Carlton Home Care Ltd

Carlton Home Care

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Our inspection of Carlton Home Care took place between 4 and 8 November 2016. The provider was given 48 hours notice of our intention to inspect the service. This is in line with our current methodology for inspecting domiciliary care agencies.

At the previous inspection in November 2015, we found breaches in staffing, medicines management and good governance. At this inspection we saw some improvements had been made to meet requirements. However, we found further improvements to medicines management and quality assurance systems needed to be made.

Carlton Home Care is a domiciliary care agency based in Shipley, West Yorkshire. At the time of our inspection, the service provided care and support to 52 people living in their own homes.

The service was required to have a registered manager in place. 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. However, the previous manager had left the service before completing the registration process with little notice two weeks prior to our inspection. We saw plans were in place to recruit a new manager and the management team were effectively supporting the service during this time.

Safeguarding mechanisms were in place and staff understood how to keep people safe from harm or abuse. Risk assessments had been undertaken to mitigate risks.

Medicines were not always managed safely with systems not in place to record and monitor some people's medicines.

Incidents were documented with outcomes and action to prevent reoccurrence. However, accident reports were not always completed appropriately.

Staffing levels were reasonable although stretched due to a number of staff recently leaving the service without giving any notice. We saw action was being taken to reduce late or missed calls and the service was actively recruiting new staff.

A recruitment process was in place to help ensure people received their support from staff of suitable character and staff had the necessary training to carry out their duties. A system of staff supervisions and appraisals was in place although some supervisions were out of date.

The service was working within the legal framework of the Mental Capacity Act 2005 (MCA). Staff had received MCA training and the group governance lead understood their legal responsibilities under the Act.

People's needs were assessed and person-centred plans of care drawn up which were reviewed regularly. We saw evidence people's independence was supported wherever possible.

Where people were supported with their diet, care plans outlined people's needs, preferences, likes and dislikes. People were supported with their health care needs.

A complaints procedure was in place although some people thought these had not been addressed effectively by the previous manager.

People told us staff knew them well and supported them in a kind and caring manner.

Some people and staff told us the previous manager had not been approachable and they found it difficult to contact the office. However, they said this situation had recently improved. We found the management team were working hard and willing to look at ways to improve the service.

Although some quality assurance was in place, there was a lack of effective audits of some systems and processes including medicines, incidents/accidents and staff files.

Regular staff meetings were held and quality questionnaires and surveys were sent out to people who used the service, or telephone surveys carried out.

You can see what action we told the provider to take at the back of the full version of the report. We have also asked the provider to send us regular updates to demonstrate action is being taken to address the shortfalls found.

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

Medicines were not always managed in a safe manner.

There were sufficient staff to keep people safe and people felt safe with their care workers.

A robust safeguarding policy was in place and appropriate safeguarding referrals had been made.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff supervisions were not always up to date.

People told us communication from the service had not always been effective. However some people told us this was now improving.

Peoples' needs were assessed and plans of care put into place.

Is the service caring?

Good

The service was caring.

People told us the care they received was good and staff were caring.

People's privacy and dignity was respected by staff.

Staff knew the people they visited including their likes, dislikes and care needs.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and regularly reviewed.

Appropriate person centred plans of care were in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance system in place was not effectively implemented.

People, their relatives and staff told us the management of the service had improved recently.

Surveys were conducted to assess how people felt about the service.

Staff meetings were held regularly.

Carlton Home Care

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 4 and 8 November 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience used had experience of domiciliary care services.

Prior to the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and any statutory notifications the service had sent us. We also contacted the local authority contracts and safeguarding teams and asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made judgements in this report.

During our visit to the provider's office we looked at six care records of people who used the service, some in detail and others to check specific information, five staff recruitment files, training records, medicines records and other records relating to the day to day running of the service. During the inspection we spoke with the governance lead, the operations manager, the clinical lead and a support manager. We spoke on the telephone with 11 people who use the service, five relatives and five members of staff.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe with the care workers who provided their care and support. Comments included, "Oh yes; when they are here no issues for safety", "Oh gosh, definitely do feel safe", "Yes I am happy now. In the past they sent one care worker who I did not feel comfortable with. I am happy now", "Absolutely; very pleased with one care worker", "No issues whatsoever," and, "Yes I do feel safe." Relatives we spoke with agreed, commenting, "I am very happy with how the carer makes my relative feel at ease", "We don't have any issues once they are here," and, "Happy; quite pleased with the care worker who attends to my relative."

Staff we spoke with demonstrated an understanding of safeguarding and how to report concerns, had received safeguarding training and told us they thought people who used the service were safe. A number of safeguarding incidents had occurred within the service, but following these few incidents the service had followed the correct procedure by raising an alert with the local authority and completing a Care Quality Commission notification. From speaking with the management team in place during our inspection we felt confident safeguarding alerts were raised appropriately.

At the last inspection we found that medicines were not being managed safely. At this inspection we found that although some improvements had been made, medicines were still not consistently being managed safely.

People's care plans included guidance for staff to follow such as how people liked to take their medicines. Care records clearly identified any food and drink to avoid when giving medication. For example, we saw one person was not to eat or drink grapefruit products whilst taking a particular medicine.

The governance lead told us only one person received support in the administration of medicines. Other people were self-administering, being supported by family or just required a prompt. However we noted some people's care records indicated they required a prompt but the documented instructions indicated an administration of medicines. For example, one person's records who was identified as requiring a prompt with their medicines informed staff to make sure the time and date of the medicines pot was correct, take the top off the pot, give medicines in the pot to the person explaining what they were because the person could be confused, offer a drink and wait until the person had swallowed the tablets. The service medicines policy for administration of medicines stated, 'If the tablets or capsules are in a monitored dosage pack (dosette box), open the appropriate section and check the correct medications are contained, then hand it directly to the service user.' We discussed this with the governance lead who showed us their communication with the pharmacist who had told them such a prompt was not classed as administration. However, we raised our concerns with the Care Quality Commission medicines management team who stated, 'when a person doesn't take their medicines by themselves and only take them if reminded or assisted by staff then that is more than prompting.' Following our inspection, the governance lead told us they had requested these medicines be re-classed as administered and had issued Medicines Administration Records (MARs) for those people.

We asked for the MAR for a person who received full support with the administering of their medicines. The governance lead could not show us any MAR charts despite informing us the process was for past MARs to be returned to the office to be checked by the manager. The governance lead queried this with staff during the inspection and staff said they had not been using MAR charts since June 2016. This meant medicines were not able to be accounted for and had not been recorded in line with good practice guidance. The provider's policy on medicines had been updated following the last inspection and indicated a list of the person's medicines should be present when prompting. We were not shown a list of medicines for this person.

Therefore, although some work had taken place since the last inspection regarding the safe administration of medicines, we identified further concerns at this inspection.

This was a Breach of Regulation 12 (1) (2) (g), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested regular updates from the provider to demonstrate action taken to address the shortfalls found.

Assessments of people's environment were carried out in their homes before staff provided care. This assessment included identifying potential hazards such as those associated with uneven flooring or the use of equipment. Guidance was provided on the actions that staff should take to reduce risks. There were clear arrangements in place for emergencies and a member of the office team was on call outside of office hours.

Personalised risk assessments had been completed. People's care records identified areas of risk for individuals including self-neglect, verbal aggression, falls, personal care, eating and drinking and the use of a crash mat at their bed side. Risk assessments were fully completed and reflected people's current needs, however additional pertinent information was absent. For example, falls risk assessments lacked information about a history of falls or if the person was scared of falling. We mentioned this to the governance lead who agreed it would be useful information to minimise risk further.

Recruitment procedures were in place to ensure staff were suitable for the role and safe to work with vulnerable people. This included obtaining a Disclosure and Barring Service (DBS) check and two positive written references before staff commenced work. We reviewed five staff files and saw correct procedures had been followed in most cases. However, we saw a reference in one staff file which was blank apart from the referee's name, occupation and address, and another person had obtained references from their mother and a friend. The company recruitment policy stated 'all offers of employment are made on condition that two satisfactory references are obtained in respect of the applicant.' We spoke with the governance lead who agreed these were not acceptable.

The provider had sufficient numbers of staff to meet the needs of the people using the service. The governance lead told us they had recently lost a number of staff without notice which had impacted on the service. We found the management and staff had worked together to minimise the impact to people as much as possible. We noted some missed calls had been recorded and the area manager had recognised these, however people who were at higher risk and had no other support networks had been prioritised. During the course of the inspection, we heard people in the office making phone calls to people to explain the situation and letting people know who their new care workers would be. The area manager showed us they were currently recruiting to address the shortfall and had new staff starting employment soon, pending background checks. We concluded although staff levels were stretched at present the service had put appropriate measures in place to remedy the situation.

Some people we spoke with commented they had recently experienced late or missed calls. However, we saw the provider had taken action to address this and were contacting people affected by the recent staffing issues. Comments included, "There is a great problem with timing; one did not even turn up; they did not even contact me," and, "I was panicking when the care worker did not turn up until 11.30 am; this was not normal. I rung the office; they said they would get someone; no one came until late." However, one person told us when staff were late, they were informed, commenting, "Yes they do come late; it's traffic, what can you say? They do call me to let me know." Some relatives we spoke with also told us calls had been missed or staff turned up late. From speaking with the governance lead, we were confident actions were being taken to address issues raised.

We spoke with care workers who gave mixed comments regarding the rotas and travel time between calls. Those who had small numbers of people to provide care and support to expressed no problems with the rota or travel. Those who had a full day of calls had concerns with the organisation of the rota and the time it took to travel to each call. One care worker stated, "I had clocked over 55 miles in one day for calls made in Bradford. I am not paid extra for mileage. I am hoping the new management will change this." However, another care worker told us when they had issues with the rota they spoke with management who changed their rota to make it more practical. They said, "Yes the rota was crazy and impossible to do. I am quite confident; I went in and told the management. They changed the rota, planned a sensible rota which was practical. Now all my regular service users are happy as I am not late."

Some people had raised some concerns about care workers and made comments such as, "I was concerned about one care worker; reported this to management. The care worker was short with me. Management have rung me to send the same care worker again. They apologised; they said they are so short staffed. What can I do?" and, "Some of the new young care workers rush and don't give that time. I had to tell management about this; they sorted it for me. I do not have this care worker anymore."

We reviewed the incidents file and noted 16 incidents had been reported in 2016 with details of actions taken as a result. For instance, we saw one person who used the service was referred to outside support agencies following a reported incident. However, some incidents had required accident forms to be completed and this had not been done. For instance, we saw two separate incidents where people had fallen in their homes in May 2016 and sustained injuries and another in April 2016 where the person required hospital admission. No accident form was in the file. We spoke with the governance lead who was unable to locate any accident forms and agreed this was an omission.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care, applications must be made to the Court of Protection. We found no people were currently subject to Deprivation of Liberty Safeguards (DoLS). Staff had received training in the Mental Capacity Act.

We spoke with the group governance lead who had a good understanding of the Mental Capacity Act and we were confident the service would ensure any decisions made for people without capacity were in their best interest.

The majority of people who used the service did not have any concerns with the way their food was prepared for them by staff. One person told us, "They know what I like; they ensure that it is warmed up." Care plans outlined people's preferences, likes and dislikes. They gave staff specific guidance about how people preferred to have their food. For example, one person's care record indicated they required a high calorie diet. The daily notes confirmed care staff supported the person with a high calorie diet and offered encouragement to eat more when they were there. Another person's care records indicated the person would often not eat in front of staff so encouraged staff to leave food out for them. Daily notes from people's care records documented what they had eaten.

We saw peoples' health care needs were supported through evidence in the care records we reviewed. People we spoke with confirmed staff supported them to access health care when required.

We reviewed the staff training matrix and saw this was up to date. Some training was completed using workbooks and some via face to face training given by the company in-house trainer. Subjects covered included health and safety, safeguarding, moving and handling, medication, equality and diversity, infection control, food hygiene, MCA/DoLS, First Aid, Dementia and Care for a Dying Person. Staff new to care completed the Care Certificate. The Care Certificate is a set of standards to equip health and social care support workers with the knowledge and skills they need to provider safe and compassionate care. Staff told us they felt the training was sufficient to equip them with the skill to care and support people effectively.

The majority of people and their relatives who we spoke with during our telephone interviews were clear in telling us they were happy with the support given by care staff and felt the majority of time they were trained and skilled. Comments included, "Yes they are skilled, no issues whatsoever", "They seem to know what they are doing", "Yes, definitely trained; if not I would tell them" One relative told us, "No problems at all, absolutely wonderful. They know what to do with my relative," and another commented, "Once they turn

up they seem to know what they are doing."

The service told us staff received appraisals annually and supervisions every six to eight weeks. These were an opportunity to discuss concerns and development, and we saw appraisals contained sections to document future objectives. We saw appraisals were up to date. However some staff files we checked showed supervisions had not been undertaken recently. The operations manager told us they were aware of this shortfall and were in the process of addressing the problem. We saw staff received observations of their care delivery which were also used to audit their practice and contained details of actions required as a result. For example, we saw one action was for the staff member to attend infection control training and at the next observation this had been completed.

People we spoke with told us communication from the service had been poor until recently. For instance, one person told us, "Before I would be ringing and ringing but they would never pick the phone up." However most people told us this had improved over the last couple of weeks. One person told us, "Previously no one would pick the phone up; ringing all the time. Quite good now; picked up in the last two weeks. You can tell it's getting better."

The governance lead told us the service had been using an electronic rota system. However they had stopped this since they had identified it had been set by the previous manager to automatically generate the same rotas weekly which included staff who had recently left the service. This had led to calls being missed, so rotas were now being completed manually until the issues with the electronic system could be addressed.

Throughout the day of our inspection we heard staff ringing people to explain what was happening with changes with care staff and apologising for late or missed calls. This showed us the service was being open with people about the current staffing issues and communicating appropriately with people who used the service.

Good

Is the service caring?

Our findings

People we spoke with praised the care they received from the service and told us their care workers treated them with kindness and compassion. Comments included, "The care workers are exceptional; very warming", "They are very caring; they chat with me," and, "I really look forward to my care worker coming to see me." One person told us they had not been happy with the way their previous care worker had talked to them and they had complained to management who had changed the staff member providing their care. They told us, "The new one is lovely and caring; no problems now at all."

Relatives also praised the care provided by staff with comments such as, "My relative looks forward to seeing the care worker; this gives us the confidence", "Up to now they have been very good; my relative has no complaints."

Staff we spoke with told us they had been trained to respect people's dignity and people we spoke with confirmed this. One relative we spoke with told us, "When I am here they always give my relative respect and dignity."

We reviewed responses from recent satisfaction surveys which included comments about people liking their care staff, saying they provided good quality care and respected their privacy and dignity, as well as being cheerful.

Staff told us they had built up very good relationships with the people they provided care and support to. We saw people who worked at the service head office also knew people and were able to tell us about them and their care and support needs. However, one relative explained how difficult it was for their relative to build up a relationship when their care workers altered so much. They said, "There are too many different care workers; my relative can't build a relationship up with them; they keep changing."

Staff told us they tried to help people retain their independence where possible. People we spoke with confirmed this. For instance, one person told us, "They help me to chop and cut (food); they also let me be independent; let me do what I can as well."

We heard staff in the office talking on the telephone with people who used the service in a calm, compassionate and respectful manner.

People told us and we saw from reviewing care records they were involved in the planning of their care and support. Relatives told us they were also involved, saying, "The care worker also gets us involved."

Good

Is the service responsive?

Our findings

Assessments of people's needs were carried out before the start of the care package. This assessment reviewed the individual's mobility, health, communication and preferences. The initial assessment was then developed into a care plan which provided staff with clear guidance on how people's needs should be met. Care plans detailed specific requests from individuals such as how they liked to start the day, what they liked to eat and what they enjoyed.

We saw that people's care plans were reviewed monthly or earlier if people's needs changed. There were written notes on a review sheet to reflect changes to people's preferences and needs. For example, we saw at one review there was a discussion about an individual's increasing needs and how staff were to support these.

Care records were written in a person centred way. We saw personalised specific information important to each individual had been included in their plans. For example, one person's file said they enjoyed to eat fruit loaf with cheese. People had different areas of support. We saw plans in place which covered areas such as mobility, elimination, skin integrity, sleeping, end of life, religious and spiritual needs and social events. Care records were easy to follow and reflected the person's current needs.

We saw the wording in people's care records showed and encouraged staff to treat people with respect and dignity. For example, one person's file acknowledged they did not want to discuss end of life care with the staff. Another person's records informed staff to encourage a person with their person hygiene but to remind them in private. This showed us documentation for people was current and represented good practice.

We reviewed information about complaints received by the service and saw these had been responded to and appropriate actions taken. People told us, "Management listen to me; very good. I made a complaint about a care worker; they stopped sending this one," and, "I had to make a complaint. Had a care worker who hardly spoke English, wanted to take over. I could not be independent. I complained; management changed this care worker immediately." Some people we spoke with felt their complaints had not been dealt with to their satisfaction previously, saying, "We have made complaints in the past; no point really, never came back to us." However, most people told us they thought this had improved recently.

Requires Improvement

Is the service well-led?

Our findings

When we arrived at the head office for our inspection, the governance lead who was supporting the service was open and candid about the issues the service had been facing over the last few weeks. They told us both the registered manager and deputy manager had left the service with little or no notice and they had since been working with other members of the management team to support the service, identify issues and put action plans in place to address these. They showed us the action plans. A number of issues we had identified during our inspection were those already with action plans in place. From speaking with the governance lead, and other members of the management team, we were confident they were passionate about improving the service and addressing identified issues.

We saw the service had an audit system in place which analysed a range of areas such as complaints, surveys, staff files, care records, incidents and medicines. We saw some evidence of lessons learned as a result. However, although the service had a system of quality assurance in place, this had not identified a number of issues we found at inspection. For example, we saw incidents were audited monthly but had not picked up where accident forms should have been in place. We also saw some incidents had been filed in the wrong month which then altered the audit analysis results. Staff files were audited monthly but had not identified a lack of up to date supervisions. Medicines were audited. However, a robust a robust implementation of the audit system would have picked up would have picked up the issues we found at inspection. This meant systems and processes in place to enable the service to identify and improve where quality and safety was being compromised were not always effective since these were not always implemented. We discussed this with the governance lead who agreed this was an area for improvement.

This was a breach of Regulation 17 (1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recognised some improvements had been made since our last inspection and the service had been dealing with a number of care staff and the manager leaving without notice. We felt the proportionate response appropriate under these circumstances was to require the provider to send us regular updates to demonstrate action taken to address the shortfalls found.

People we spoke with commented on the management of the service. The majority of people told us they felt there had been issues with the previous management and things were now getting better. Comments included, "Management listen to me; very good. I made a complaint about a care worker. They stopped sending this one," and, "Previously no one would pick the phone up, ringing all the time. Quite good now; picked up in the last two weeks; you can tell it's getting better." Some relatives told us, "The management we feel are effective and approachable; we have not had a problem as we have had the same care worker from the start." However other relatives told us they had received little contact and said, "Left in the dark by management as to why no one has turned up," and, "It seems the management is being swapped; no contact with us to say what has happened; seem to be very disorganised." However, we saw the governance lead and management team had identified this issue already and were contacting people about the recent changes.

Staff we spoke with reported a lack of leadership and support previously but felt this had improved recently. Comments included, "A lot of staff left all at once; no idea why. Very unfair on the service user; we are running around like headless chickens to help. Staff shortage is having a knock on effect. New management are trying to train new staff, they are coming out shadowing me. It takes time to train as well. There is no management at the moment. In the past management were not approachable at all; last three weeks its has been brilliant", "It seems previous management stopped caring," and, "Management is fantastic now; they always pick up the phone now."

We saw evidence of regular staff meetings held and these were an opportunity for staff to discuss best practice as well as issues and concerns. We reviewed the recent staff meetings and saw the management team had reassured staff about the recent events with management and staff leaving and an open discussion was held.

The service sent out questionnaires to a random selection of people who used the service to complete monthly and spoke to others via the telephone. We saw the use of an easy completion questionnaire was used to aid completion by as many people as possible. We saw responses and analysis of these questionnaires and surveys seeking feedback from people reflected actions taken as a result.

Statutory notifications had been sent by the service to the Care Quality Commission in a timely manner.

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 proper and safe management of medicines; procedures were not in line with current legislation and guidance regarding administration and recording of medicines. Regulation 12 (1) (2) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place failed to effectively assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. This was a breach of Regulation 17 (1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.