Local Solutions

# Scotland Road Branch

## Inspection report

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13 December 2016
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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | **Requires Improvement** |
| 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 announced inspection took place on 13, 14, 15, 16, 19, 20 December 2016 and 27 January 2017. The service was last inspected in in March 2016 and was found to be in breach of six regulations. These were in relation to regulation 9 person centred care, 11 consent, 12 safe care and treatment, 13 safeguarding, 17 governance and 18 staffing. The overall rating of the service was inadequate resulting in the service being placed in special measures.

On this inspection we found the service had improved and was no longer in special measures. However, some improvements where still required and the service remained in breach of regulations 12 safe care and treatment, 18 Staff training and 9 Person Centred Care. We also made recommendations in relation to governance and leadership.

There was 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.'

'Local Solutions' Scotland Road Branch is a not for profit social enterprise, predominantly operating across the North West of England. The organisation is a registered charity and it does not recruit nurses. The organisation provides personal care and support for people living in their own homes. At the time of our inspection there were 681people using the service and 331care staff.

Since our previous inspection in March 2016 there were changes within the management of the service including a newly appointed registered manager. The service had changed their referral procedure and had worked towards improvements set out in their action plan which we requested from them. They had sourced agency quality officers to drive improvements within the service some of whom were being employed by the service.

On our last inspection we found there were not enough staff to provide care when people needed their care. Staff were not provided with travel time in between calls and were call cramming. We checked this during our inspection and found not everyone we spoke with was receiving their care at the time they needed it. We were informed by the provider travel time was now incorporated into the rotas for staff. The provider had made improvments since our last inspection and were no longer on breach of the regulation related to staffing levels. However, there were still some concerns raised during this inspection of staff not always being able to provide care at the time specified on the rota.

We recommended that the provider undertook a staffing analysis to ensure there are enough staff to provide care for people when they need their care.

We found during our last inspection that people were not always safeguarded from abuse. This was because

not all reportable incidents had been reported to the local authority. The provider was in breach of regulations in relation to this. We found during this inspection that there was a clear system of reporting safeguarding concerns and staff were aware of the signs of abuse. Staff were also aware of whistleblowing and what to do if they wanted to raise concerns.
The provider was no longer in breach of these regulations in relation to safeguarding.

At our last inspection in March 2016, we saw that consent was not always being sought in line with legislation. The service was in breach of this regulation. We saw during this inspection that consent was being sought in line with the Mental Capacity Act 2005 and the care plans we viewed contained information regarding the person's mental capacity with evidence they had followed a best interest's assessment.
The provider was no longer in breach of this regulation related to consent.

During our last inspection in March 2016, we found that staff were not always trained to provide the care they were delivering for people. We saw during this inspection this was improved, however some staff had not always received the appropriate training to be able to deliver effective care for people such as stoma care and enough practical manual handling training and experience to be able to use a hoist. The staff member who was responsible for assessing and writing manual handling risk assessments and care plans had completed the mandatory manual handling training but they had last undertaken manual handling risk assessment training in 2009.

The care provider remained in breach of the regulation related to staff training.

There was a staff supervision structure in place. However, some staff had only received supervision annually. Some staff told us they were receiving supervision once each year. Appraisals were being undertaken .There was an induction and the staff files we viewed demonstrated safe recruitment practices were in place.

Fluid and nutrition balance charts were being recorded when appropriate and staff were supporting people with food preparation and eating/drinking.

People and their relatives told us they were not always being listened to.

Staff we observed who were speaking with people spoke to them in a respectful manner. We were present whilst a staff member was talking with one person during a care call and they spoke with them in a gentle and calm manner and asked them if it was alright for them to support them before they provided care.

We received mixed views regarding whether staff always treated people with respect and dignity. Staff told us they wanted to do the right thing for people they were caring for.

People were being involved in the planning of their care and relatives were also being consulted with.

The complaints policy and complaints procedure were not consistent for people to be clear what they needed to do to make a formal complaint.

Communication systems were not always effective which were impacting on people. Computerised records were incomplete with no system of checking what was being entered onto the system.

The service were not making their complaints process clear for people using the service for them to ensure they were always learning from concerns people had.

Audits had been completed with trends analysis and action plans. This demonstrated they were driven to improve and act on the information from the audits undertaken. However, they didn't always pick up on the concerns we found. Further work was required to ensure an effective system of quality assurance was in place.

We recommend that the provider continues to review their approach to quality assurance and takes action accordingly.

The service had strong links within the community and was seeking guidance outside the organisation to ensure they were aware of best practice.

Following our inspection the registered manager provided us with an action plan of further improvements required.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Risks had not always been identified for people who were prescribed PRN medication, who needed pressure care and manual handling.

There was a clear system of reporting safeguarding concerns and staff were aware of what actions to take if the suspected someone was being abused.

There were adequate staffing numbers but staff were not always remaining with the person receiving care for the duration of the call.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had not always received the appropriate training to be able to deliver effective care for people.

Consent was being sought in line with the mental capacity act 2005 and the care plans we viewed contained information regarding the person's mental capacity with evidence they had followed a best interest's assessment.

There was a staff supervision structure in place with some staff only receiving supervision annually. Annual appraisals were being undertaken.

Fluid and nutrition balance charts were being recorded when appropriate and staff were supporting people with food preparation.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Not all people and their next of kin/relatives we spoke with told us they were always being listened to.

Staff we observed speaking to people receiving care spoke with them in a respectful manner.

Staff wanted to do the right thing for people they were caring for and people's views were being sought.

The service were aware of advocacy services available for people.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care needs were being assessed and reviewed however, the risk assessments were not detailed enough for staff to know what to do.

People were being involved in their plan of care and there was person centred information seen in the care plans we viewed.

The complaints policy and complaints procedure were not consistent for people to be clear what they needed to do to make a formal complaint.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

Communication systems were not always effective which were impacting on people.

Audits had been completed with trends analysis and action plans. However, they didn't always pick up on the concerns we found on this inspection. Further work was required to ensure an effective system of quality assurance.

The service had strong links within the local community.

A registered manager was in post and based on site.

# Scotland Road Branch

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 13, 14, 15, 16, 19, 20 December 2016 and 27 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to be sure that someone would be in.

The inspection team consisted of an adult social care inspector 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.

We reviewed information we held about the service including a PIR (Provider Information Return) which contains information we requested from the service. We also liaised with the Commissioners of the service.

The methods that were used included talking to people using the service, their relatives, interviewing staff, pathway tracking and a review of records.

We looked at 12 care plans, visited four service users in their own homes, spoke with 10 staff, 14 people who used the service and five relatives.

Requires Improvement

# Is the service safe?

## Our findings

The service was last inspected in March 2016, and received a rating of 'Inadequate'. We identified three breaches of The Health and Social Care Act 2008 for this domain. This was in respect of medicines not being managed safely staffing levels, a lack of knowledge and training around safeguarding procedures and risk assessments did not contain enough detailed information.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet the breaches. On this inspection we checked to make sure requirements had been met and we found some improvements had been made to meet necessary requirements. Two breaches of regulation had been met and one breach remained.

One person we spoke with said "I need to be lifted by the hoist if I need to use the commode. Last Saturday, they sent two new staff together and neither of them knew how to use the hoist. I was able to tell them what to do and how to fix the straps but I was very frightened and I don't know how anybody would have coped who couldn't explain to them. I would have been stuck. I rang the office and they said that they were very surprised that the two staff didn't know how to use the hoist and they would look into it. They said that they might need to sort out extra training." We looked at the two staff member's staff files to ascertain what experience they had previously had prior to working for Local Solutions. We found they had not had any previous experience working in care and were relatively new to the role of being a carer.

We visited the person who was being hoisted by staff as they had experienced a "near miss" when staff who visited did not know how to use the sling to attach to the hoist. We viewed their care records including their manual handling care plan and risk assessments. We raised concern with the registered manager that the manual handling care plan assessment was not detailed enough and it was basic. It did not provide guidelines for staff to know how to attach the sling to the hoist. It is imperative that a person who is assessed as needing hoisting has a detailed assessment and care plan so staff know which tabs to use to attach the sling to the hoist with. If the incorrect tabs are used this can lead to the person being positioned incorrectly when being hoisted which can be frightening for the person or lead to discomfort as the sling can tighten in places such as around the inner thighs. We asked the provider to undertake a more thorough assessment and review of the person's manual handling needs.

The manual handling risk assessment and care plan was reviewed and a new one placed in the person's home which detailed specifically how to attach the sling to the hoist. A new manual handling protocol was devised by the service and the action plan we were provided with stated that the 125 people who needed two care staff to support them with manual handling would receive a review of their care plan by March 2017.

In view of the risks of staff not being able to use the hoist and insufficient detail in the care plan for staff to follow, we highlighted this to the registered manager who agreed to look into this. The registered manager took immediate action. Both staff members were taken off care visits which involved hoisting people until the registered manager had looked into the matter further.

Two people who were receiving pressure care from staff did not have a pressure care risk assessment in their care plan for staff to know what the risks were and why the care plan was specifying the person needed to be turned regularly. We also found gaps in the care records were information had not been entered by staff to say whether the person had been turned or not. Therefore, we could not be certain staff were always following the care plan. We spoke with the registered manager about this and they took immediate action and devised a pressure care risk assessment for the two people we had highlighted there were pressure care concerns about.

We looked into how people were being supported with their medicines including prescribed creams. One person receiving care told us "I sort out my own tablets but they do watch to make sure I've taken them properly and at the right time and I think they write it in the book."

For people who did not have capacity to monitor their medication, there were instructions for staff to follow to support them. However, we found one person had no information in their care plan or a risk assessment for their prescribed PRN medication. PRN means as and when required. . There were no instructions for staff which explained when the person would require the PRN, signs and symptoms to indicate they needed it or timed intervals of when it was safe to be administered. This meant that staff were using their judgement as to whether the person needed their PRN medication. We raised this with the registered manager who explained they did not have a PRN risk assessment or care plan in place for any of the people receiving care. Therefore, we asked the registered manager to ensure they sought the appropriate advice to devise a PRN medication risk assessment/care plan so staff were clear when to give medication for people.

Another person's records we viewed was prescribed proshield plus cream to be applied four times per day and proshield foam and spray to be applied before the cream was applied four times per day. We found there were numerous gaps on the daily records over several days where staff had not recorded they had applied the creams as prescribed. Another person's care plan did not contain instructions for staff for them to know how many times per day to apply the prescribed cream. However, the MARS (Medication Administration Record Sheet) stated it was to be applied four times per day. We checked the daily records and there were several gaps where staff had not entered cream had been applied. We discussed this with the registered manager as we could not be sure people were having their prescribed creams applied when they needed them. The registered manager arranged for a pressure care plan to be placed in the person's care plan and also devised a pressure care risk assessment to highlight to staff the risks posed to the person if creams were not applied as directed.

The service had undertaken work around medicines management and they had undertaken checks to ensure MARS sheets were being completed appropriately, completed some medication observations of staff and looked into medication errors. Further work was needed to ensure the provider was meeting the regulation related to medicine management.

Another person had not had their pressure care mattress switched on at night by staff and was therefore, being placed at unnecessary risk of harm. However, we found the care plan did not contain a pressure care plan to make it clear to staff they needed to ensure the pressure mattress was switched on before they left at night.

Due to a number of concerns regarding pressure care the registered manager took action and devised a pressure care risk assessment and plan which was to be rolled out to every person who needed pressure care. The action plan provided to us by the service stated they were intending to implement the use of the pressure care plan/risk assessment for people who were deemed as high risk of pressure areas developing and ensured they were in people's homes within two months of our inspection. The service aimed to ensure

all people with pressure care risks would have this within their care plans by June 2017.

Even through some improvements had been made the provider was still in breach of this regulation.

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

During our last inspection the service was in breach of regulations relating to staffing. This was because there were not enough staff deployed to meet people's needs. Following this inspection the provider wrote to us to tell us what action they were going to take and we checked this as part of this inspection.

We checked if there were enough staff being deployed to provide care for people and if staff arrived when they were expected. We viewed the missed visits log and there had been missed visits logged. There was an analysis of this which concluded 50 percent of the missed visits were as a result of the staff member not attending the call. The registered manager was looking into the reasons why missed visits were occurring.

We asked people who used the service their views. One person said "At weekends they are too late coming." Another person told us "'I think they might be a bit short staffed because sometimes they can be a bit late and I think it's because they've had somebody before me who needs a bit more help." Another person we spoke with told us "It's not often that they're late but it's a nuisance when they are because I tell them I don't want a shower then – it's too late."

Another person who uses the service said "I have had to complain about the time of my call in the morning. It should be 9am but it was creeping up to around 10am and I don't want to be getting up that late. I've complained and it's alright now during the week but not so good at weekends. Sundays are the worst and it has been as late as 10.20am. I feel as though my life is on hold when it's that late."

We highlighted travel time as an issue on our last inspection and although the provider told us they were now providing staff with travel time in between care calls some people were still experiencing late calls. However, we did also find staff were remaining with people for longer than the call time. One person told us on one occasion the staff remained with them for over an hour longer than expected due to them being distressed.

We viewed the Electronic Call Monitoring contact time report and over a period of six months, contact time had improved from 71.46 percent to 75.53 percent. The service had a 90 percent contact time target which they were gradually moving towards which was an improvement since the last inspection. The service had improved enough not to be breach of regulation. However, further work was still required to ensure that people receive care at the time when they need it.
We recommended that the provider undertook a staffing analysis to ensure there are enough staff to provide care for people when they need their care.

At our last inspection, we found that not all staff were aware of their roles in relation to safeguarding and not all incidents had been reported to the local authority. The provider was in breach of regulations in relation to this. Following this inspection, the provider sent us an action plan detailing what action they were going to take to ensure they met this breach. We checked this as part of this inspection.

During this inspection, we checked if staff were aware of their responsibilities to report abuse or suspected abuse. One staff member told us "It's not easy when people can't speak very well but I watch out for their body language. If somebody loses interest in things or loses their appetite for example". Meaning these are

signs of abuse. Another person described what they would do if they became aware of abuse and told us they would report it to the registered manager. We found staff were aware of the different types of abuse and of their responsibilities in reporting suspected abuse. Staff had received safeguarding adults and children training and they were also aware of whistleblowing. We found evidence of a safeguarding trends analysis and staff files we checked contained certificates to confirm the staff members had completed safeguarding training.

The service had improved and were no longer in breach of this regulation related to safeguarding.

During this inspection we asked people who use the service if they felt safe. One person told us "they look after me really well. They are nice staff and I feel very safe with them." Another person we spoke with told us "I feel very safe with them" [meaning the staff]. A third person told us "They came and had a look round to make sure there weren't rugs or things that I might fall over".

We checked the service's recruitment practices. We found all staff files we checked contained a valid Disclosure and Barring Service check to confirm the appropriate checks had been undertaken and they also contained an application form and references.

Requires Improvement

# Is the service effective?

## Our findings

At our previous inspection we identified a breach of regulation in relation to consent. This was because the care provider was not following the principles of the Mental Capacity Act 2005 (MCA). We also identified a breach in relation to staff training, as staff did not always have the skills required to support people. The effective domain was rated 'Inadequate'.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet the breaches. On this inspection we checked to make sure requirements had been met and we found some improvements had been made to meet necessary requirements. The provider was no longer in breach of these regulations.

On this inspection we checked the recruitment practices within the service. We found an induction in the staff files we viewed and we asked staff about their training. One staff member told us "I did seven days training at the start (employed six months ago) and I shadowed another carer. I have done training in MCA and safeguarding as well as moving and handling. I've recently asked if I can do training for PEG feeding as well because I want to develop a full range of skills."

The induction was over seven days which included policies and procedures, dignity and person centred care, moving and handling legislation, practical use of equipment and assisting someone to stand, medication awareness level 1 and 2, incidents and near misses.. Another staff member told us "I transferred from another service so I already had a lot of experience but I'm still getting regular updates and appraisals. I've asked to update on dementia but there is a lot of demand for that so I'm still waiting."

We viewed the training matrix for 331 staff employed by the service. There was a clear system in place which listed the mandatory training with dates when staff needed to update their training. Mandatory training included Safeguarding, medication awareness, health and safety, first aid, food hygiene, manual handling, dementia awareness, communication/behaviour management and mental capacity act/mental health training. People who had complex care needs such as stoma care had not always received care from staff who were trained to deal with aspects of stoma care. Staff who were undertaking manual handling risk assessments had not received updated manual handling risk assessment training since 2009. We discussed this with the registered manager who took action by reviewing how many people required stoma care and how many staff they had to provide stoma care. We were informed by the registered manager the service were no longer accepting referrals to provide care for someone without first checking they had enough staff who were trained to provide specialist care such as stoma care. The registered manager also arranged for two staff to receive updated training in undertaking manual handling risk assessments and provided additional manual handling training for some staff. In view of the provider making some improvements we highlighted that the manual handling assessors were not up to date in their manual handling training and not all staff providing manual handling care were confident or competent to undertake manual handling.

This is a breach of Regulation 18 Staffing of the Health and Social Care Act Regulations 2014.

We viewed competency checks which were being undertaken by the service. For example, we viewed the Medication Observations Summary Report for November/December 2016 which detailed 19 staff members who had received a competency observation. These observations were on-going. However, we did not always see staff had received a manual handling competency check prior to them undertaking manual handling with people.

Mental Capacity Act 2005 training was being provided for staff and was mandatory training since the previous inspection. Although we found not all staff had received Mental Capacity Act training, the service were working towards all staff receiving this training.

We saw during our last inspection in March 2016, the provider was in breach of regulations relating to consent. This was because the principles of the Mental Capacity Act were not always being addressed. Following our inspection, the provider sent us an action plan detailing what steps they were going to take to meet this breach. We checked this as part of this inspection.

The 2005 Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We asked staff about what they understood about the Mental Capacity Act 2005 legislation. One staff member told us they would refer a person whose mental capacity was impaired to the Local Authority for an assessment and they would request a best interests meeting. We found significant improvements had been made in how the service were documenting if someone had mental capacity or had difficulty in making specific decisions. We viewed evidence that the service were involving the General Practitioner (GP) and family members as part of a best interest's process when appropriate however, further improvements were needed to ensure clear instructions were being provided for staff to ensure they were aware of what to do and how to act in someone's best interests if for example, a person declined to eat.

We found consent was being sought in people's care plans we viewed. For example, we found consent had been sought for aspects of people's care such as staff to enter a person's property using their key, to provide personal care including stoma care and to support with medication administration. It was also clearly documented when someone was not providing consent and preferred a family member to support them with an aspect of their care. The provider had improved and was no longer in breach of regulation.

There was a supervision structure in place however, we identified there were gaps and we found some staff were not receiving regular supervision with no clear supervision plan. Some staff told us they had received supervision once per year. The registered manager completed a review of the supervision structure and confirmed to us within an action plan that a supervision plan would be implemented for all staff. This was to commence in January 2017 with dates when their supervisions were being planned and a supporting action plan for further training and any actions in relation to performance to be documented and followed up. Appraisals were being carried out.

We checked to see if staff were trained and skilled in delivering care and referred people to other medical professionals when needed. One person told us "I think they are really well trained in the care they deliver. I am diabetic and they are very careful about noticing any changes to my feet. I can't bend down to see them

myself. For example, a few months ago, the carer noticed that I'd got a burst blister on my toe and she sorted out a phone call to the chiropodist. Then I was referred to the hospital because you have to be careful with your feet if you're diabetic. At the moment, I have a rash on my right foot and I'm waiting for an appointment. It was the carer who told me about it." Staff were contacting healthcare professionals when appropriate and we found details of some health care professionals detailed within people's care plans.

Most people's care plans we viewed all provided important information about people's nutrition such as the level of support and assistance people needed with preparing food and drinks and eating and drinking. The care plans also contained information about the type of thickener the person needed for staff to be aware the person was unable to drink unthickened fluids due to the risks of them choking. People were being provided with assistance to eat and drink at times in the day which had been agreed with them in accordance with their plan of care.

We found the service had strong links within the local community, with other organisations and also were seeking guidance outside the organisation when needed. For example, the registered manager confirmed they were sourcing the skills and expertise of a qualified nurse to advise them regarding more complex nursing aspects of people's care to ensure they were following up to date practices.

Local Solutions continued to run the 'The Carer's Service' for unpaid carers. The service had strong links within the Liverpool community including Liverpool City Council and took part in the Older People's Conference, Older People's Awards and the Winter Assistance Partnership Campaign which aimed to support elderly and vulnerable people. They held a Carer of the Month/Year award organised by senior management for Care Support Workers who go above and beyond or demonstrate best practice. Each year 12 carers of the month are put forward for the Carer of the Year award.

Requires Improvement

# Is the service caring?

## Our findings

On our last inspection this domain was rated requires improvements. We asked people their views about the care they received and found the majority of people were positive however, we received some concerns regarding how people were being spoken with and treated by staff.

One person said, "I'm very happy with the carers. I tell them what I need and they are really obliging."

Another person said, "I have the same staff in the week and other people at weekends and they are all really nice." One person we spoke with told us "Sometimes the carers don't listen to me because they're rushed, it makes me frustrated". Another person said "Overall I'm very happy. They generally come when they should and do what they need to do. They are good people and very kind to me."

One person told us "The main thing I like is that they clean the commode really well after I've used it which really matters because it bothers me if I think it's going to smell."

We spoke with a next of kin for one person who was receiving care who raised concern with us during the inspection. They said were not being listened to by the service regarding the person's difficulties. They raised concern they had Lasting Power of Attorney but they were not being listened to. We spoke with the managers who told us the next of kin was regularly contacting them but they had no evidence the person was a Lasting Power of Attorney. When we spoke with the next of kin they told us they were concerned the service were not listening as they had explained to them they had LPA during a review but the service were continuing not to listen to their concerns regarding the person's care. We viewed the care plan which had been reviewed recently which did not detail the next of kin had LPA. We discussed this with the manager who took action immediately and upon requesting confirming of LPA status updated the persons care plan to reflect this. This was very important so staff were aware the person may need support from their LPA.

People were being involved in their care planning. One person said "They did an assessment at the beginning and they wrote down what needed to be done and I signed the paper." We observed people had signed their plan of care when they had been visited by a staff member to review it. People who we visited during our inspection told us they were being visited by staff who were coming to review their plan of care with them.

We were present whilst a staff member was talking with one person during a care call and they spoke with them in a gentle and calm manner and asked them if it was okay for them to support them with personal care. The person requested this to be undertaken with them later.

Staff we spoke with were aware they needed to gain people's trust, they told us "I've had personal experience of being a carer for family members and I know how important it is to really care about people. I have regular clients and I like to really get to know them so that they trust me and are comfortable letting me do personal things for them without getting embarrassed."

Another staff member told us "One thing I'm very aware of is dealing with people's embarrassment. For example one person was refusing to get out of bed and I knew it was because they (defecated) so I didn't feel I could just leave it. I managed to jolly [person] along and they told me what they had done and was upset. I was really matter of fact about it – which [the person ] needed – and then they was happy for me to wash them, strip the bed off and make them comfortable." This demonstrated staff were aware of the importance of supporting people in maintaining their dignity and were respectful of people. Staff were aware of the impact of the particular problem and were aware of psychological and emotional affects resulting in embarrassment.

The care plans we viewed provided information for staff to be aware how to encourage a person to maintain their independence. People we spoke with told us they were being enabled to be as independent as they could be with daily activities.

Some people we spoke with told us they were being provided with choices for example one person told us "They do everything I want. I'm down for an hour but I don't mind if they go ten minutes early as long as everything is done and it usually is." Another person told us "If I don't feel like getting showered then they don't insist. I like that I can make my own decisions."

The service were aware of advocacy services for people locally and knew how to access this for people who needed it.

Requires Improvement

# Is the service responsive?

## Our findings

During our last inspection in March 2016 we rated this domain as 'Requires Improvement.' We identified a breach of regulation in respect of care not being delivered in a way which was meaningful. On this inspection we found the care provider had made improvements but were still in breach of this regulation.

Of the 12 care plans we viewed during the inspection we found risk assessments had been written such as environmental risk assessments, mobility and falls risk assessments, moving and handling risk assessments, medication risk assessments and nutrition risk assessments. Although a risk for one person was they were nil by mouth as advised by their Dietician, this was not clearly documented for staff to be aware of this risk. We found it was documented within the body of the care plan on a loose piece of paper which was next to the care plan. We raised concern with the registered manager that the piece of paper could easily be moved or misplaced and it needed to be secured to the care plan. The implications for someone who is at high risk and is nil by mouth being provided with a drink can be aspiration which is where fluid can enter the lungs and result in an infection or choking.

We found other care plans which contained risks assessments were not always detailed enough. For example, the manual handling care plans we viewed lacked sufficient detail for staff to know what to do. We also found people who had pressure care needs did not have a risk assessment in place for staff to be aware of the risks for them.

This is a breach of Regulation 9 Person Centred Care of the Health and Social Care Act Regulations 2014.

We found staff were monitoring and assessing people's care needs. One person told us "The carers are excellent people. I like them and I get on with them. I'm just waiting now to be reassessed because they think I might need an extra call." Another person told us "They come and massage my legs and put cream on because I can't do it myself and they tell me if they think I'm looking a bit 'off colour' and ask if I'm feeling alright. It's very reassuring".

All of the care plans we viewed contained some person centred information about the person such as their background were the person was from, what their occupation was prior to them needing care, their interests and hobbies. Person centred care plans enable staff to be aware of important things about the person they are providing care for, based around the person's needs and not the services.

People we spoke with were aware when they could expect to receive their care and most people were pleased staff arrived when they needed care. People's preferences were being documented for example, the person's preferred choice of name.

We checked to see if the service were following a complaints procedure and the policy in place. The complaints procedure we viewed was dated October 2016 and stated 'Complaint should be directed to the registered manager/operations manager. All verbal/written complaints to be acknowledged in 24 hours.' We noted the policy did not state they were to provide the complainant with an outcome to their complaint but

would make every effort to provide an outcome and response within 7 working days. We asked people who used the service what their understanding was of the complaints procedure. All people and relatives we spoke with told us they had been informed by staff to contact the care coordinator if they had a complaint. One person told us they had made complaints to the care coordinator but had not had a response. Another person told us they had made a complaint via the service' webpage and not received a response.

Therefore, we were concerned not all of the complaints raised by people were being treated as a complaint as they were not being directed to the registered manager or operations manager. We discussed this with the registered manager that people were not clear what they were required to do to raise a complaint. We asked the registered manager to review their complaints policy and how they communicated the complaints procedure. The registered manager took immediate action and the service devised a new complaints leaflet and revised their policy. The new policy explained people were required to raise a concern with their care coordinator and a formal complaint to the registered manager. We were assured by the registered manager that this was distributed to all of the people who used the service.

We viewed the complaints which had been made in the complaints file. One complaint had been made by a relative who we had met on our previous inspection. The complaint was regarding tasks not being completed, record keeping by staff, continuity of staff arriving to provide care and contact time. We spoke with the relative who told us things had improved since making the complaint apart from in respect of continuity of staff. A response had been sent to the relative with actions set out.

Requires Improvement

# Is the service well-led?

## Our findings

On the last inspection we found a breach of Regulation 17 Good Governance due to ineffective quality control systems not capturing what needed to improve within the service. Following our inspection the provider sent us an action plan detailing what action they were going to take and we checked this as part of this inspection.

On this inspection we found some improvements had been made. The provider had responded quickly to the concerns we found on this inspection when they were pointed out to them. However, work was still required to ensure improvements continued to be made in respect of the quality assurance systems the service had in place so they could be more effective in identifying concerns and areas for improvement.

Following the last inspection changes had been made to the management of the service. There was a new registered manager in place since September 2016 who was now based at the branch. They had oversight of the day to day running of the service. There was another director on site available for support if needed and the safeguarding and dignity manager had an active role in driving improvements within the service. The director for strategy performance and communications was also visiting the branch regularly to support the registered manager.

We asked staff for their views about how the service was being led. One staff member told us "The whole branch has improved". Another staff member told us "It's improving [meaning the service], we do quality assurance checks and on the job supervision but the calibre of staff coming through needs to improve. Training is good here. I have supervision once each year".

The service were seeking the views of the people receiving care. We viewed a telephone quality assurance check report dated 15 December 2016. The report confirmed a total of 146 people receiving care had been contacted by telephone to request their feedback about the staff member who was providing their care by asking six questions. Questions included were "How would you rate your service overall, are you satisfied with the care/support that this particular member of staff provides, does this member of staff make you feel safe and secure?". The report analysis concluded that 51 percent of people rated their care as "Good", 27 percent as "Excellent", 17 percent as "Average" and 5 percent as "Poor". There was an action plan seen following this analysis demonstrating the service were collating the information to improve the service being provided for people.

Since our last inspection the service had implemented a new referral screening system. This was an innovative new system which they had implemented to reduce the risk of new care packages being taken on without receiving all the information they required to determine if they were able to meet the needs of the person from the outset. Previously the service had an automated referral system whereby they would accept all referrals sent to them by the Local Authority. The oversight of the care pathway from referral onwards had been improved with a focus on working collaboratively with the Local Authority to ensure all care packages being referred to the service were going to be sustained. This ensured care packages were not breaking down due to a number of factors such as not having adequate staffing numbers skilled in a particular area

such as stoma care, and the service not being informed of a person's full diagnoses or problems.

Staff we spoke with all raised concern about the rotas. One staff member told us they received a call from the office a few minutes prior to them being requested to attend for an additional visit being added to their rota which made it impossible for them to achieve. We found evidence of this as one person said "The carers are wonderful and the office staff are always polite and friendly. The only criticism I would make is that if they are sending somebody new they should check how far that person has got to come but they don't. They send somebody from miles away and then it's not the carer's fault if they are late." One staff member told us "I check the rota last thing at night and again first thing in the morning before I set off but they change it all the time. I look at it half way through the morning and it will have been changed."

Another staff member told us "They add in extra calls without telling me and then I'm either rushing or late for the next call." Other comments from staff were "I check the rota last thing at night and again first thing in the morning before I set off but they change it all the time. I look at it half way through the morning and it will have been changed." "They add in extra calls without telling me and then I'm either rushing or late for the next call."; "They are supposed to inform me of any changes they make to the rota but they don't. You have to keep looking at it for yourself." Also "Recently it was my day off and I looked at the rota at five minutes to three and saw they'd put me down for a call at 3pm. I went as fast as I could but the client grumbled because I was late.";"Everybody grumbles about the rota. It is always being changed and you don't know if you're coming or going. You have to have a smart phone so you can access it on the internet but sometimes you might be in an area where there is no connection or it loses the signal. It's a nightmare."

We raised concern about this with the registered manager who took action and confirmed they were now implementing a supervision structure for staff responsible for devising the rotas. The registered manager told us they were trialling a new system and were developing a new way of ensuring checks were undertaken to highlight any issues with the rotas.

We looked into how effective the service' communication systems were. We found some of the communication systems were not robust enough. For example, we raised concern regards the computer records being entered into the system not always being kept up to date. We viewed the computer records and found some people's records had not been updated for several months despite there being changes or events which had occurred. We raised this with the registered manager who took action to review this by addressing it within supervision sessions and by completing an audit of the records.

We found there was no system in place to audit the records made by staff onto the computer based. As we had identified records were not always being completed. The service conducted a specific audit during our inspection of some of the records being written by staff. We viewed the outcome report which evidenced only two out of 10 of the records checked had been completed appropriately. Not all staff were documenting pertinent information for example, one person's fall had not been reported to the registered manager or the service's health and safety officer in line with their policy and on another occasion a safeguarding concern had not been reported.

Another person's care call had been cancelled by the service but it was not documented whether this was investigated and followed up with no evidence of an apology to the person or response from the service. We viewed documentation including a warning given to one staff member regarding their performance and we found a performance plan was in place. We were assured by the registered manager they were acting on the information from the audit and they were following disciplinary processes. We viewed the action plan from this audit which documented the service were implementing more robust checking systems.

The service had completed a range of audits and reports such as in Medication, Safeguarding analysis, Incidents and accidents, complaints, electronic monitoring and mandatory training.

The service were looking at innovative ways to drive further improvements. The Director for Strategy, Performance and Communications devised a report called 'Homecare: A Good Future; Liverpool Action Plan 2017-18' which we viewed. It outlined the way the service was to be changed in the future to continue to improve the service provided. There was also another Director on site who staff had access to if they needed support. During the inspection we were provided with a copy of the newly developed manual handling protocol by the Safeguarding and Dignity Manager and also a copy of the new complaints policy and procedure they had developed with the registered manager. We were therefore, confident that the service were listening to concerns and were implementing new ways of working when needed in a timely way to mitigate risks identified.

When we returned to complete the inspection on 27 January 2017 the registered manager had already taken action and arranged for a PRN medication risk assessment to be devised for people who were on prescribed "as required" medications by their GP and were deemed by the service as "High Risk". They had also developed a new pressure care risk assessment and care plan which they had begun to roll out across the people who were needing pressure care. Staff who had completed refresher training or induction had received manual handling training to include a wide range of transfers and the service were reviewing their manual handling training. People who were requiring two staff members to assist them with being hoisted had been provided with an updated manual handling detailed care plan and two senior staff members had attended a manual handling course to update their training in manual handling.

Following our inspection we were provided with an updated action plan which provided us with timeframes for when the service were set to achieve the outstanding work needed to implement all the actions required. The service had achieved a number of actions and were continuing to work towards the following actions to ensure all people who were receiving PRN prescribed medication to have a risk assessment for staff to follow. , People who were receiving pressure care to have a detailed section in their care plan which provides staff with information about the risks for people. A new protocol for undertaking manual handling assessments had been devised during the inspection and was to be applied for all people who required use of a hoist, to have a detailed manual handling care plan in place, staff to complete more in depth refresher training in manual handling and for staff attending their induction. The managers had actioned in the action plan for them to complete audits on the computer system to ensure they continued to identify any gaps in record keeping and recording of pertinent information to ensure each person had contemporaneous care records.

We recommend that the provider continues to review their approach to quality assurance and takes action accordingly.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>We found care plans which contained risks assessments were not always detailed enough. For example, the manual handling care plans we viewed lacked sufficient detail for staff to know what to do. We also found people who had pressure care needs did not have a risk assessment in place for staff to be aware of the risks for them. The care provider sent us an action plan including how they were planning to reduce these risks. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>We found people did not always receive care which was safe due to staff not having the appropriate level of detail within the risk assessments such as manual handling risk assessments. PRN prescribed medication was seen on MARS sheets with no care plan or risk assessment for PRN medication for staff to know when it was safe to administer. People who required pressure care did not have a pressure care section in their care plan for staff to know how to reduce the risks. For example, it was not documented for one person that they needed staff to ensure their pressure mattress was switched on prior to them leaving at their bed time call. The care provider sent us an action plan to address these concerns. |

| Regulated activity | Regulation |
|---|---|

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

We found staff were not always trained to ensure they were skilled or knowledgeable to provide care. This was related to manual handling training and other specialist care such as stoma care. The care provider sent us an action plan which addressed these concerns.