However, we found the records were still not always fully completed which meant it was not always clear which medicines had been given or taken. We found that the arrangements in place to manage medicines did not always work effectively.

We saw that there was still no method of checking if people had been given the correct medicines on the correct days because no records were made as to when the packets were started or how much medication was in their home each month. For example, when we viewed the medication administration record (MAR) for one person there were gaps in the records for all medications prescribed, one of those medications being Warfarin. We also noted that the dosage of warfarin changed following blood tests and the dose prescribed was sometimes variable. Although the provider had systems in place to ensure there was an up to date record of the current Warfarin dose, there was no system in place to check that the correct dose was being given.

Other MARS viewed also identified several gaps, which meant there was not an effective system in place to audit, monitor or investigate omissions or assess the impact this might have on people using the service.

We viewed the missed visits record held at the service and found there had been 13 missed calls since January 2016, none of which had been reported as potential safeguards or investigated thoroughly. Six of these calls, were subsequently cancelled by people who use the service or their relatives.

The registered manager told us that they were looking to implement an electronic call monitoring system. The registered manager told us that they hoped that this would help to monitor missed or late calls and calls made too close together more effectively.

We also viewed safeguarding records and care notes that identified late visits or visits where care staff did not stay the contracted time. We identified from eight records that calls were late, too close together or care staff had not signed out to evidence call time.

These safeguarding incidents had not been reported following the provider's own policy or to meet the safeguarding legal requirements of the local authority.

Not all staff had received training in safeguarding adults from abuse. We saw following a visit from the local authority in June that only 45% of staff had completed safeguarding training. The provider was able to evidence that additional training had taken place since this visit. On the day of our visit 32 staff were still to complete this training.

Staff we spoke with had completed training about how to support people safely and recognise the signs of and how to report abuse. They knew the actions to take, such as reporting issues to their manager and other agencies, including the local authority safeguarding team. Staff told us about the whistle blowing process and said they would not hesitate to report other staff if they had concerns. One staff member told us, "I let office know straight away, and also call social service if I am worried."

The on going issues with recording were a continued breach from our last inspection and the lack of training as well as monitoring of medication were additional breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

At this inspection we also found that the concerns identified at the previous inspection had not been addressed, at a previous inspection on 23 September 2015 it was identified that people who use the service were not protected from the risks of unsafe care because the recruitment procedures were not adequate. Following the previous inspection the provider had submitted an action plan that told us corrective actions would be completed by December 2015.

During this inspection we reviewed seven staff personnel records. Out of the seven staff files we checked, three did not have suitable references, including one staff member that had been recently recruited and was therefore employed with no valid references on file. This meant the provider was still failing to operate effective recruitment procedures and therefore could not be assured that staff members employed were suitable and safe to carry out their role and work with vulnerable adults.

People who use the service were not protected from the risks of unsafe care because the recruitment procedures were not adequate. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had arrangements in place to deal with emergencies, whether they were due to an individual's needs, staffing shortfalls or other potential emergencies. The service operated an out of hours on call service.

Risks to people's safety had been routinely assessed at the start of a service and these had been managed and regularly reviewed. People stated they had been part of the risk assessment process and a variety of risk assessments had been completed. These related to the environment, people's mobility needs, falls, nutrition and skin integrity. The risk assessments had clear instructions to staff on how risks were to be managed to minimise the risk of harm. Copies of this documentation could be found in people's homes and helped to ensure staff had up to date information and were kept safe.

People told us they felt safe when the care staff visited. One person said "Oh yes, I get on alright with the carers." Another person told us, "Yes I feel very safe." A third person told us, "Oh yes, I have to be turned and hoisted because I am a dead weight really and they always make me feel safe when they do it. They know what to do properly".

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us that carers generally had the skills and experience to deliver their care effectively. One person told us. "They 100% understand what they are doing." Another person told us, "Yes depend who comes, some are better than others." One relative said, "Very professional. Staff are really knowledgeable about Person's] complex health needs."

Staff received an induction prior to commencing employment, which included opportunities to work alongside experienced members of staff and read the service's policies and care plans. One member of staff told us, "We have induction training and then shadow qualified staff for one week." Another member of staff said, "I have done a lot of training and they spot check me."

Staff had received training and this included a mix of online and classroom-based training. These included mandatory courses in medicine administration, moving and handling, safeguarding, first aid and infection control. However, training records identified that there were staff that did not have up to date training, following a recent visit by the local authority it had been identified that only 47% of staff had up to date training records. The provider told us that they had an action plan in place to address these shortfalls.

Staff were not always regularly supervised. One member of staff told us, "We have a spot check every three months." Another member of staff told us "I started in May 2016 but have not received supervision or a spot check visit to see how I am doing." Supervision records were not kept in individual files but in a central folder, so it was difficult to identify how frequently staff were supervised. The provider showed us a supervision list, which identified a programme of planned supervision from July 2016 to September 2016.

Staff did not always receive the support and training they needed to carry out their role effectively.
This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We looked at what consideration the service gave to the Mental Capacity Act 2005 (MCA) and checked whether the service was working within the principles of the legislation. The 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.

The service provided care and support to people who sometimes lacked capacity to make certain decisions for themselves. However, we did not see any assessments in relation to a person's capacity to make their own decisions, where this may affect their health and wellbeing especially in relation to medicines and identified risks. We spoke to the quality manager about this and they told us that the local authority did mental capacity assessments and best interest decisions. People or their representatives signed their care plans to indicate that they provided consent to their care being provided by the agency. We viewed records and saw that other professionals were contacted on behalf of people who lacked capacity.

Staff we spoke to had a good understanding of the MCA, one staff member told us, "I get their agreement, or talk to family, the social worker or the office." Another member of staff told us, "For example, I am out shopping for a client today, I sat down with him and he told me what he wanted, we made a list together and I went out to get what he wanted."

Care records demonstrated that there was involvement with healthcare professionals. For example, a speech and language therapist (SALT) had visited one person after concerns were identified. Another person was visited by an occupational therapist that provided the person with a hoist after staff had identified concerns about the person's mobility. We saw examples on care notes of concerns being reported and followed up appropriately, such as health concerns being reported to the GP or District Nurses. We saw that people's needs were assessed and recorded and information about them was available for staff to follow at the person's home.

Some people were supported with their meals. People made positive comments about this. One person said, "Yes they are very good. They get me out of bed for lunch as well and put me back before they go when I want to. They give me my meals on time, as I need them on time because I am diabetic. They have to do everything for me because I can't do anything myself I'm too unwell." Another person said, "They get my food, but they always ask what I would like."

Requires Improvement

Is the service caring?

Our findings

People told us that generally, that staff were kind and knew how to support them. However, some of the feedback we received from people was about the lack of continuity of staff. One person told us, "I have two carers and at least one of them will be a regular, I have overnight care and have the same person for the whole week." Another person told us that they were supported by a regular carer who they described as, "Lovely" but told us the others that come are not so thorough.

A relative told us, "They do try and make things right. I just want continuity of carers. [Named] has lots of different carers four times a day. Two of them each visit, having so many different ones can be frustrating."

People using the service told us the staff were kind and caring. Their comments included, "They do an unbelievable job. We couldn't survive without them." and "Yes, most are good, occasional slow one." A relative said the staff were, "Very helpful, as I like things done in a particular way.". Another relative told us, "[Named] likes to do things for them self, wash themselves, our regular carer is very patient and allows them time to do it." Another relative that we spoke to on the phone told us, "The staff are very well trained, very conscientious, very dedicated." Before our phone call ended the member of staff called from downstairs asking if they could prepare anything for them while they were making [relatives] lunch. They responded that they would eat later and if [carer] could just prepare some fresh vegetables that would be fine.

People told us their privacy was respected. One person commented that the staff were, "Very respectful and polite." Another person told us, "They always explain what they are doing and ask me. They cover me up when washing me."

Staff described the different ways they respected people's privacy and dignity. One staff member told us, "It all depends, close doors and draw curtains, and I would use towels to cover people."

Most people told us there was always sufficient time made available for the staff to be able to carry out care and support in an unrushed manner. One person told us, "No I am never rushed. Sometimes they come at the same time as the district nurse who comes to change my dressings for my bed sore. They are really good and wait for the nurse to finish and stay longer to get things done if needed."

People told us they had been asked and were listened to about how they wished for their care to be provided. They told us their care plans, which were kept in their home, were read by staff when they visited a person so they knew how to provide care for that person. One person said, " "When I need to get up or down in the shower my regular carer puts their hand on my back, just knowing it's there gives me confidence." Another person said, "They do what I ask."

Records showed that people, and where appropriate relatives had been involved in their care planning and they had agreed with the contents. Reviews were undertaken and where people's needs or preferences had changed these were reflected in their records.

The staff we spoke with had a good knowledge of people's needs and were able to explain people's preferences and daily routines, likes and dislikes.

Requires Improvement

Is the service responsive?

Our findings

When we asked people and their relatives if they knew how to complain, they told us they did. One person said, "I would go to the office." One relative told us they were totally confident they could raise any concerns. They explained. "We set up a very good working relationship from the start of the service and they had good communication. An open relationship, I discuss with them and they discuss with us,"

We saw that people had copies of the complaints policy and procedure in their records and this had details of contact numbers and what people should do if they wished to log a complaint. However, at our last inspection in September 2015 we saw concerns were not formally logged as complaints, which meant that people did not always get a clear outcome or closure. At this inspection we also identified concerns that were not logged as complaints and this meant people had still not received an acknowledgment or outcome. One person told us, "I don't always know who is coming, they don't phone and let me know, I complained about this too but it hasn't made any difference. "One complaint that was logged included information that should have been reported to the local authority as a safeguarding concern. When we discussed this with the provider, they told us this would be reported.

There was not an effective system in place to deal with people's complaints and information was not used as an opportunity to learn and improve the service. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service provided personal care based on each individuals needs and preferences. Some people needed full support with all their personal care needs whereas others were more independent and only needed a few hours support each day. People's care needs had been assessed before receiving the service, which helped to ensure the service was able to meet their needs.

The assessments and care plans we saw showed that people had been consulted and included in their care planning. There was an assessment completed by the person concerned, which outlined their care needs and included any individual care requests. The care plans we saw included a breakdown of each visit and what care had been agreed.

People's care needs were reviewed if changes were required by the person or their individual circumstances changed. One person told us, "I was involved with a review of the care plan with [named manager]." Another person told us, "They often come out and ask how care is and watch the staff."

People had the choice to decide what they wanted staff to do and how staff supported them. We observed this during our inspection and a visit to a person's home. One person was moving house and staff were providing support. The person told us that staff had been very helpful including helping her to bid for suitable properties. This person told us, "My carers are fabulous; I wished they were here all day and I look forward to them coming."

Requires Improvement

Is the service well-led?

Our findings

The service had a quality auditing system in place, but this was not robust enough to identify areas where improvements were required. We viewed a quality audit that recorded an audit period from 1 January 2016 to 31 March 2016, this audit mainly focused on people's care files and looked at medication administration charts, food charts, turning charts, financial forms and incident reports. The audit did not contain any detail only recorded either yes or no in boxes under the forms, in the areas where the auditor had ticked no, there were no action points or plans recorded to address the shortfalls identified in the audit.

The provider was aware of some of the concerns that we had raised at the inspection but did not have the appropriate systems in place to accurately collect, record and analyse the information to take appropriate action.

The checks in place to ensure that staff were supporting people correctly with their medicines were not effective. The acting manager told us the Medicine Administration Records (MARs) were in people's homes and were not brought to the office until the end of the month.

Given the concerns noted during our inspection, this meant that the manager was not always proactive in identifying and resolving shortcomings in the service. For example, people did not always receive their care and support as planned as staff had missed some people's calls and did not always spend the agreed time on the calls. The service had failed to identify gaps in recording and reporting that we found during the inspection, such as medication errors, shortfalls in supervision records, training and recruitment processes and failed to take action to ensure these were completed accurately in the future.

The provider's systems to monitor and assess the quality of service provision were not effective.
This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following a recent visit from the local authority in June 2016, it was identified that safeguarding incidents had not been reported following the provider's own policy or to meet the safeguarding legal requirements of the local authority. Concerns included people's personal care needs not being met and people not receiving their medicines at the prescribed times. We found the local authority had temporarily suspended new placements to the service because they had concerns about the service being provided

We checked our systems to confirm if the provider had informed the Commission of the concerns that had been raised and found that no statutory notifications had been received by the Commission related to the safeguarding's that had been identified by the Local Authority.

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 registered provider had failed in their duties to ensure they met their legal obligations in reporting to the Care Quality Commission all safeguarding incidents which had occurred at the home

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not an effective system in place to deal with people's complaints and information was not used as an opportunity to learn and improve the service

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems to monitor and assess the quality of service provision were not effective

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive the support and training they needed to carry out their role effectively.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use the service were not protected from the risks of unsafe care because medication was not always managed safely.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use the service were not protected from the risks of unsafe care because the recruitment procedures were not adequate. Regulation 19(3)

The enforcement action we took:

Warning notice