S & M Healthcare Ltd

S & M Healthcare

Inspection report

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11 December 2018

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service:
S & M Healthcare is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our inspection the service was providing personal care to 28 people.

People's experience of using this service:

At our last inspection we identified a breach of regulation relating to recruitment practices which were not robust and placed people at risk. At this inspection we found improvements in recruitment practices but identified other areas of the service which required some improvement.

Systems did not alert the registered manager quickly when calls were missed. This meant some people had gone without their care visits. Although people told us that there had been missed calls, it was acknowledged that things had improved in recent weeks. People's experience was mixed. One person who used the service commented, "They get somebody in an emergency. Not always the best somebody, but somebody...I think if I were to rate them I don't think they'd be outstanding but they're pretty good."

The registered manager carried out person centred assessments of people's needs and preferences. However, sometimes the information from these assessments was not placed promptly in people's homes so that staff could refer to it. Some aspects of the care plans for people with complex health conditions needed more detail to help staff provide safe care. The registered manager regularly reviewed care plans but did not always update care plans with people's changing needs promptly. Staff were not always clear about people's needs as a result.

Staff were trained to give people their medicines but we found some errors with the medication administration records. Staff received a structured induction and other training to help them carry out their roles. Some important training had not been given to staff which could have placed people at risk.

Informal support from the manager was very good, although structured, regular support was not in place for all staff. The registered manager was addressing this by developing the role of one member of staff to help carry out spot checks and supervisions to monitor the quality of the service.

People were very positive about the kindness and caring nature of the staff, with some being singled out for particular praise.

The provider regularly asked for feedback from the people who used the service and addressed people's informal concerns well. Formal complaints were responded to in a timely manner and to people's satisfaction.

Staff understood their responsibilities with regard to keeping people safe from abuse and knew how to raise

concerns if they needed to.

People, or their relatives consented to their care and were able to express their preferences with regard to how their care was delivered. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice

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

Rating at last inspection:
At the last comprehensive inspection the service was rated Good (report published 21 April 2016). This inspection was followed by a focused inspection which rated the key question of Safe as Requires Improvement and the key question of Well-Led as Good. This report was published on 5 October 2017 but did not change the overall rating of Good. At this inspection we found the overall rating to change to Requires Improvement overall and now the four key questions of Safe, Effective, Responsive and Well-Led have all been individually rated as Requires Improvement.

Why we inspected:
This inspection was carried out as part of our regulatory schedule. The inspection was brought forward due to an increase in the number of concerns about missed calls and staffing levels.

Please see the action we have told the provider to take section towards the end of the report.

Follow up:
We have issued a requirement notice for the breach of regulation. We will require the provider to send us an action plan detailing how they will make the necessary changes and in what timeframe they intend to do this. We will carry out another inspection in the future to check if the improvements have been made and sustained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

S & M Healthcare

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 team consisted of one inspector.

Service and service type:
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults in the Watton, Thetford and Haverhill areas. At the time of our inspection 28 people were using the service.

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

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

Inspection site visit activity started on 30 November 2018 and ended on 11 December 2018. It included visits and telephone calls to people who used the service, their relatives and to staff. We visited the office location on 30 November 2018 to see the manager and office staff and to review records, policies and procedures. We also carried out a final visit to the office on 11 December 2018 to provide and discuss our feedback with the registered manager.

What we did:
We used the information the provider sent us in the Provider Information Return (PIR). This is information

providers send to us to give some key information about the service, what the service does well and improvements they plan to make. We also looked at other information we held about the service including notifications which relate to significant events the service is required to tell us about. We also requested feedback from the local authority quality monitoring team. This information helped us to target our inspection activity and highlight where to focus our attention.

During the inspection we spoke with five people who used the service, four relatives, the director, the registered manager, six members of the care staff and an administrator. We reviewed six care plans, five medication administration records and looked at three staff files which documented recruitment procedures and ongoing support for staff. We also reviewed rotas, staff training records and other documents relating to the safety and quality of the service.

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.

Assessing risk, safety monitoring and management; Using medicines safely

● The registered manager had assessed potential risks to people's safety and welfare and documented these in their care plans. However, information was not always current and staff did not always have the information they needed to keep people safe. For example, one person's care plan had not been put in place until several weeks after they had begun to receive a service. They had a condition which affected their breathing and used oxygen but there was no specific information about this to guide staff. They told us that if they became unwell staff would need to check their oxygen levels but there was no guidance for staff to follow and staff told us they did not know how to do this.
● Staff confirmed that sometimes information about how to provide safe care and support was not available to them when they first visited a person. One staff member told us, "When we go in it is kind of blind as notes on the [electronic record] are quite basic. Until a folder goes in, sometimes we are blind for a couple of weeks." This has the potential to place people at risk.
●Staff worked initially from local authority assessments of people's needs or hospital discharge notes for days or even weeks, before the service's own assessment was made available in people's homes. This meant that although staff had some information about people's needs, it was not detailed enough to guide them when they first started to provide care for people with complex needs.
● Staff received training in administering medicines but their practice was not routinely spot checked. Some staff did not demonstrate an in depth understanding of people's medicines and documentation needed to contain more information to help and guide staff and ensure people were not placed at risk. Some medication administration records had gaps which meant that we could not be fully assured that people had received their medicines as prescribed.
●We noted that one person was receiving a medicine alongside others when it should have been administered on its own. We brought this to the attention of the senior carer who told us they would discuss with the manager.
●There was limited information about people's medicines and staff did not know what they were giving to people. There were no protocols in place to guide staff about giving medicines which people only took occasionally, such as those for intermittent pain. Staff asked people about their pain relief but there was no information about how much to give or when staff should contact a GP or healthcare professional for a medication review for example.
●People told us staff supported them to take their medicines. One person said, "They watch me take my medicines and make sure I've had them and take them properly."

We found when people were new to the service or when their circumstances changed the provider did not

always provide or update information promptly on the risks to people's health and welfare and how to mitigate them. This put people at risk of not receiving the support they needed to keep them safe.

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

Staffing and recruitment

● The provider had reviewed their recruitment procedures following our last inspection when we identified a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to check that staff were of good character and had the required skills and experience before they worked independently. At this inspection we found significant improvements in the recruitment and induction process. However, one person's references had not been robustly checked which could have placed people at increased risk.

●We received mixed feedback about the availability of staff. People told us that staffing levels were sometimes a problem. This had been a particular concern in the months leading up to our inspection. Six people told us they had had occasional missed calls, with so e people experiencing this several times in recent months. One person said, "It has improved. [Missed calls] are not as regular. The first couple of weeks it was horrendous. I didn't know who was going to turn up and often they didn't." Another person commented, "Just once they never came and I never had a hot meal."

● However, people also reflected that things had improved recently. One person said, "They do turn up now." Another person confirmed, "They are really good – on time and never late." The registered manager acknowledged that a period of staff sickness had put the service under pressure but things had improved in recent weeks.

Systems and processes to safeguard people from the risk of abuse

● The provider had effective systems in place to safeguard people from different kinds of abuse. All the staff we spoke with were able to tell us how to spot the signs and symptoms which might indicate that someone was being abused. Staff were able to tell us how they would report abuse if they suspected it and received training as part of their induction, although we noted that two staff had not yet undertaken this training.

● The registered manager had raised safeguarding concerns appropriately with the local authority and had notified CQC when they suspected a person might be being abused.

Preventing and controlling infection

●Staff used personal protective equipment such as aprons and gloves to reduce the risk and spread of infection. Staff had received training in infection control, although three staff were yet to undertake this training.

Learning lessons when things go wrong

● The registered manager demonstrated a willingness to analyse incidents and we saw that investigations had taken place following incidents of poor practice. We noted that the registered manager had changed and tightened procedures where they felt these had contributed to poor outcomes for people.

●Accidents and incidents were analysed and we saw that when a particular incident happened which placed staff at risk, action was taken to ensure a similar incident did not happen to another staff member.

Requires Improvement

Is the service effective?

Our findings

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

The effectiveness of people's care, treatment and support was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Staff told us they worked from local authority assessments or hospital discharge notes initially until the registered manager was able to draw up the service's own assessment of people's needs. These initial assessments were not always detailed enough to guide staff effectively.
- The provider assessed people's needs in line with their preferences. Care plans we reviewed in the office showed some detailed assessments of people's everyday needs and information on how staff should meet them. Care plans viewed in people's homes did not demonstrated that all the people who used the service had had their needs comprehensively assessed.
- The registered manager reviewed care plans regularly once they were in place.

Staff support: induction, training, skills and experience

- We received mixed feedback about the skills and experience of staff. One person said, "I am confident in their training…I can't fault them in any way." Other people told us that they felt some staff did not know what was expected of them. One person told us that a member of staff had not been trained to carry out one aspect of their relative's care. They told us,, "A lady we had never met before turned up and was horrified….she told us she had never done that before"
- New staff received an induction and undertook the Care Certificate which sets out a nationally recognised set of minimum standards for staff new to care. We noted that a lot of training was delivered in a short space of time which could be challenging for staff new to care. Spot checks of staff practice were not routine, although a staff member had been employed to support the manager to do this more effectively.
- New staff told us they shadowed more experienced staff and people who used the service confirmed this. One person commented, "We have had some excellent carers. The new ones watch the others."
- Staff received training to help them carry out their role but some staff told us they would like more face to face training. The registered manager told us this was planned and were converting a training room at the office to do this. One staff member, new to care, praised the training they had received about dementia and talked very knowledgeably about people living with this condition. They told us they would not have been able to do this prior to their training at S & M Healthcare.

Supporting people to eat and drink enough to maintain a balanced diet

- Staff received training in diet and nutrition and supported people at risk of losing weight as well as bariatric clients who required support to reduce their weight.
- Care plans identified people's needs with regard to their eating and drinking. We observed staff respecting people's wishes and preferences when supporting them with their meals. We noted that staff always made sure people had access to food and drink before they left and went on to their next call.

Staff working with other agencies to provide consistent, effective, timely care

●The provider worked in partnership with social workers, district nurses, GPs and other healthcare professionals to support people's health and care needs.

●Some staff worked alongside staff from other agencies who acted as live-in carers for example. Staff and people who used the service told us this worked well.

Supporting people to live healthier lives, access healthcare services and support

●Staff supported people's basic healthcare needs and helped co-ordinate additional support by arranging GP appointments for example.

●Information about how to care for people's complex health needs and specific training was not promptly available in all cases. This meant there was a risk that people's health needs would not be met.

●The registered manager had taken prompt and robust action to address an issue when a staff member had not understood the healthcare needs relating to a person's delicate skin and had caused them injury. The registered manager had met with the staff member, provided additional training and included extra information in the care plan for all staff to follow.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA.

●Care plans documented people's consent to their care and treatment but sometimes incorrect people had signed them. For example, one person was assessed as having capacity to make their own decisions but their relative had signed their care plan and this was not explained. We fed this back to the registered manager who told us they would review their records.

● Assessments of people's capacity to consent to care and treatment were not always present in people's care plans. This meant there was a risk that people who could provide consent to aspects of their care were not being given the opportunity to do so.

●Staff demonstrated that they knew how to ensure people were involved in decisions about their day to day care and respected their choices. Staff had received training in MCA and had an understanding of people's rights to refuse care and treatment.

Good

Is the service caring?

Our findings

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

People were supported and treated with dignity and respect; and involved as partners in their care.

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

- Staff were kind and showed compassion towards people. We observed staff taking time to chat to people and make sure they were comfortable before they moved on to their next call. A person who used the service commented, "I get the same people mostly. I don't have any difficulties. They are all very kind."
- Staff had a laugh and a joke with people who enjoyed this. One relative told us, "They have a joke and a sing song with [my relative]."
- People told us they had opportunities to express their views about their care. The registered manager held meetings with people regularly. One person said, "The co-ordinator reviewed [my care plan] after three months… and then again a month ago and then yesterday again." They confirmed that their care plan reflected their current needs and wishes.
- The provider sent regular surveys out to people to ask for their views about their care and acted on the feedback they received.

Respecting and promoting people's privacy, dignity and independence

- People told us they were treated with dignity and respect. One relative commented, "Generally speaking it's ok. I wish they'd slow down and listen to [my relative] a bit more. Some carers are wonderful though."
- We observed staff promoting people's independence and needs relating to people's independence were recorded in care plans. One person had previously had certain care needs met by staff but had decided they wanted to do these for themselves now. The staff member told us, "[They are] very independent. We used to do [person's] personal care but [they] wanted to do it [themselves]."
- We observed that staff made a flask of hot tea for one person and made sure that the lid was on but not too tight that the person would not have the strength to open it themselves. The person was keen to point this small detail out to us as it was very important to them as they were unable to get up to make their own hot drinks.
- One person told us they wanted to change the times of an evening call for their relative as staff came too early to put them to bed. They felt this compromised their dignity and had a negative impact on family life. The provider had not yet been able to ensure a later visit for them but told us they hoped to do so in the future.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

End of life care and support

● Care plans contained some information about people's end of life wishes. Nobody was receiving active end of life care at the time of our inspection but staff had provided this kind of care in the past.

●Some staff had received end of life training and told us they would be confident in delivering this care. However, two staff commented that some training, including end of life training might not be enough to equip new staff to carry out this sensitive care role.

●Records relating to whether a person wished to be actively resuscitated if they had a cardiac arrest were not always easy to find and staff were not clear. Two staff were not able to confirm if a person had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place. One staff member said, "It's usually written down. Experienced carers know where to look." We asked one carer if the person they were caring for had a DNACPR in place. They said, "I was going to ask. I don't know." This meant that there was a risk of this carer not complying with the person's wishes should they go into cardiac arrest.

We recommend that the service ensures that people's DNACPR status is clearly identified in their care plans and that all staff are aware of where to find this important information.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

●Care plans contained information about how to meet people's individual needs and preferences. As stated in earlier sections of this report, some plans did not contain enough detail about people's complex need to ensure staff delivered safe and individualised care.

●People told us they were able to contribute to their care plans and felt listened to. One person said, "My [relative] used to shop for me but now we've arranged for them to help me. I absolutely trust them. They listen to me and do what I want."

Improving care quality in response to complaints or concerns

●The manager responded robustly to formal and informal complaints. Informal matters, raised on the telephone or in the regular surveys received a prompt response. One person told us, "They do deal with problems when they arise. I e mail [the registered manager] and [they] respond to me."

●We reviewed four formal complaints which had been made since the last inspection. Each had been investigated and responded to in a timely manner. Where appropriate, action, including disciplinary action, had been taken with individual members of staff. In each case the registered manager ensured that people who had complained were happy with the response. One serious complaint was still being investigated at the time of our inspection but measures had already been taken to reduce the likelihood of a repeat incident.

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. There was a breach of regulation.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility;
●We found a disconnect between some of the registered manager's records and the experience of the staff. Information was not always well communicated to staff.
● Care plans, although detailed and person centred, were not always current and information staff needed to help care and support for people was sometimes delayed or was incomplete.
●The registered manager accepted our feedback on this matter and, by the end of our inspection process, they had begun to review their own procedures. We found the registered manager to be honest about the issues at the service and willing to engage with us.

Continuous learning and improving care;
●The provider had a quality assurance system in place. An annual health and safety audit took place and results were analysed by the registered manager.
● Although a system of spot checks was in place, not all staff had been checked in this way. The registered manager addressed poor performance by individual staff promptly and robustly, but proactive steps, to assess people's performance before issues occurred, could be improved. ●One staff member told us, "[I have] never had any spot checks." Another staff member told us they had received training in moving and handling and administering medicines but had not been observed carrying out any of these tasks in people's homes. We could not be assured that the registered manager had effective oversight of the day to day running of all aspects of the service.
●We discussed this with the registered manager who told us that a member of staff would be taking over some of the spot checks. However, we found that the person concerned did not demonstrate all the knowledge and skills that this role demands, and might themselves require further training and support to carry this role out effectively.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●Surveys sent out to people who used the service were also analysed to see how the service could improve. A comprehensive annual survey was sent out in addition to twice yearly surveys, asking people to rate the service and provide feedback.We noted that where people had rated the service as good the provider had tried to assess how this rating could be improved to excellent. There was a strong focus on people's experience and an understanding of people's individual preferences.
●Staff were not asked for their views in the same way. Regular staff meetings and supervision sessions were

not in place for all, although some staff had received structured support and the induction staff received was comprehensive. The registered manager told us they found it difficult to engage the staff through formal meetings and had tried to support people informally. They told us they would carry out two telephone supervisions and then would require staff to attend a face to face session. This meant there could be a nine month gap between face to face sessions.

●Despite the lack of formal meetings, all the staff we spoke with told us they found the registered manager supportive and ready to listen to them.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager demonstrated an understanding of their role and responsibilities. They had notified CQC appropriately about significant incidents at the service and had been open and transparent with people who used the service, or their relatives, when things went wrong.

● The system to flag up missed calls was not robust as calls were not identified quickly. The registered manager told us that a missed call would not be automatically highlighted on the electronic record. They said that they had arranged the calls so that the first person on the carer's list would be someone who would be able to ring in to the office to let them know that a carer had not turned up.They also told us they had asked the software company to place an alert on the electronic record so office staff would be promptly aware that there was a possible missed call.

● The provider had a business continuity plan which covered how they would continue to provide a service in the event of bad weather or significant staff sickness for example. They had also looked at a new system for ensuring shifts were covered by having one or two carers be paid as 'retained staff' who would be expected to cover shifts at short notice. This demonstrated flexible thinking and was a popular idea with staff.

Working in partnership with others

●There was good partnership working in place and staff were clear about the importance of sharing information with appropriate health and social care professionals.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that they had assessed and mitigated the risks to the health and safety of people who used the service. The provider had also failed to ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) and (g).