

Thurrock Borough Council

Homecare Reablement Team

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place over a number of days and included 18, 23, 24 and 25 May 2016.

The Homecare Reablement Team (HRT) provides personal care and support to adults who live in their own homes in the geographical areas of Thurrock between the hours of 07.00 a.m. and 11.00 p.m. They provide care and support within people's homes and a reablement service for up to six weeks for people who have been discharged from hospital. The focus of their support is to rehabilitate people back to independence.

The service is also a 'provider of last resorts (POLR).' This is where Thurrock Borough Council are unable to find another contracted service to provide care and HRT will then assist with the care until another provider can be found. This is aimed to be a short term service.

The service has a registered manager in post. 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.

There were not sufficient numbers of staff, with the right competencies, skills and experience available to help meet the needs of the people who used the service. They are in the process of recruiting more staff to ensure they have sufficient number when staff are on leave, sick or when the work as a POLR increases.

Systems were not in place to assist people with the management of their medication and to help ensure people received their medication as prescribed.

Sufficient recruitment checks had not been carried out before staff started work to ensure that they were suitable to work in a care setting. Staff did not feel well supported to carry out their work and had not received regular support and training.

People were not always receiving the support they needed to eat and drink sufficient amounts to help meet their nutritional needs. Staff knew who to speak with if they had any concerns around people's nutrition.

People had not always given consent to their care or been involved in the decision making process. They had not been asked how they would like their care provided. Assessments had been carried out and care plans had been developed but these were not always around each person's individual needs.

The registered manager had a good understanding of Mental Capacity Act 2005 and who to approach if they had any concerns and the appropriate government body if people were not able to make decisions for themselves. Staff had not been provided with training for the MCA and had limited knowledge on this subject.

The service did not have an effective quality assurance system. The quality assurance system was not effective and improvements had not been made as a result of learning from people's views and opinions.

Staff had a good knowledge of safeguarding procedures and were clear about the actions they would take to help protect people. Risk assessments had been completed to help staff to support people with everyday risks and help to keep them safe.

People were supported by staff to maintain good healthcare and were assisted to gain access to healthcare providers where possible.

People said they had been treated with dignity and respect and that staff provided their care in a kind and caring manner.

People knew who to raise complaints or concerns to. The service had a clear complaints procedure in place and people had been provided with this information as part of the assessment process. This included information on the process and also any timespan for response. We saw that complaints had been appropriately investigated and recorded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not consistently safe.

People could not be sure that they would receive the assistance they needed when being supported with medication.

The provider had systems in place to manage risks, which included safeguarding matters and this helped to ensure people's safety.

There were not enough staff available, with the right competencies, skills and experience to help meet the needs of the people who used the service.

Is the service effective?

Requires Improvement ●

This service was not consistently effective.

People were not always cared for by staff that were well trained and supported.

Staff did not have knowledge of the Mental Capacity Act (2005) and did not always know how to keep people's rights protected.

People had gained assistance regarding their health and support when needed.

Is the service caring?

Requires Improvement ●

This service was not consistently caring.

People were not provided with care and support that was tailored to their individual needs and goals.

Staff had a good understanding of people's care needs and were caring, but did not always have the time to provide the care people required.

Is the service responsive?

Requires Improvement ●

The service is not consistently responsive

People's needs were assessed but their care and support needs had not been routinely reviewed and updated.

People did not always receive personalised care that was responsive to their needs.

People were provided with information to encourage them to raise concerns and share their experiences.

Is the service well-led?

This service was not consistently well-led.

The manager understood their responsibilities and demonstrated good management and leadership skills, but was not always able to follow this through due to other work responsibilities.

Staff understood their roles and were confident to question practice and report any concerns.

Effective quality assurance systems were not in place to monitor the service and identify any areas that needed improvement.

Requires Improvement 

Homecare Reablement Team

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 was unannounced and took place on the 18, 23, 24 and 25 May 2016. The inspection team consisted of one inspector.

Before the inspection we reviewed the information we held about the service. This included notifications, which are documents submitted to us to advise of events that have happened in the service and the provider is required to tell us about. We also reviewed a Provider Information Return (PIR). A PIR 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. We used this information to plan what we were going to focus on during our inspection.

During our inspection we visited four people within their own homes and spoke with three on the telephone. Questionnaires were sent out by CQC to gain the views of people who received a service and also their relatives. Eleven were received back and their responses have been added to the report where appropriate. We also spoke with the registered manager, the deputy manager, a co-ordinator and eight staff who worked for the service to gain their views.

As part of the inspection we reviewed three people's care records and four care plan folders within people's own homes. This included their care plans and risk assessments. We also looked at the files of three staff members and their induction and staff support records. We reviewed the service's policies, their audits, staff work sheets, complaint and compliment records, medication records and training and supervision records.

Is the service safe?

Our findings

The registered manager advised that the service had 27 staff and they were providing both rehabilitation and general domiciliary care; this was due to their service being a provider of last resorts (POLR). They advised that a number of domiciliary care providers had ceased to provide services within their geographical area and due to this the HRT had needed to provide services to these people until another service could be found. This had a large impact on the service and the care people had been receiving and the registered manager was aware that people had not been receiving regular times for calls or continuity of care staff. They had also not been able to provide people with a rehabilitation service due to staff being busy covering essential care. It was reported that staff could be allocated between 7 – 10 calls on the morning round and many people had not been receiving their morning call until after 11.00 am. Staff spoken with confirmed this and that their lunchtime calls often merged with morning calls. One care staff member reported, "More carers are needed. Carers are leaving and not being replaced." The registered manager advised that they had been trying to recruit new staff, but this had been a slow process."

People told us they did not feel the service had enough staff and they did not always receive the care and support they needed from the care workers. People did not have regular care workers and some added they had seen quite a few staff members since they had started their support and their times had been very adhoc. Examples were given and this included; "Worse issue is that I do not know what time my carers are coming to see me. For example, my breakfast call can be from 7.00 am to 11.00 am. If they are late, I struggle through and get ready myself," "My mother does not know when the carer will attend. For example at breakfast time this can be between 07:00 and 11:00. If it is after about 9:00 my mother will get up and struggle to get herself ready and to make her own breakfast. I worry about this because she is putting herself at risk." And, "Time is a problem. Calls range from 7.00 am to 11.00 am and when the morning carer was late they turned up at the same time as the lunch carer. I get up early and sit and wait. When it got to 10.30 am once, I went to get my own breakfast and then slipped on the tiles and hurt myself." Others reported, "I have had many missed calls with no explanation," "I had no regular carers, they were all over the place" and, "I had two missed visits. Sometimes they did not come till after 10.00 am. A couple of times they came at the same time as the dinner one." All people stated they would have liked more continuity of times and regular staff who visit more than once.

Staff also reported that they were very busy and felt there were not enough staff to provide the time people often needed. Some reported that they were still doing morning rounds when people should have been receiving a lunchtime call. Feedback included, "It is very confusing for people, we try to work out who needs their call first to help reduce the risk," "We do not have regular rotas. If we are in an area we do not know and we do not know if people have a time specific call they could be at risk. One day a person could be at 7.00 am and the next day they will be on our rota for 10.00 am" and, "There is no consistency in staff and times. People with dementia get confused with different people going in, they need to see the same people or it confuses them." The service did not have sufficient numbers of staff and staff were not being effectively deployed to keep people safe and meet their needs.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

We found that the standard of medicines management in the service was variable and some people did not receive their medicines safely or as prescribed. The medication policy had last been reviewed in 2012, but the registered manager advised they had produced a 'handout' for staff to advise them of the 'dos and don't' within their own service to try and make the process clearer. The registered manager advised that any assistance with medication would be identified during the initial assessment and would be part of the person's care plan. The registered manager advised they had a trained nurse on the team who could help with any medication advice and would visit to ensure the paperwork had been correctly completed and was in place for staff.

The service's medication policy stated that staff would only 'prompt' medication, but from feedback from staff and people who received a service many received more support, which included 'assisting'. One person stated that staff would help to take the medication out of the pack and place in their hands so they could take it. When visiting people we found documentation in their houses was not always correct. In one home it stated the person required 'prompting' for their morning visit medication, at lunchtime, tea time and at bedtime, but when speaking with the person they advised us that they only had medication once a day. Another care plan seen stated that the person did not need any assistance with medication, but when looking in the care notes it was noted that medication had been recorded by staff as 'prompted' and they were receiving medication assistance.

Feedback from those people who received assistance with medication included, "We stopped evening visits as the carers came at 7.00 pm and tried to give me my night tablets one hour after my tea time tablets – dangerous" and, "This service does not provide calls at a certain times, even though the person needs four hourly gaps for medication." Staff also raised concerns around the medication process and their comments included, "It is suppose to be timed medication but people are not getting it on time. It is terrible. Carers are altering work to ensure people receive their medication on time," "People are not getting gaps between their medication. A safer system is needed. They may have lunch with half an hour difference from breakfast" And, "The medication policy is not up to date, it is an accident waiting to happen. Aspirin is in dossett boxes and staff do not know which one to dissolve if there is more than one white one. Families are doing dossett boxes and we do not know what is in them. Time specific medication, we do not get the same people and never know who has been in or when the previous call has been done, so pakinsons, diabetic and antibiotics are not being given as prescribed."

We were advised that staff received medication training as part of their induction and at regular intervals thereafter. When looking at the training documentation this showed that four staff had not received medication training and eleven needed an update. Although the service had systems and policies in place to assist with the management of people's medication and staff had received training, people could not be sure that their medicines would be managed correctly and they would receive them as prescribed and safely. For example, we found that people who required assistance with medication did not always receive this in line with the prescriber's instructions. Safe systems were not in place for staff to record and monitor people's medication to an appropriate standard and care plans were often incorrect. Regular medication audits had not been routinely completed, which should have identified the areas of concern highlighted during this inspection.

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

Staff knew how to protect people from abuse and avoidable harm and had completed relevant training and

received updates. Staff spoken with stated they would feel confident in raising any safeguarding concerns they may have and they found the management supportive when they had raised issues in the past. Feedback from staff included, "I would phone my manager if I had any concerns" and "I have done the training and would report it to the office if I needed to." Staff were also aware of the whistle blowing procedure and described who they would speak to if they needed to report anything. This showed that staff were aware of the systems in place and these would help to protect the people receiving a service.

From staff training records these showed that five staff were waiting for an update in safeguarding training. Staff were able to explain how they would recognise abuse and who they would report any concerns to. The service had policies and procedures in relation to safeguarding people and these helped to guide staff's practice and helped to give them a better understanding. The registered manager was aware of systems in place to protect people and the service monitored safeguarding's to ensure staff had followed the correct procedures and to ensure people were helped to be kept safe. People are also provided with information when they first started the service to advise them on who they could contact if they had any concerns around either their or someone else's safety.

The service had a number of systems and processes in place to help keep staff and people using the service safe. Risks to people's safety had been routinely assessed at the start of a service. These related to the environment and people's mobility needs and provided some instructions to staff on how risks were to be managed to help minimise the risk of harm. Copies of this documentation could be found in people's homes and helped to ensure staff had relevant information and were kept safe.

People were provided with written information about the service which included a reminder that they had a responsibility to ensure that any equipment in their home that was being used relating to their care must be kept safe and regularly serviced. The service also has procedures in place to help protect staff when dealing with people's monies.

Training records showed that only three staff had received health and safety training and this had been during 2002, 2009 and 2013. Records showed this was one of the service's mandatory training courses that was to be provided every two years. Moving and handling training was also one of the service's mandatory training courses and was to be updated every two years. When looking at staff training records this showed that seven staff were waiting for an update, but the registered manager advised that dates for this had been organised.

The service was run from a self-contained office, which has access for those people who may have a disability. Appropriate risk assessments were in place and the service had appropriate insurance in place.

The service had a recruitment process which included relevant checks to help keep people safe. This included gaining a full employment history, two references, a completed health declaration and a disclosure and barring check, which establishes if the applicant has any cautions or convictions, which would exclude them from working in this setting. The employment records of two recently recruited staff files were inspected. Both files were well set out and information was easy to find. Files showed that only one had a full employment history and although both had two references these had not always been sought from their last employer. Interview forms had been completed, but these did not include details of any employment gaps or why referees had been changed from their last employer to ones that were not care related. The manager advised that they did have forms which were to be used to record this form of information; but from the documentation seen on files these had not been routinely completed.

The service had a disciplinary procedure in place, which could be used when there were concerns around

staff practice and helped in keeping people safe.

Is the service effective?

Our findings

The registered manager stated that newly recruited staff would complete their induction training before they started working in the community. They would also arrange for new staff to complete the corporate induction and were looking to introduce the Care Certificate training, which is a recognised induction qualification for people working in the care sector. When looking at the documentation for induction training for the two most recently employed staff, neither had any information to show they had completed any form of induction. One staff member had started work with the service in October 2015 and the second had been employed since January 2016, but neither had any evidence that an induction had taken place or they had shadowed other staff members to check their competency. Neither had clear evidence that they had previous care experience and references gained did not provide information on previous skills or knowledge regarding care. One worker had received the service's mandatory training in moving and handling, safeguarding and medication before they started work, but the second had not received this until three months after starting. It was not clear from the information gathered that all staff had the knowledge and skills they required in their role as a care worker before they started work within the community which meant that people could be at risk of receiving care from staff that do not have the right skills to care for them safely and effectively.

The registered manager advised that staff are provided mandatory training, but due to the recent pressure of workload, training courses had not been organised and they were aware that some staff needed refresher courses organised. Staff confirmed this and their comments included, "I was down for moving and handling last year, but due to work loads I was taken off the course" and, "My moving and handling training is out of date." When looking at the training records this included dates when staff had received training and when updates would be required. It was noted that the document had a number of gaps in some areas of training. This showed that a number of staff needed updates on the service's mandatory training and this included moving and handling (6), safeguarding (5), medication (11), infection control (29) and first aid (19). Although mandatory training had not been updated people stated they felt staff had the skills to provide the care they needed and a large number of staff (23) working for the service had achieved a recognised qualification in care. Staff not having up to date training could place people at risk of receiving unsafe care.

Staff also told us they received mandatory training and many added that they were either 'up to date' or 'needed a refresher'. Training documentation showed that there were also gaps in specialism training or training for specific conditions, so we could not be sure that care workers had the skills and knowledge to provide appropriate care to people. For example, training in areas such as Parkinson's disease, diabetes and stroke awareness were not up to date and many staff did not have the skills and knowledge to care for the people they provided services to. Staff told us, "They only do mandatory training, they do not do much specialism training." Staff added they would like some more specialised training, so they had the knowledge to care for people with specific conditions. Training documentation also showed that many staff needed training or an update on dementia awareness and the registered manager advised that a training course to 'train the trainer' had been booked and then this would be offered to staff.

The registered manager advised that they were in the process of looking at the training on offer to staff and

source updates on the subjects that were needed. They were also in the process of introducing e-learning to staff and felt that this may help with staff training needs. Information taken from the training documentation also showed that a large number of staff (19) had not completed the training course on reablement, which was the aim and objective of the service. The registered manager stated that she felt it would be good for all staff to receive this training as this was the focus of the service, but due to being a POLR they had not been able to promote this within their work.

Staff stated they received supervision and support, although the frequency and quality varied. Staff support records showed that most staff had been seen formally on a one to one basis at least four times within the last 12 months, but there were no evidence of meetings available and annual appraisals had not been completed. Feedback regarding supervision and meetings appeared to depend on the team you worked in and these included, "We have small meetings with our co-ordinator. They are quite good as they are an opportunity to discuss things and ask questions," "It is ten months since we had a meeting. I do not feel they listen at meetings, it all falls on deaf ears" and, "We used to have a meeting every three months. I have not had one for at least a year. It was a good time to speak about problems and gain support." One staff member also added, "We don't get supervision as we are too busy. It is written out for us and we just sign to say we agree." All added that they can phone their co-ordinators or the office if they needed advice or support. Comments included, "You can always gain support when needed" and "We can see the line manager if needed. They are very helpful, but they are really busy." The lack of consistent supervision and support meant that not all staff were able to review their practice and discuss their training and development needs to ensure continued quality of their care delivery.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had an understanding of the Mental Capacity Act (MCA) 2005 and how to ensure people's rights were protected. When looking at the training documentation this showed that only five staff had received training in MCA, which included the registered manager, deputy manager and three care co-ordinators. The registered manager advised that this training was not routinely provided to care staff. When speaking with staff they had an understanding of how to keep people safe, but did not have an understanding of the MCA with regard to protecting people's rights and how people's ability to make informed decisions can change and fluctuate from time to time. Only one staff member had a good understanding of the MCA and they added that they had received training on this with a previous employer.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us that they had agreed to the service providing their care and support and they had been part of the decision making process, whilst others were not aware. Files contained a form for people to sign, but this was more with regard to sharing information with other professional than people agreeing with their care plan. This was brought to the registered manager's attention who stated they would look at their present form and change this to ensure it also gained people's consent to care. From documentation seen

in people's homes and also within the office, not all people had given consent for staff to assist with their medication.

People did receive assistance with meals, but this was usually in the form of snacks or heating frozen meals in a microwave. Staff told us that they would ensure that people had access to their food and drink before they left the person's home. They added that if they had any concerns that someone was not eating properly they would speak with their manager so that they could speak with other health care professionals and get help and advice if needed. The service had food charts which staff could complete to assist with monitoring food intake if any concerns had been raised regarding nutrition.

Some concerns were raised by staff that people often receive their calls too close together and this could have an effect on food provision, especially if people were diabetic. Feedback from people confirmed this and included, "They come in around 6.30 – 7.00pm and prepare a microwave meal. This is too late, sometimes I eat my dinner and then go straight to bed. I often do not get my breakfast until 11.15 am" "Calls range from 7am to 11am and when the morning carer was late they turned up at the same time as the lunch carer" and, "[Person's name] is a diabetic and needs daily on time calls especially in the morning, but they are a bit hit and miss that is my main concern. The carers tend to call about 1.00 pm for lunch then again 3.00 -3.30 pm for dinner, [person's name] cannot eat at 3.30 pm because it would mean at least 15-18 hours before breakfast. Most carers will return about 5pm but others refuse to come back." People could not be sure that their meals would be appropriately spaced and flexible to their needs or that they would be supported to have sufficient to eat, drink or maintain a balanced diet.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had been supported to access healthcare services and receive on going support. The registered manager told us that they worked in partnership with other agencies and they also had a number of health care professionals who were employed by the service which included a physiotherapist, social worker, occupational therapist and a qualified nurse. Staff confirmed that they would approach the office if it was identified that people needed additional equipment or support with their care needs. They added that when they noticed a change in someone's health or if their needs changed they reported it to the office or call an emergency service.

Is the service caring?

Our findings

Although people told us that the staff treated them with kindness and compassion their comments and feedback varied with regard to the service. This included, "The two staff who attend to me are always polite and friendly. I enjoy the time they spend with me," "The people who care have been amazing" and, "I don't know what I would do without them." Other comments included, "I am happy with the care, but would prefer regular carers and regular times," "Carers are different all the time, continuity is a problem" and, "We are happy with the carers, but one day they are an hour early and the next an hour later." Although they felt the care was good they had concerns around the continuity and times of calls.

People told us that the staff were, 'caring and respectful.' They added that staff listened to them and helped them with their care. Even though most had issues around the time of the calls and not receiving regular care workers they were complimentary about the staff. When asked to give a mark out of ten for the care staff all rated them between 8/10 and 9/10. People were generally happy with the quality of care and support they received and stated that the staff treated them with dignity and respect. There were two issues raised around dignity, but these were more around not having a choice of care worker due to not having enough staff available, the manager was aware of this and attempting to support the person's requests?. It was noted that in the service's 2016 survey people were asked if they were treated with privacy and dignity by their care workers. The response was 91.1% said 'always' and 8.1% said 'mostly.'

Some relatives confirmed they had been present when the service had visited for the initial assessment. For people who needed extra support to make decisions about their care and support, the service had information about advocacy services. Advocacy services help support and enable people to express their views and concerns and provide independent advice and assistance where needed. They also had access to The Silver Line, which was a lottery funded help line to offer information, friendship and advice.

The service did not presently have documentation in place for people to sign to confirm they had been part of the care planning process, or they had agreed with the care to be provided. The registered manager was aware that this was an area that needed to be further developed to ensure people had been routinely involved in the decision making process with regard to their care.

Staff spoken with had an awareness of the day to day care needs of the people they visited and this included any care needs due to people's mobility, health or diverse needs. The registered manager explained that it would depend on the time before a service needed to be provided on the process they would follow to gather information about the care required. Either information would be taken from the health care professionals assessment and placed on a care plan within each person's home or if they had time a co-ordinator would visit and complete the assessment, care plan and risk assessments. This helped to ensure staff had information on the care to be provided. Feedback from staff included, "Care plans are not right. More information is needed and first visits are not always being done before we go in." This meant that staff might not have up to date information at all times to ensure people received the care they wished or required.

Is the service responsive?

Our findings

People we visited stated they had been visited by the service to find out what care and assistance they needed and that they had been involved in the planning of their care. They told us this was mainly around the number of visits and tasks they needed assistance with, rather than the times of their calls; unless they were 'time specific'. People confirmed they had care plans within their homes which advised staff on what care they needed assistance with. During our visits to people's homes we found that the information on the care plans could vary in content and some were very informative whilst others were incorrect. As an example some care plans included details that the person needed assistance with medication, but they were actually self medicating. Another had 'p/c, food, drink, inco pad' and nothing else had been recorded for what this person may be able to do for themselves or how they may like the care to be provided.

When speaking with staff some felt the information could be better and comments included, "It is not updated and the information is not always relevant," "It is mostly ok, but sometimes things are missing. I had information about people being diabetic missing" and, "They could be better. Care plans sometimes have essential information missing." Staff went on to say that if they knew the person and their care needs they would change their rotas to ensure they were 'time appropriate calls' and they would be there for essential medication or if people had to go out on specific days to hospital visits or clubs. They added this was sometimes difficult due to the daily changes in the rotas and not knowing who they would be visiting from one day to the next.

Although HRT is a rehabilitation service, it was noted that clear goals had not been set with each person during the assessment process, and people had not had their service regularly reviewed to assess their progress. Some people had been visited around the 6 week timespan, but due to the lack of other domiciliary providers to refer people who needed long term care to, the HRT had not been able to transfer any work. This had had an impact on the ethos of the service and staff were now providing long term care rather than rehabilitation as stated in their aims and objectives. Some people we spoke with had been receiving a service for over a year and some even longer. Feedback from staff included, "We are not doing reablement. The service is confusing for people. One staff member may encourage them to do things for themselves and others will do it for them. We are not achieving what we are about," "We will promote independence, but other staff will just do the care and get out, so people get confused" and, "You cannot monitor people's progress if you do not go in regularly. We do not have the time to do rehabilitation." Although weekly meetings took place with management to look at whether the service was suitable to meet the person's needs, due to lack of resources the service would often have to take cases that needed long term care and not rehabilitation.

The service received a large influx of work around November/December 2015 due to a domiciliary care service closing down very quickly. As HRT are a POLR they had to take the extra work on, but their staffing levels have not increased sufficiently. Due to the extra work co-ordinators have been assisting staff with providing 'hands on care' and they have not been able to fulfil their own role and responsibilities. Due to this, care plans had not been regularly viewed or updated over the six week period people received their rehabilitation service.

The service was not at present person centred and care was not arranged around each person's individual needs and situation. People had not been actively involved in their care or received regular reviews to ensure they received care in line with their changing needs. Where people were unable to achieve independence due to lack of alternative care providers, the service had been unable to support these people to gain a service that was more appropriate to their needs. Due to staffing numbers, the times of calls and lack of continuity, the service was not empowering people to make decisions and set goals and review their care to help them achieve their independence again.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were effective systems in place for people to use if they had a concern or were not happy with the service provided to them. This information could be found in the care folders in people's homes. Where complaints had been received there were records that these had been investigated and action taken. Senior management in the organisation monitored complaints, so that lessons could be learned from these, and action taken to help prevent them from reoccurring. The service also had systems in place that documented missed visits, complaints, safeguarding etc, so they could look at trends in the service. The registered manager felt this helped to improve communication and also the quality assurance of complaints.

People confirmed they knew who to contact if they had a concern and they all knew where to find this information in the folder in their home. Staff spoken with said they knew about the service's complaints procedure and that if anyone complained to them they would advise them what to do, or would notify the manager. Compliments the service had received included, 'Just wanted to thank you for the support and encouragement you have given me since last July. All the carers have been enthusiastic and cheerful, even though they are often tired through exhausting jobs (May 2016)' and 'All the nurses were brilliant, very clean, smart and kind...proud of them all. (March 2016)'

Is the service well-led?

Our findings

The service had a registered manager who was aware of their responsibilities. They had completed relevant courses in management and care and had a number of years experience in managing a rehabilitation service. The service also had upper management to help support the day to day running of the service, the managers and staff.

The ethos of the service is to provide short term care for people to enable them to regain their independence or if this is not possible to refer them to service's who provide long term care. This had not been taking place as the systems were not in place to support this process. Staff had not been allocated regular rotas or work programmes and they were having to ring into the office each day to get their work for the next. Staff reported that they found this very time consuming and comments included, "We used to get a weeks rota so you knew what was needed. Now we only get Saturday and Sunday rotas and have to ring up for work daily and they changed all the work from what is on the rota." This lack of information and organisation of staff support and deployment further caused problems for people's continuity of care.

The morale of staff at the service was low and this had an impact on staff continuity and timely service delivery to people. Staff we spoke with said that they were able to gain support from the office and management, but the frequency of regular staff meetings and formal supervision varied. Not all staff felt listened to and did not feel they were kept up to date with information about the service and the people. They added that management had an 'open door' and they could call in at any time, but due to the pressure of work and number of visits they were doing each day this was not always possible to just 'call into the office'. Feedback from staff included, "Staff morale is not good, we are working three weeks on and one weekend off. There is no quality time with family," "Morale is really low, lot of good carers have left as they could not cope with the work" and, "The last year has been rubbish. It was a professional service and they were on the ball, but now it is pear shape. People do not know who is coming or what time," Another added, "Carers are leaving because they cannot cope with the work loads, it has been going on too long."

The registered manager and the office team advised they had been working hard to try and resolve some of the issues around the times and continuity of service that people had been experiencing. They were aware that they had not been achieving the service's aims and objectives, which included dignity, independence and choice. They were aware of the ethos of the service and had a good understanding of the standards and values that people should expect, but due to pressure of work and not being able to refer people to more appropriate domiciliary services they were unable to achieve the service's objectives.

The service had a number of systems in place to help monitor the standard of care people received. This included quality surveys, postal customer satisfaction surveys and end of service questionnaires. Co-ordinators also completed a bi-monthly questionnaire over the phone to gain people's views. Audits and checks were available for staff recruitment, service user files, care reviews, staff training and supervision, and issues relating to the quality of care people received. They also had a system which enabled them to monitor missed visits, complaints, safeguarding's, referrals etc. and a monthly report could be printed off and analysed. The service had an internal audit report completed which provided an independent overview

of the service and this had been completed in May 2015.

From our findings at this inspection it was clear that although systems were in place these had been ineffective and had not picked up the areas of concerns we have highlighted. This included issues around staff recruitment, staff induction, accurate medication records, providing regular training and supervision, ensuring people's care was reviewed and care records correct and people receiving the support and care they needed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>People did not receive adequate support with their nutrition and hydration as assessed and within acceptable time scales. Regulation 9 (1) (a) (b) (c) (3) (i).</p> <p>Care was not person centred and being provided around each person's individual needs. People had not been actively involved in their care through assessments or received regular reviews. Regulation 9 (1) (a) (b) (c) (3) (a) (b) (d).</p>
Regulated activity	Regulation
Personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Consent to care had not been gained and that staff were not provided with knowledge and understanding of the Mental Capacity Act. Regulation 11 (1) (3).</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Medicines were not being managed in a proper and safe way. Staff did not ensure the storage, dispensing, administration and recording of medication was in line with their own policies and procedures and current legislation and guidance. People did not always receive their medicines as prescribed. Regulation 12 (2) (g).</p>

Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>There was not enough trained and qualified staff available to provide the care people require and within an acceptable time scales. Regulation 18 (1).</p> <p>Staff did not receive appropriate training and supervision in their role as a care worker. Regulation 18 (2).</p>

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not have appropriate and effective systems and processes established to assess, monitor and improve the quality and safety of the service to mitigate the risks relating to the health, safety and welfare of service users and other who may be at risk. Regulation 17(1),(2)(a, b, c, f).</p>

The enforcement action we took:

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