St Martha's at Home

St Martha's at Home

Inspection report

16-17 Thornhill Park
Sunderland
Tyne and Wear
SR2 7LA
Tel: 0191 565 6443

Date of inspection visit: 8 and 20 January 2015
Date of publication: 15/05/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place over two days. The first visit was on 8 January 2015 and was unannounced. Another visit was made on 20 January 2015 on that day the provider knew we would return.

St Martha's at Home is registered to provide personal care to people in their own homes. At the time of our inspection they were 76 people using the service.

We last inspected the service in January 2014. At that inspection we found the service was meeting all the regulations that we inspected.

No registered manager was in place at the time of our inspection. The manager advised us they had applied to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Summary of findings

The provider had not undertaken the necessary checks to ensure staff were suitable to work with vulnerable people. Staff we spoke to were not aware of safeguarding procedures and had not received any training on this subject.

People's risk assessments were not regularly reviewed therefore we could not be sure they were an accurate reflection of people's risk and needs.

We found care plans contained little personalised information about the person and their preferences. We saw care plans were not up to date and did not reflect a person's current needs.

People told us they did not have any complaints about the service and all said they would contact the office if any arose.

Training records were not up to date and staff did not receive regular supervisions and appraisals, which meant that staff were not properly supported to provide care to people who used the service.

We were told by people using the service and their relatives that most of their health care appointments were arranged by themselves or their relatives. One service user told us, "If I'm poorly the girls get the Doctor for me and always look after me".

People told us that care workers were caring and compassionate. One person said, "Staff are very caring." Another told us, "My carer is excellent, we have a lovely relationship".

People told us that they had very little communication from the staff in the office. Another commented, "I never get the same person to speak to when I ring the office; they have not been out to see me for a long time".

Staff told us they gave people privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain the person's safety, for example if they were at risk of falls.

The provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

We found policies and procedures relating to the running of the service had not been reviewed and maintained to ensure that staff had access to up to date information and guidance.

The manager told us they had introduced a new memo system to improve the communication with staff.

During our inspection we identified five breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 the provider had not undertaken the necessary recruitment checks to ensure staff were suitable to work with vulnerable people.

We found staff had not received training on safeguarding and were not aware of safeguarding procedures.

The manager told us they ensure staff with the appropriate skills are in placed to deliver each person's individual package of care.

We found Information about people's medication and support required was not recorded in care plans.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the provider did not have an effective system in place to ensure staff received appropriate training.

Staff were not receiving regular supervision and appraisals.

People were supported to eat and drink according to their plan of care.

Is the service caring?

Good

The service was caring

Staff told us they gave people privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain the person's safety, for example if they were at risk of falls.

People told us that they had very little communication from the staff in the office.

The management regularly allocated the same care workers with people who used the service to maintain continuity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained little personalised information about the person and their preferences.

We found care plans were not up to date and did not reflect a person's current needs.

People told us they did not have any complaints about the service and all said they would contact the office if any arose.

Summary of findings

Is the service well-led?

The service was not always well-led.

The provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

The provider did not ensure statutory notifications had been completed and sent to the Commission in accordance with legal requirements.

People told us there was a lack of involvement from management (i.e. visits) and all communication was through the carers or office staff.

Requires Improvement

St Martha's at Home

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 over two days. The first visit was on 8 January 2015 and was unannounced. Another visit was made on 20 January 2015 on that day the provider knew we would return.

On 8 January 2015 one inspector spoke with the provider about concerns raised by members of the public and gathered contact details of staff and people who used the service.

On 14 and 15 January 2015 an expert by experience conducted telephone interviews with four people who used the service and three of their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

On 19 January 2015 one inspector visited four people who used the services in their own homes.

Before the inspection, we reviewed the information we held about the service. We gathered information from Sunderland Council Safeguarding, Sunderland Council Commissioners and Sunderland CCG.

We looked at five care plans for people who used the service. We examined five staff records including recruitment, supervision and training records and various records about how the service was managed.

We spoke to eight people who use the service, three of their relatives, one care co-ordinator, four care workers and a manager.

Inadequate

Is the service safe?

Our findings

We found the provider did not carry out appropriate checks to ensure staff were suitable to work with vulnerable adults. We looked at the Recruitment and Selection Policy and Procedure dated 13 October 2010. This detailed the processes to be taken before new staff started their employment. The policy stated, 'All candidates will be required to undergo Criminal Records Bureau and ISA checks' and 'A minimum of two referees will be contacted.'

We examined five staff records. We found one recruitment record did not hold or record that reference checks had been received and included a Disclosure and Barring Service (DBS) check for a previous employer dated ten months prior to starting with the provider. We noted no further DBS checks had been conducted for the staff member's current employment. We saw another record held a DBS certificate dated after the start date for employment. DBS checks, replace the Criminal Records Bureau and ISA checks. DBS checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults.

This meant the provider had not undertaken the necessary checks to ensure staff were suitable to work with vulnerable people.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We viewed documentation relating to safeguarding concerns. The manager advised two safeguarding concerns had been brought to her attention in 2014. However we saw the information was recorded within the complaints file.

We asked how safeguarding concerns were referred to the local authority safeguarding team. The manager advised that she would always ring them. There were no details within the complaints file of any person contacted nor any advice received in relation to the two safeguarding incidents.

One of the safeguarding incidents had been investigated by the manager and was found to be substantiated. The manager confirmed that no other records were available which contained this information.

We asked what measures were in place for the monitoring of safeguarding concerns. The manager advised that no process was in place to capture the data for analysis. This meant the current arrangement did not protect people using the service from the risk of harm.

We spoke to staff about safeguarding procedures. On care worker told us, "I don't know what to do, I would tell a manager". Another said, "I have had no safeguarding training whilst at St Martha's". We viewed the computerised training records. These showed that no new starters had received any form of safeguarding training. The manager confirmed the records were up to date. The manager informed us that it was her intent for safeguarding training to be rolled out in the near future. The manager advised us that all new staff received a staff handbook on induction which included information on the safeguarding procedure and responsibilities of senior staff and care workers for reporting abuse.

We asked the manager about making safeguarding notifications to the CQC; she stated that she was not aware of the requirement. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We reviewed five people's care records held in the office and four care records in people's own homes. Care records included information and guidance for staff about how people's needs should be met. The files also included falls risk assessments, medication and moving and handling assessments. We found four people's care records recorded the last review dates between April and May 2013. We asked the manager what system were in place to ensure risk assessments were reviewed. The manager stated that nothing was in place.

This meant that risk assessments were not current and staff would find it difficult to gain suitable guidance about a person's care by reading them.

We asked people about their medicines. People told us they were happy to administer their own medication. Some used NOMAD packs for their medicines and others described how care workers would give them a little help with their medicines, however we noted there were no records to support the safe administration. NOMAD systems allow various medication to be split up into separate compartments for different days allowing a person to manage their own medication more effectively.

Inadequate

Is the service safe?

We considered that further improvements were required to ensure the safe management of medicines by means of the making of appropriate arrangements for the recording of medicines.

People told us they happy with their care workers and the service they received. One person told us, "I like to have my regular girls as they know what I like and don't like, new people don't give me the care the way I like it". One relative said, "My mam prefers older care workers for her personal care".

The manager told us they consult with the person when developing their package of care. They advised they ensure staff with the appropriate skills are in placed to deliver each person's individual package. We saw staffing levels were adjusted according to the needs of people using the service. One person told us, "I am going to reduce my hours then in spring I will increase, I just contact the office to arrange".

People told us, "I've never had missed calls", another said, "if someone is late I ring the office and they get someone out straight away". A co-ordinator told us care workers advised her of any issues with shifts and staff are always happy to fit in. One care worker told "We work very well together and help each other out, and cover for each other to make sure service users are visited".

Requires Improvement

Is the service effective?

Our findings

We found that training and development was not up to date. We looked at staff training records for all staff and viewed an electronic training matrix. This showed the last training for staff had taken place in September 2013. We asked the manager what training was available for staff. They advised that they were aware of issues in training and had recently employed a new HR manager to deal with this matter.

We spoke to staff regarding training; one care worker told us, "I have not had any training at St Martha's at Home". Another advised, "Yes I received training when I first started at St Martha's". Another care worker said, "I'm not qualified for what I'm doing. I've pushed for training but nothing has happened".

This meant that we were not able to confirm that staff had the appropriate skills and knowledge to ensure people's needs were met.

Staff told us and lack of records confirmed that staff were not receiving regular supervision and appraisal. Supervision and appraisal is important so staff have an opportunity to discuss the support, training and development they need to fulfil their caring role.

We examined five staff records, we saw two records did not hold information on supervisions and one record showed the last supervision was held in April 2014. None of the five held details of any appraisals having been conducted. One care worker told us, "No one has mentioned about appraisals or supervisions". Another said, "I have never had an appraisal". The manager told us the new HR manager was in the process of evaluating all areas of recruitment plus training and development.

We found the registered person did not have an effective system in place to ensure staff received receiving appropriate training and development. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We viewed the minutes from a staff meeting that had taken place, these included details of the new mobile call logging system. One care worker confirmed she had attended this team meeting which was held sometime at the end of last year. The manager told us she intended to implement an on-going programme of team meetings.

We observed care workers preparing food for a person in their own home at lunch time. They asked what the person wanted and prepared it for them; they placed the meal close to hand and ensured the person had everything they wished close by. Staff confirmed before they left their visit that the person was comfortable and had access to food and a drink.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals.

The manager advised that no one had been assessed as lacking capacity. They told us management had received training in MCA and DoLS and were able to articulate the principles behind them.

We were told by people using the service and their relatives that most of their health care appointments were arranged by themselves or their relatives. One service user told us, "If I'm poorly the girls get the Doctor for me and always look after me".

Good

Is the service caring?

Our findings

People told us that care workers were caring and compassionate. One person said, “Staff are very caring.” Another told us, “My carer is excellent, we have a lovely relationship”. A relative told us, “We are very happy with the service” and “The carers are lovely, they go the extra mile and always ask if there is anything else they can do for [relative]”.

People told us about the importance of having one or two regular carers. One person told us, “I don’t always get the girls who know me, and then it can be difficult”. A coordinator advised us that all attempts are made to ensure that the same care workers attend the same people.

A care worker confirmed that management tried to regularly allocate the same care workers with people who used the service. A care worker told us, “This is good as we get to know the people and how best to help them”.

We asked people who used the service if care workers spent the allocated time with them. One person said, “They [care workers] are very busy, but they always make time for a chat”. Another person we spoke to advised us, “I recently waited two hours for my carer to arrive and had to phone in, they sent someone straight away”. Other people told us that they have never had a missed call.

We asked people who used the service if care workers treated them with respect and dignity. One person told us, “I have no concerns or problems at all” and another person commented, “The carers are trustworthy and very caring”. However, one person told us, “I don’t like it when they call me ‘darling’ I think it is disrespectful” and a relative said, “Sometimes they (carers) are too young – my [relative] prefers older carers for her personal care”.

We observed a friendly and happy encounter between care workers and a person receiving care. The person told us, “They (care workers) are lovely and they know me”. Care workers were sensitive when assisting the person and maintained their dignity. Whilst preparing lunch the care worker chatted to the person about the previous night’s television. Before leaving they ensured the person had everything they wanted and it was in close to hand.

Staff told us they gave people privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain the person’s safety, for example if they were at risk of falls.

Three people told us that they had very little communication from the staff in the office. Another commented, “I never get the same person to speak to when I ring the office; they have not been out to see me for a long time”.

Requires Improvement

Is the service responsive?

Our findings

We found care plans did not contain sufficient detail and reference people's needs. We looked at five people's care plans held in the office and four care records in people's own homes and saw these contained little personalised information about the person and their preferences.

We found care plans were not up to date and did not reflect a person's current needs. For example, we saw one person's care plan did not have the personal history, daily routine with duties to be carried out and falls risk assessment completed. In another we found moving and handling assessments were not completed for a person with mobility needs.

We found four people's care plans recorded the last review dates between April and May 2013. We asked the manager what system was in place to ensure that care plans were reviewed. They stated that nothing was in place and declared, "It's embarrassing. All the care plans need looking at".

We asked people if they were involved in planning their own care. One person told us, "I have just had a review; I am still waiting for a copy of it though". A relative said, "My mum's care plan is updated regularly". However another person told us, "I have a care plan but it has not been updated for quite a while, I have not had a visit from management in over a year".

This meant staff did not have access to up to date information about how people should be supported and cared for. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people what they would do if they had a concern or complaint about the service they received. People told us they did not have any complaints about the service and all said they would contact the office if any arose.

We viewed the complaints, comments and compliments policy it was last reviewed in October 2010. The manager told us they were in the process of reviewing all policies and procedures.

We looked at complaints received and found these were of a safeguarding nature. We saw records were completed and logged. Records included a description of the incident and the action taken. We asked the manager if an analysis was carried out to identify any trends or contributory factors which may require investigation. They advised no such audit was in place. This meant that the service was failing to conduct an analysis of complaints, in order to improve the care being provided to people who use the service.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we identified areas of concern. We found that the provider did not have effective systems in place to identify these issues and other areas of concern.

We asked the manager for evidence of specific audits or quality checks including checks of staff training records, staff recruitment records, complaints and safeguarding. We were not provided with any evidence that these were regularly undertaken. We asked the manager to tell us about the audit systems currently in place. They said no audits were carried out and there were no formal quality assurance processes in place. This meant that the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We examined all the policies and procedures relating to the running of the service. We found that most of these had not been reviewed and maintained to ensure that staff had access to up to date information and guidance. For example, the policies we viewed had been last reviewed between 2009 to 2012.

We asked people for their thoughts about the service they receive. People told us, “The management ring me now and then, they are very pleasant”. Another said, “I don’t know who the management are, I speak to a different person every time I ring”. Three of the people we visited told us there was a lack of involvement from management (i.e. visits) and all communication was through the carers or office staff. One staff member told us, “I feel very supported in my role”. Whereas another said, “I don’t know who is in charge”.

Staff did not have structured opportunities to share information and give their views about people’s care. The provider did not hold regular team meetings. We asked the manager for details of any staff meetings that had taken place. They advised one had taking place recently.

We viewed the minutes from a staff meeting, these included details of the new mobile call logging system. One care worker confirmed she had attended this team meeting which was held sometime at the end of last year. The manager advised us she intended to implement an on-going programme of team meetings. The manager also told us they had introduced a new memo system to improve the communication with staff.

We looked at what the provider did to seek people's views about the quality of the service. We asked the manager if the service conducted any surveys or how they ensured people and their relatives were involved in the development of the service. They told us client surveys were sent to people who use the service. The manager told us the information is collated if any issues are identified and action plans are put in place. The manager showed us a number of returned surveys from the previous year. People we spoke to told us that at some point during their use of the service they have received a questionnaire.

We asked the manager for confirmation that statutory notifications been completed and then sent to the Commission in accordance with regulatory requirements. The manager stated they were not aware of the requirement to inform the Commission. They confirmed there was no monitoring system in place to ensure that statutory notifications were being completed and submitted when required. We are dealing with this matter separately from the inspection process.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Appropriate recruitment checks were not always undertaken before staff started to work at the service to ensure staff were suitable to work with vulnerable people.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person did not have suitable arrangements in place to identify, prevent and investigate any safeguarding allegations.

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider did not have suitable arrangements in place to ensure staff were appropriately supported to enable them to deliver care and treatment to people because they were not receiving necessary training.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who used the service were not always protected against the risks of inappropriate care because accurate records in relation to their care were not in place.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider did not have an effective system in place to regularly asses and monitor the quality of the service provided.**

The enforcement action we took:
A warning notice was issued.