Brew 13 Services Limited

Kare Plus Altrincham and Trafford

Inspection report

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29 September 2020
30 September 2020
01 October 2020
02 October 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Kare Plus Altrincham and Trafford is a domiciliary care service providing personal care and the treatment of disease, disorder and injury to older people, younger adults, learning disabilities and autistic spectrum disorder and people living with dementia. 41 people were using the service at the time of the inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People were not always receiving timely visits from staff to support them at home. This was evident from the phone calls we undertook with people and their families and call logs. While the provider had identified this concern, people were still receiving support from staff up to an hour earlier or an hour later than scheduled. The variation between the times of calls also put people at risk of receiving their medicines without the required intervals. There was further evidence one person was not receiving a time specific medicine within the correct time frames. Some staff felt they were not given enough time to travel from one property to another which impacted upon the call times for people. Risks to people were assessed, monitored and reviewed. Staff were aware of safeguarding procedures and how to report any concerns.

The management team had identified where people had been receiving untimely calls and had tried to remedy the issue. We made a recommendation; the provider reviews all scheduled calls to ensure they are at people's commissioned time and incorporate timely gaps between the calls if this is appropriate. We also recommended staff travel times are reviewed to ensure staff have enough travel time in-between each visit. Following the inspection, the provider instigated further processes to manage the rota more effectively. Audits were in place to monitor and improve the service and while some audits had identified shortfalls, concerns around the timeliness of medicines being administered had not been highlighted and rectified. People, their relatives and staff gave mixed responses on the support the provider gave.

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

Rating at last inspection The last rating for this service was good (published 6 April 2018).

Why we inspected We received concerns in relation to late and missed calls and inconsistency staff teams supporting people. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We did not find any evidence of missed calls.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kare Plus Altrincham and Trafford on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Kare Plus Altrincham and Trafford

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by one inspector. Three inspectors made phone calls to staff members working for the provider and an Expert by Experience made phone calls to people using the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

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 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 29 September 2020 and ended on 2 October 2020. We visited the office location on 29 September 2020.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We spoke the local authority who commissioned care from the provider and reviewed any notifications sent to us by the provider. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager, the nominated individual and nine staff members. We also spoke with 13 people or their relatives.

We reviewed six care plans and associated risk assessments and daily records. We reviewed two people's medicines. We checked six staff recruitment files and training records and looked at policies and procedures, safeguarding, complaints and audits to monitor and improve the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals prior to the inspection who have regular contact with 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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant 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.

Using medicines safely

● People received support with the management of medicines if that was their assessed need. Medicines were recorded on a medication administration recorded (MAR) and signed for by staff following administration.

● We reviewed one medication record where we noted paracetamol was being given too close together. The required interval for doses of paracetamol is four hours and there was evidence it had been given on 15 occasions over 23 days with less than the four hourly required intervals. We raised this with the provider who said the paracetamol had not been administered, however, there was no evidence to suggest this was not the case. The same person also required a medicine to be given four times daily at the same time for each dose. We found the administration of each dose could vary by two hours which potentially put their illness at risk of being uncontrolled.

● A relative told us, "The carers visit four times a day but there can be issues. They can be here at any times which of course affects [Name's] medications."

The provider did not ensure people received the correct support to receive their medicines in a safe and timely manner. This put people at risk of harm. This is a breach of regulation 12 (Safe and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2008

● Staff received training and competency checks to enable them to support people with their medicines.

Staffing and recruitment

● We received mixed feedback from people and relatives about very late or early calls. Rota's evidenced calls were not always scheduled or undertaken at the correct time which meant some people received their visits too close together.

● People and relatives told us, "The timing of carers arriving is poor. Sometimes I have waited up to two hours. A 9.30 call can be 10.30. The carers I get are not consistent." and "Time keeping is a bit hit and miss, it could be 10 or 11 in the morning or 19.30 for bed which is too early for me." and "Carers' times can be a bit erratic, they will sometimes call [to say they are late] but not always."

● The registered manager told us they had recently changed the call runs around but had found this had not been effective and changed them back to the original call runs. While some people were happy with this, it was evident some calls could be up to an hour earlier or later than planned and scheduling of calls was not always at the person's preferred time.

● We received mixed feedback from staff about having the time to travel to others' calls. Comments included, "Some calls we have enough time but quite often there is 20 minutes to travel and we only have

five minutes" and "We might have five minutes to travel 15 minutes and this happens three to four times and we are half an hour behind." It was evident from staff log in and out times that this was impacting on timely calls of support from staff.

● Staff told us sometimes they didn't need to stay the full length of the commissioned call and this was evidenced in rotas. For some people, this had been raised with commissioning authorities.

● Staff were recruited safely and appropriate pre-employment checks were in place before staff commenced employment with the provider.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives told us they generally felt safe with the staff supporting them but wanted more consistency with staff visiting their homes.

● Staff received training and could describe signs and symptoms of potential abuse and what action they could take.

● Staff told us they would report any concerns to the management.

● Any safeguarding concerns had been raised by the management team as appropriate.

Assessing risk, safety monitoring and management

● Risks to people were assessed, recorded, monitored and reviewed.

● Staff could describe risks to people and how to mitigate each risk.

● Staff received additional risk assessing for lone working and for support during the current pandemic.

Preventing and controlling infection

● Staff were aware of their responsibilities in preventing and controlling infection. Training was undertaken and additional support offered to understand the guidance around the management of the COVID-19 pandemic.

● People and relatives told us staff always arrived with personal protective equipment (PPE) and staff confirmed there was always PPE available.

Learning lessons when things go wrong

● Accidents and incidents were recorded and shared for wider learning.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered manager understood their responsibilities under their registration and provided staff with supervision, training and competency checks.
- The registered manager shared with us how they had employed additional staff to assist the management team in trying to improve the lateness of calls, however, care staff were changing the runs to suit people without informing the office.

We recommend the provider reviews all scheduled calls to ensure they are at people's commissioned time and incorporate timely gaps between the calls if this is appropriate. We also recommend staff travel times are reviewed to ensure staff have enough travel time in-between each visit.

- Staff told us they knew and could describe how to care for people.

Continuous learning and improving care; Working in partnership with others

- It was evident the provider had identified areas for improvements, in particular with the timeliness of calls. However further improvement was urgently needed to ensure people received timely care and support. Following the inspection, the provider instigated further processes to manage the rota more effectively.
- Audits were in place to monitor and improve the service, however, they had failed to find the concerns we found with the management of medicines.
- The provider and registered manager were keen to improve the service and was working with the local authority to ensure they were meeting regulations and the expectations of stake holders.

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

- The provider had sought feedback from people and relatives being supported by the service. 45 responses had recently been received with 25 being positive and a further 20 highlighting concerns about late calls and inconsistency of staffing.
- A relative told us, "The carers can be the same for a couple of days and then change, there is no consistency." One person said, "I have phoned the management and they say they will get it on the system." Another relative told us they did have a blip about call timings, but this has been improved now.
- Staff gave mixed feedback about the communication from the office staff. While some said

communication was good, others told us, the communication was not great from office staff and they felt not listened to when reporting to the office.
● The registered manager communicated with staff using a WhatsApp group which had reduced the footfall to the office for staff during the pandemic. Staff felt this was a good tool for communicating to the team.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had reported any notifiable incidents to the Care Quality Commission.
● The provider was committed to learning about their legal responsibility and promoting duty of candour,

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and relatives spoke positively about the staff team and told us the staff were caring and attentive.
● People and relatives were involved in care assessments and planning which were reviewed at regular intervals.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure people received the correct support to receive their medicines in a safe and timely manner.