Thurrock Borough Council

Thurrock Care At Home

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

Summary of findings

Overall summary

This comprehensive inspection took place on the 28, 29 June and 3 July 2018 which was announced; the inspection team consisted of one inspector on all three days.

Thurrock Care at home is run by Thurrock Borough council and provides care services to people within their own homes. Care services include personal care, a sitting service and domestic services. The service is funded by social services. The service delivers across Thurrock. At the time of our inspection the service was providing support to 133 people.

The service was first registered with the Care Quality Commission on the 31 May 2017.

The service had 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.

Medication practice required improvement to ensure that people received their medication as prescribed. The auditing system needed to be improved to ensure that it is effective in all areas of the service including medication management.

The registered manager had systems in place to identify and monitor the safety and quality of the service however they had proved to be ineffective as they either did not recognise the shortfalls, or when they did there was a lack of action to rectify them.

Views about staffing levels were mixed and some people felt that there was not enough trained and experienced staff available to meet their needs. We also found that people or their relatives were not fully involved in planning and making decisions about their care. The service was not responsive in identifying and meeting people's individual care needs.

The manager could not demonstrate how the service was being run in the best interests of people using the service. Arrangements in place to keep the provider up to date with what was happening in the service were not effective. As a result, there was a lack of positive leadership and managerial oversight. Systems in place to identify and monitor the safety and quality of the service were ineffective as they either did not recognise the shortfalls or when they did there was a lack of action to rectify them.

We found that staff did not always have enough time to spend with people to provide reassurance, interest and stimulation. There was a lack of knowledge around supporting and caring for people living with dementia including understanding how it affected people differently and how each individual should be cared for to promote their wellbeing as far as possible.

Whilst staff were able to recognise poor practice, suitable arrangements were not in place to respond appropriately where an allegation of abuse had been made.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

People were not always protected against the risks associated with medicines because the service did not have appropriate systems in place to manage and monitor medicines safely.

Although staff knew how to recognise and respond to abuse correctly, not all people felt safe and we found that the arrangements to keep people safe were not always robust.

Individual risks had not always been updated and shared with staff and people.

People who used the service felt safe. Staff knew what to do if they were concerned about people's safety and welfare.

The recruitment process was robust in ensuring that staff were safe to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were required to ensure that staff's training was effective and good practice was embedded through their everyday practices with people who used the service.

Staff training provided did not always equip staff with the knowledge and skills to support people safely.

Is the service caring?

Good

The service was caring.

Staff treated people kindly and respected their privacy.

Staff were knowledgeable about people's individual care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs.

Not all people's care records were sufficiently detailed or accurate.

Effective arrangements were in place for the management of complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality assurance system was not effective because it had not identified the areas of concern found during our inspection and there were no plans in place to address them.

Staff felt valued and were provided with the support and guidance to provide a high standard of care and support.

Thurrock Care At Home

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 checked 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.

This comprehensive inspection took place on 28, 29 June and 3 July 2018, was announced and carried out by one inspector.

We looked at notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also looked at safeguarding concerns reported to CQC. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

We spoke with seven people who used the service, three of their relatives, five staff, the registered manager, two care co-ordinators and two medication officers. We looked at records in relation to six people's care, staff recruitment, supervision records and the systems in place for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We found that the arrangements for the management of medicines were not consistently safe. Medication Administration Records (MAR) sampled showed that these had not been consistently completed to indicate that medication had been given as prescribed as we found several unexplained gaps and omissions in recordings. Of the 10 Medication Administration Records (MAR) we sampled we found several unexplained gaps, when we spoke to the registered manager it was evident the service did not have a robust audit or monitoring system in place to check all records when they were returned to the office for safe keeping. Despite the registered manager showing us people's daily care records were staff had recorded medication as given. We could not be assured that people's prescribed medication had been administered as prescribed.

The service had a medication audit system in place, whereby the medication officer reviewed a sample of the returned Medication administration charts in the office. However, we found this to not be a robust system as some MaRs containing omissions/gaps where not always audited. In addition, the medication officer informed that they did not carry out a medication count or check dispensing packaging as part of the audit, so they were unable to confirm if all the medication had been administered as prescribed. Due to our findings we suggested that the service encourages all staff to check daily if MaRs have been signed for daily and report to the office were omissions are apparent. We also suggested that the medication officer carries out regular home visits to people to check MaRs and count people's medication as to ensure the service can evidence that people have received they medication as prescribed.

Despite one of the medication officers telling us they had obtained medication "train the trainer" training. The service was unable to provide us with evidence to show that the medication officers had obtained the necessary training to equip them to train other staff on the appropriate use and administration of medication. The registered did however inform that they held the qualification and had trained the medication officer who was also supported by the in-house nurse.

We also found the service had PRN protocols in place to staff show why, when and how to administer prescribed 'as and when' required medication.

Although staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, we found that appropriate arrangements were not always in place to manage risks to people's safety. Information relating to the specific nature of the risk to the person and the steps to be taken by staff to alleviate the risk were not robust or recorded.

Of the 13 records we reviewed, we found people's risk had not always been reviewed and amended when their needs had changed or health related events had occurred. For example, in March 2018 a safeguarding concern had been raised regarding a grade 4 pressure for one person during a hospital admission, despite this information being shared with the service, we could not see any reference to this in the person's newly completed risk assessment following discharge from hospital. This meant without appropriate measures in place the person would continue to be at risk of skin breakdown. We spoke to some of the staff visiting this

person and they were able to tell us tasks they would carry out such checking skin integrity at each visit and applying body cream to risk areas how this information had not been recorded on the person's risk assessment.

In addition, we also found each one of the risk assessments we viewed had identified a potential risk however failed to state how the risk/potential risk would be mitigated. For example, risk of pressure sores developing, falls, use of equipment such as a hoist, commode, wheelchairs, walking frames. Despite risk assessments stating that people used these pieces of equipment, associated risks had not been recorded therefore we were not able to determine how the service and staff ensured people were safe when using the equipment. Records we viewed could not evidence if people or their relative had been involved with discussing changes in these risks. The records did not include any reference of discussion with people or their relatives.

In response to the above concerns the registered manager informed us after the inspection that they were addressing these shortfalls urgently and they would ensure that the review of these plans would not be signed off until they accurately reflected people's needs and risks to their wellbeing.

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

Staff knew how to keep people safe and protect them from harm. Staff were able to identify how people may be at risk of different types of harm or abuse and what they could do to protect them. The service had a policy for staff to follow on 'whistle blowing' and staff knew they could contact outside authorities, such as the Care Quality Commission (CQC) and social services. Staff were certain that their concerns would be taken very seriously by their managers. One member of staff said, "We have received training on how to keep people safe. During our training we were informed how to raise a concern and who to contact if we think abuse has occurred." The registered manager had a good understanding of their responsibility to safeguard people and dealt with safeguarding concerns appropriately. The provider's policies and procedures were in line with local procedures and they worked closely with the local safeguarding team.

Staffing rotas showed us there were sufficient staff on each day to meet people's assessed needs. The registered manager informed us that staffing levels were based on the Local Authority's funding arrangements for each person. The registered manager and staff informed us that should people's need change they could deploy additional staff to meet the needs whilst waiting for a new assessment from the local authority.

Despite these findings people's views on staffing levels were mixed. Relatives and people we spoke to informed that staffing could be problematic and staff either did not turn up within the agreed time slot or on some occasions, staff did not turn up at all. One relative informed us, "I have a lot of concerns in relation to staff turning up, on several occasions my relative has rung to say the staff have not carried out their calls or turned up too late." One person informed us, "Staff do try to get to me on time however, this is not always the case as often when they get to me they are telling me they have been held up at the last visit, and I don't need much support; they will not stay for the whole visit as they are rushing to the next one." However, another person we spoke to was very complimentary for the times, they informed us, "I don't get a lot of calls like the others but I cannot fault the staff as they are always here on time even in the bad weather someone will come to me."

An effective system was in place for safe staff recruitment. This recruitment procedure included processing applications and conducting employment interviews. Relevant checks were carried out before a new

member of staff started working at the service. These included obtaining references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS).

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 found staff at all levels lacked knowledge on the Mental Capacity Act and Deprivation of Liberty Safeguards despite staff having attended training provided by the service. Staff did not understand the legal requirements of the Mental Capacity Act. Staff reported having done online training on the Mental Capacity Act however could not explain how or when it would be used.

Staff knowledge in regard to the Mental Capacity Act were mixed, despite staff having attended training provided at the service. When asked about the Mental capacity act, some of the staff informed us the following, "Is it to do with medication or mental", "I am not sure what it is about, but I have been to the training". These staff members did not understand the legal requirements of the Mental Capacity Act. This showed us that despite staff stating they had attended training they could not evidence a full understanding of the Act when support people. Another member of staff we spoke informed us, "Since you have been to visit the office we have now all been booked for Mental Capacity training." Staff informed us that they did offer people choice however did not understand that the legalities behind their actions.

Where some people's capacity may be in question, the service had not involved the person or others in order to ensure that a best interest decision was made. For example, we found the service had not assessed one person's ability to make an informed decision about their medication despite them being visibly unable to recall why they took their medication during a home visit with one of the care staff. None of the records we reviewed had evidence of the service considering or assessing people's ability to make an informed decision. There were also no records of best interest decisions being made in the interests of the individual.

After the inspection the registered manager informed us in an email, "Consent to care and treatment is gained prior to service users being referred to Thurrock care at home. We will get agreement to care provision by the signing of care plans where possible. Carers are advised to ask service users daily if they consent to having personal care, meals provided etc. Thought will be given to requesting a copy of the consent to care and treatment documentation prior to accepting ongoing referrals." However, this was not recorded in people's care plans and also did not evidence that the service was formally assessing people's ability to make an informed decision where they lacked capacity to do so.

We recommend the provider reviews best practice guidance and requirements of the Mental Health Act 2005 to ensure that all people using the service is effectively supported in terms of their capacity and abilities to make informed choices.

People and their relatives told us they found staff to have good knowledge and the skills on how to best meet people's needs and that they always provided good quality care. One person told us, "The officer team and the staff look after me very well and seem to have got to know my needs very well." A relative added,

"Staff are trained and have a reasonable knowledge of how to care for my loved one."

Staff told us they received an effective induction over two weeks depending on their role and responsibilities. This included an induction into people's homes, shadowing of experienced staff and training in key areas appropriate to the needs of the people they supported. Staff told us and records we reviewed showed that staff had received a wide range of training appropriate to their role. One staff member said, "The training is good we cover a range of interesting subjects that helps me to do my work." Another said, "Most of the training is in-house such as moving and handling, first aid and fire safety." Some staff told us they had completed a national qualification this being National Vocational Qualification in Care. Files we reviewed confirmed this.

Staff felt supported by team meetings, formal and informal supervision and they had a structured opportunity to discuss their practice and development. One staff member informed, "The manager makes the team feel welcomed, we can ask them anything and they will always support us and involve us in decision making." During the inspection the registered manager informed that they were currently in the process of reviewing and planning staff's annual appraisals.

People's healthcare needs were monitored and supported through the involvement of a range of relevant professionals such as General Practitioner (GP) and nurse specialists. We found that people received appropriate healthcare support to meet their diverse needs. People and most relatives were happy with the level of healthcare support provided and told us that they were kept informed about people's health and wellbeing.

Good

Is the service caring?

Our findings

People we spoke to told us they received a good service from kind and caring staff. One person told us that the staff were always positive and always seemed have the person's interests to heart and found most of the care staff to be respectful and care for them in a dignified way.

Some of the records we reviewed lacked narrative in regard to the person that was being supported, this being preferences, how they care was to be delivered and by whom. Despite the registered manager and staff informing us that they worked closely with all professionals and relatives to undertake specific ways of providing care for all the people using the service and this was not recorded in the care plans kept in people's homes. We found records kept in the office computer had a clear narrative who the person was and how they care was to be delivered however this information was not always available to all the staff. The registered manager informed that us that the service was in the process of reviewing and updating every person's support plan as to ensure all staff had a holistic picture of the people they were supporting. The lack of up to date records as addressed in the responsive section of this report, had not negatively impacted on people's care as found during this inspection.

Staff were knowledgeable of the people they were supporting. One person informed us, "The group of staff I have visiting me, always ask me about my life history and that is how we have got to know each other." People and their relatives were aware of their support plans and had review meetings with the management team to identify any needs or wants they may have, along with their overall well-being.

Some people informed they were involved in their care and support and would participate in care planning reviews. The registered manager informed us that where people did not have support from friends or relatives they would request advocacy services to support them. An advocate supports a person to have an independent voice and enables them to express their views when they are unable to do so for themselves. However, a relative we spoke to informed that they had not always been informed of when their relative's care reviews were carried out. They added, "On one occasion I turned up to visit my relative and found staff present doing a care review, I was really upset that no one had told me this was happening." The registered manager informed that they were closely working with the family and were aware of this situation and this was close to being resolved.

Requires Improvement

Is the service responsive?

Our findings

People's care and support needs were well understood by the staff working for the service; however, we found this information was not reflected in detailed support plans and individual risk assessments. The service had not assessed people's needs when the service started, instead they used the information either from the Local authority and/or hospital when the people's care commenced. In one person's support plan we found the service had retained four different care plans from the hospital for every time the person had gone into hospital. From reviewing the person's folder, it was not clear which care and support plan staff where working from as each support plan had different instructions. This placed the person at risk of receiving incorrect or outdated support from care staff.

We noted that work has commenced on updating support plans, however information held in one person's house was not up to date on the 29/06/2018 despite the service having received an amendment (decrease in calls) on the 15/06/2018. We also found that paper copies supplied to us during the inspection were different to those stored electronically. In addition, when we visited one person on the 29/06/2018 they informed us they preferred a night(PM) visit rather than Tea time, however this information had not been recorded in their care plan. We noted this was a similar concern raised in the local authority quality report for another person. With no indication how, the service had tried to respond to these requests.

Although the registered manager told us that a comprehensive assessment was carried out prior to the commencement of the service, there was no evidence available to show us that these had been completed. Files viewed contained minimal information on the needs of people using the service and the support they required from staff. Furthermore, the care plans viewed listed tasks to be completed during visits, but did not describe in detail how the care should be delivered. This meant staff had very basic information on the needs of the people using the service and how to deliver person centred care.

People's paper care plans showed little evidence that they had been involved in their care. There were people's signatures in some, but not all, of the care plans we checked. There was no system in place for people to review their care with the service on a regular basis. Records were inconsistent regarding people's involvement in planning their care and treatment. Some support plans contained of details about people's preferences for support while others were task focussed.

We discussed the findings with the management team who assured us that they would take action to introduce a robust assessment and develop care plans to ensure more detailed person-centred information was developed for staff to reference.

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

The service had policies and procedures in place for receiving and dealing with complaints and concerns received. The information described what action the service would take to investigate and respond to complaints and concerns raised. We reviewed one complaint that had been made in the last twelve months

and found that the service had responded appropriately to the complainant and had also ensured that other organisation mentioned in the complaint had responded to the complainant in a timely manner and with acceptable response. Staff, people and relatives knew about the complaints procedure and that if anyone complained to them they would either try and deal with it or notify the manager.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems and processes which assessed, monitored or improved the quality of the service were not effective or established. The service could not evidence any effective systems or processes which assessed, monitored or mitigated the risks relating to the health, safety and welfare of people using the service. During our office visit the registered manager was unable to demonstrate how they continually analysed, evaluated and sought to improve the governance and auditing processes and practices in line with their own quality assurance policy.

Although there were quality monitoring systems in place which had been purchased from an external company the manager informed us that they had not started using them. This meant they were not monitoring or able to provide numerical information relating to accidents and incidents and pressure ulcers, or other arrangements in place to assess and monitor the quality of the service provided. We found some people were at risk of experiencing poor care outcomes because the service had not recognised the failings within the service, including areas such as medication management, care planning and risk management.

In some cases where people had missed calls no communication had been made with them or their relatives leaving them vulnerable and without proper care. People and relatives, we spoke to informed us there had been some missed calls however the office had not always communicated with them when this had happened. One person informed us, "Missed or late calls often happen at the weekends, evenings or when one of the care staff go off sick, and sometimes the office does not call me or my relative to let us this is what is happening." The manager also informed that an audit system to monitor missed or late calls was in place and further communication would be made with people and relatives that had raised concerns as to find an appropriate resolution.

The registered manager informed that due to the rapid growth of the service, they were looking at employing office staff to support in reviewing and monitoring the service's quality assurance systems. In addition, the service had purchased a software which would support the service in the monitoring of the service but was yet to be fully implemented.

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

People benefited from a staff team that felt supported by the registered manager. The ethos to enhance the wellbeing of the people using the service was put into practice by value based training and a robust induction process. Staff received regular supervision from the management team and a yearly appraisal, which was documented within individual staff files. Staff received positive feedback, encouragement and motivation from their management team.

We found the registered manager to be open, transparent and highlighted their own errors and areas which needed to improve, to ensure the service was running smoothly and continually improving the care delivered to people. People felt that staff and the management team were approachable.

During the inspection the registered manager informed that the service was in the process of recruiting a manager to support with the running of the service. Staff said this would help them to assist people to maintain their independence and showed that people were being well cared for by staff who were well supported in undertaking their role.

Personal records were stored in a locked office when not in use. The registered manager had access to up-to-date guidance and information on the service's computer system which was password protected to help ensure that information was kept safe.