Hartlepool Care Services Limited

Coastal Care North East Redcar and Cleveland

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Coastal Care North East Redcar and Cleveland is a domiciliary care agency providing care to people in their own homes. 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. At the time of the inspection there were 42 people in receipt of personal care.

People's experience of using this service and what we found
People and staff continued to give mixed feedback about the service. Some people told us they were not informed when call times changed or when different staff would be coming to their home. We have made a recommendation about this. Some staff felt the registered manager did not always listen to their views and some felt under pressure to pick up additional shifts. We have made a recommendation about this. Other feedback we received did acknowledge improvements were being made and nobody reported a missed call.

We identified inconsistencies with COVID-19 testing amongst staff. We have made a recommendation about this.

The newly registered manager had good oversight of the service. A new system of audits had been introduced and was working well. Where concerns were identified, appropriate action was taken. Relationships with external professionals was good and the provider had been working closely with the local authority. The registered manager had an understanding of their duty to inform CQC of certain events.

Risks were identified. Care records and risk assessments gave staff detailed guidance on minimising risk. People told us they felt safe when receiving their care. Medicines were managed safely, and changes had been made to identify any issues as soon as possible. Staff training had increased, and staff told us they had seen an improvement in this area.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 27 July 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We carried out an unannounced inspection of this service on 24 and 28 May 2021. Multiple breaches of legal requirements were found. After the last inspection we issued two warning notices in respect of good governance and safe care and treatment. The provider also completed an action plan to show what they would do and by when to improve staffing and safeguarding people from abuse and improper treatment.

We undertook this focused inspection to check whether the warning notices we previously served in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We also checked whether they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Coastal Care North East Redcar and Cleveland 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?

Good

The service was 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 well-led findings below.

Coastal Care North East Redcar and Cleveland

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.

We also checked whether the provider had met the requirements of the Warning Notices in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by two 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.

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

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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We took this into account when we inspected the service and made judgements in this report. The provider was not asked to complete a 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 used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and four relatives about their experience of the care provided. We spoke with 11 members of staff including the registered manager, two directors, a quality auditor, team leaders and care staff.

We reviewed a range of records. This included four people's care records and medication records. We looked at three staff files in relation to recruitment and the training matrix for all staff. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, surveys and quality assurance records. We spoke with two external professionals who work with the service.

Good

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 inadequate. At this inspection this key question has now improved to good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to have systems in place to safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● An effective safeguarding system was now in place. The registered manager had a clear understanding of what procedures to follow in respect of safeguarding concerns. We saw evidence of changes made to working practice as a result of lessons learned.
● Staff were proactive in raising concerns and there was clear guidance for office staff to submit safeguarding alerts in the registered manager's absence.
● People told us they felt safe when staff provided their care. One person told us, "I do feel safe without a doubt."

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● An effective system to assess, monitor and manage risk was now in place. Feedback from the last inspection had been acted on and risk assessments were greatly improved. The records we reviewed were comprehensive, detailed and person centred.
● The registered manager had introduced a new pre assessment system to assess risk and ensure the service could safely meet people's needs before they started to use the service. If the person's needs could not be safely met, then the care package would be declined.

Staffing and recruitment

At our last inspection the provider had failed to put effective systems in place to manage staffing. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Sufficient staff were deployed to meet people's needs. New staff had been recruited safely with all correct pre-employment checks undertaken.
● Staff training was up to date and there was an ongoing programme of additional training to improve staff knowledge and skills. Staff confirmed training had improved since the last inspection.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● People were given their medicines in a safe manner by people who were trained to do so. Issues identified with medicines at the last inspection had been addressed.
● More thorough medicines audits were taking place, and these were also done more regularly. We saw examples of minor errors in medicines records being successfully identified and prompt action taken to minimise future risk.

Preventing and controlling infection

At our last inspection the provider had failed to follow the government guidance to manage the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● The provider's infection control system had improved. However, we identified inconsistencies with COVID-19 testing amongst staff. We were told this would be addressed by the registered manager.

We recommend the provider keeps staff testing under review to ensure best practice and government guidance is followed.

● Changes had been made to working practices in the provider's office. Staff were seen to be following government guidance in relation to social distancing. One member of staff told us, "Nobody in the office was complying with the guidance before. I felt really uncomfortable as there was no social distancing, but this has all changed now."
● People told us staff wore PPE. Staff told us there was always a good supply of PPE and they had been trained to use this effectively and safely.

Learning lessons when things go wrong

At our last inspection the provider had failed to learn lessons when things went wrong. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- Lessons had been learned from previous inspections and actions taken to improve the service.
- An electronic system was used to monitor incidents and identify any areas of concern. Patterns and trends were looked at and discussed in regular meetings between the registered manager and senior staff. In this way lessons could be learned, and changes made going forward.

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 inadequate. At this inspection, this key question has now improved to requires improvement. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

At our last inspection leaders were not effective in maintaining the quality of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- The registered manager had taken action in response to the findings of the last inspection regarding relationships between care staff and office staff. However, staff still gave mixed feedback about the registered manager's approach.
- Some staff felt they were not listened to when raising concerns and others felt they were put under pressure to take on additional shifts.

We recommend that the provider keeps the day-to-day culture under review to ensure action is taken if any concerns are raised.

- Oversight of the service had greatly improved. The new registered manager worked in the office on a full-time basis. Staff had received additional training; detailed risk assessments were in place and audits had improved. There had been no incidents which required the provider to act on the Duty of Candour requirement.

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

At our last inspection the provider had failed to effectively engage with people who used the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● A system was in place to involve and engage people who used the service; however, further improvements to this system were required. We received mixed feedback from people regarding the management of the service. Whilst one person told us, "I feel they're getting their house in order admin-wise." Others told us they were not happy with communication from the office or the responses from the registered manager. One person told us, "We have spoken to management but I'm not sure they're very active on what you tell them."
● People were not always told when to expect a different member of staff or when call times were changed. One person told us, "I've constantly said I need consistency. I need to know if they're changing times or changing [staff] but it doesn't happen."
●The registered manager explained the difficulties there had been covering calls at times. Whilst there had not been any missed calls, they told us it was not always possible to contact people to warn them of changes.
We recommend the provider reviews systems to ensure effective communication is promoted throughout the service
● Feedback from people using the service was sought on a regular basis. The provider had recently increased the number of surveys from annually to every six months. They had also taken on board previous comments regarding the option to give feedback anonymously.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure a robust system was in place to monitor the quality and effectiveness of the service. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● Monitoring of the service had improved. Changes had been made to the audit process to improve quality assurance and ensure any issues were identified quickly and in a more consistent way. However, the new electronic care plan system was still not fully operational.
● The registered manager had taken on board feedback from previous inspections. We saw evidence of positive changes being made as a direct result of our feedback. New systems had been put in place and the registered manager was working hard to embed them into the service.
● The registered manager now had additional support so was able to delegate some of the quality assurance tasks but still had good oversight of the service. The introduction of a quality officer and two quality auditors meant more regular checks were being done out in the field rather than finding issues only when records were returned to the office.
● A new administration assistant had taken pressure off the registered manager and records were now more accurate and up to date.

At our last inspection the provider had failed to submit a number of notifications and as result they were in breach of regulations 15 (Notice of changes), 16 (Notification of the death of a service user) and 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009. At this inspection we found all relevant notifications had been correctly submitted and the provider was no longer in breach of these regulations.

● All notifications were now submitted to CQC in a timely manner. The registered manager told us they had learned a lot since the last inspection and were now more confident in their role and what was required of them.

At our last inspection the provider had failed to display that rating of the last inspection on their website or in the office location. This was a breach of regulation 20A of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found the rating was displayed and the provider was no longer in breach of this regulation.

● The most recent rating and a copy of the latest report was on display in the office location. The provider's website was no longer active, however, we had reassurances that the rating would be displayed should it go live again in the future.

Working in partnership with others

● The service worked effectively with external agencies and professionals. We received very positive feedback from external professionals who worked with the service. One professional told us, "[Registered manager] is absolutely brilliant, I can't fault her. Nothing is too much trouble."

● The provider and registered manager had worked closely with the local authority to make the necessary improvements in line with a detailed action plan. They have also liaised well with CQC.