Savannah Care Limited

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

Summary of findings

Overall summary

We undertook an announced inspection of the service on 18 November 2016. This was the first inspection of this location since it was registered on 29 June 2016.

Savannah Care Limited provides a domiciliary care service, supporting people with their personal care in their own homes. At the time of our inspection 21 people were receiving a service..

The service had 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 suitable staff available to provide care in line with people's preferences and at the agreed times. The staff rota system showed that sufficient time was not allocated to enable care workers to provide care at people's preferred times and for the required length of time. Communication logs also showed that staff did not consistently attend visits at the scheduled times. People and their relatives confirmed that staff arrived at different times.

Staff had not completed the provider's mandatory training and did not attend regular refresher training courses. Staff had also not received regular supervision. There was a risk that staff did not have up to date knowledge and skills to provide people with care in line with good practice guidance.

The registered manager had not appropriately assessed the risks to people's health and safety. The registered manager had not identified the risks of people falling or those associated with moving and handling needs, dietary requirements or in relation to sensory impairments. The registered manager has also not developed adequate management plans to mitigate these risks.

The registered manager had not ensured the principles of safe medicines management were followed in regards to the administration and recording of topical creams. People's care records did not provide clear instructions about what creams people needed applying and to what areas of their body. Care records were not updated in line with changes in people's prescriptions.

Due to a shortage of staff, there was at times a lack of consistency in the staff supporting people. This was impacting on the relationship and rapport between people and their care workers. This also meant that some of the newer care workers did not know people's routines and preferences in regards to how support was delivered.

Care plans were not reviewed and updated in line with changes in people's needs. The care plans did not provide sufficient information and detail about a person's support needs to inform staff what action to take to meet the identified needs. The registered manager did not have an appropriate process in place to audit

the quality of care records.

There were not sufficient systems in place to review the quality of service delivery. Spot checks had not been completed and there were no systems in place to manage this process and ensure regular checks on the quality of care delivery. There were no systems in place to review key performance data and learn from complaints, incidents and accidents.

The system to review staff's compliance with people's visit times could not be relied upon and was seen to record inaccurate data, meaning the registered manager could not be assured that staff attended people's visits on time and stayed the required length of time.

The provider was in breach of the legal requirements relating to person-centred care, safe care and treatment, staffing and good governance. You can see what action we have asked the provider to take at the back of this report.

Staff were aware of their responsibilities to provide care in line with the Mental Capacity Act 2005 code of practice. They were also knowledgeable in recognising signs of abuse and were aware of the procedures to follow to safeguard people from harm.

Staff supported people as necessary with their nutritional needs. They were aware of the healthcare professionals involved in people's care and liaised with them if they had concerns a person's health was deteriorating.

People were complimentary about their regular care workers. They were involved in decisions about their care and staff provided support that respected their privacy and dignity.

People and their relatives were not always aware of the formal complaints process. However, they felt comfortable speaking with the registered manager if they had any concerns.

The staff felt well supported by the registered manager. They found them to be accessible and approachable, and felt they listened to their views and opinions.

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

Some aspects of the service were not safe. The registered manager had not assessed the risks to people's safety and had not provided care staff with sufficient information about how to manage those risks.

There were not sufficient numbers of staff to meet people's needs at the times they requested.

Safe medicines management was not maintained in regards to the recording of topical creams and care records were not updated in line with changes in people's medicines.

Staff were knowledgeable in recognising signs of abuse and were aware of the reporting procedures.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. Staff had not completed the provider's required training and had not attended regular refresher training. Staff did not receive regular supervision.

Staff adhered to the Mental Capacity Act 2005 code of practice and obtained people's consent prior to providing care.

Staff supported people when required with their nutritional needs and protected them from the risk of dehydration. Staff liaised with other healthcare professionals involved in people's care if they had concerns a person's health was deteriorating.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. The lack of consistent care workers to support people impacted negatively on the relationships between people and their care worker.

As much as possible people were able to choose which staff supported them. However, on occasion this was not possible due to a small staff pool.

Staff involved people in decisions about their care, including day

to day decisions. Staff respected people's privacy and dignity whilst providing support.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Due to the recent staff changes, not all care workers were familiar with the people they were supporting and were not aware of how people preferred their care to be delivered. Care plans did not contain sufficient detail and were not reviewed to ensure they reflected people's current needs.

Some people were unsure of the formal complaints process but felt able to raise any concerns they had with the registered manager.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. Robust and reliable systems were not in place to review the quality of care delivery, to track staff's compliance with visit times, to learn from key performance data and to ensure accurate care records were in place.

Staff felt well supported by the registered manager and felt able to have open and honest conversations with them. They felt listened to and involved in staff meetings.

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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.

This inspection took place on 18 November 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. One inspector undertook the inspection.

Prior to the inspection we reviewed the information we held about the service including statutory notifications we received about key events that occurred at the service.

During the inspection we visited the service's head office and spoke with the registered manager and the senior care worker. We viewed three people's care records, six staff records and records relating to the management of the service. We spoke with three people, three people's relatives and three care workers over the telephone.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt safe with their permanent care workers. However, they did not feel safe with some of the new care workers supporting them as they did not feel the new care workers had the knowledge and skills to support them, particularly regarding support with moving and handling.

The registered manager had not appropriately assessed the risks to people's safety. We saw the registered manager had undertaken standardised risk assessments in regards to personal care and the environment. However, these were on a standardised form produced by another organisation. They were not tailored to people using the service. The registered manager had not assessed the risks to people with limited mobility in regards to falls and moving and handling. One person's care records stated they "walk with assistance". However, it did not say what level of assistance the person required or how that was to be delivered. The registered manager had also not assessed the risks to people in regards to their dietary requirements or in relation to sensory impairments. Whilst speaking with the senior care worker it was identified that one person used bed rails to maintain their safety. However, the use of bed rails was not mentioned in their care records meaning staff may not know that they should be in place and an assessment had not been undertaken in regards to the risks associated with bed rails.

Staff supported those that needed it with their medicines administration. However, safe medicines management practices were not observed in regards to medicines records, especially in regards to topical creams. People's care records stated staff were to apply people's topical creams. However, the senior care worker told us some people had more than one cream to be applied and they were to be applied to different parts of the person's body. This information was not made available to care workers and with the recent staffing changes and use of agency staff there was a risk that people would not receive the creams they required as prescribed. People's care records had not been updated to reflect changes in people's medicines prescription, which meant there was a risk that people would not receive medicines in line with their current prescription.

The two paragraphs above shows the provider was in breach of regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Whilst care workers told us they had sufficient time to meet people's needs and were able to provide care at the time people specified, we found there were not sufficient numbers of suitable staff to meet people's needs. At the time of the inspection the manager was using agency staff to support the permanent staff to ensure there were sufficient staff to cover all visits and there had been no missed visits. However, there were not sufficient staff to ensure people received visits at their preferred times.

One person told us their care worker did not always turn up at the time they were scheduled to. They told us the care worker turned up at 8am for a visit that was meant to take place at 9.30am, and that for a visit that was meant to be at 10am they turned up at 10.45am. They told us in regards to the timing of the visits, "It seems to be on [the care worker's] terms." A relative said, "They come at different times." Another person said when the care workers came late it impacted on their day and meant at times they did not have time for

their breakfast before going to that day's activities. A relative told us care workers were "in a mad rush".

We saw the staff rota had scheduled three hours and 25 minutes of calls between 6am and 9.25am to support four people. However, the senior care worker informed us the visits did not start until 7am. In order for staff to fit all the visits into their shift, it was not possible for staff to always visit at the time agreed in the care plans and to stay the allocated time to provide people with the support they needed. For example, one person's visits were scheduled to take place between 6.45am and 7.40am. However, the communication logs for this person showed this time was not adhered to. For one week the person received visits at 7.30am, 8am and 9am. The communication logs also showed that staff regularly stayed for 40 minutes, rather than the 55 minutes scheduled. The registered manager and senior care worker were also covering visits in addition to their office and managerial responsibilities because they did not have sufficient staff.

The three paragraphs above show the provider was in breach of regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had begun to advertise for additional staff as they recognised they needed more staff in order to meet people's needs. For those staff that had recently been recruited we saw that safe recruitment practices were followed. This included attendance at interview, obtaining previous employment references, checking people's eligibility to work in the UK and undertaking criminal record checks. We saw that one staff member's file did not contain a record of the completed criminal record check. The registered manager confirmed this check had been completed but they were unable to find the related documentation at the time of the inspection.

We were unable to view the medicine administration records (MAR) for people who required their oral medicines to be administered by staff as they were not available at the office for the people whose records we viewed. The registered manager informed us the MARs had recently been updated to ensure each medicine administered was recorded, as previously it just recorded whether people received the medicines in their blister packs rather than stating each medicine.

The registered manager was aware of how to raise a safeguarding concern with the local authority and the process to follow if there were concerns raised regarding an allegation of abuse. Information was provided in the staff handbook about what to do if staff had concerns a person was being harmed or abused. Staff were knowledgeable about recognising signs of possible abuse and told us they would escalate any concerns identified to their manager so they could act on it. There was no information included in the 'service user guide' for people and their relatives about signs of possible abuse, which meant there was a risk that people would not know how to report concerns they were being abused. However there was information encouraging people and their relatives to discuss with the management team if they had concerns a person was being harmed.

Requires Improvement

Is the service effective?

Our findings

One relative told us in regards to their family member's care workers, "We can't fault them." Whereas, another relative said they did not have confidence that the new care worker supporting their family member was knowledgeable and skilled. They told us, "They didn't know what they were doing. Didn't feel comfortable handling [their family member]."

Staff were required to complete the provider's mandatory training and refresh this training annually. Whilst we saw that some staff were up to date with their mandatory training, not all staff were. Three out of four of the staff we spoke with told us they had not attended training courses whilst working for Savannah Care. We spoke with staff about why they were not up to date with their training and they told us it was because they had not had the time due to the staffing shortages and were prioritising providing care and support to people. There was a risk that staff would not have the skills and knowledge to undertake their duties and ensure they carried out their tasks in line with current good practice.

The registered manager informed us staff were meant to have supervision four times a year. The registered manager had not adhered to this timescale and care workers were not receiving the supervision they were meant to have, to ensure they felt supported and to review their performance.

The three paragraphs above show the provider was in breach of regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014.

An induction process was in place to support new staff. This included spending time with the registered manager to go through the provider's policies and procedures, and completing the provider's mandatory training. In addition staff shadowed experienced staff and the registered manager was supporting staff to complete the Care Certificate. The Care Certificate is a nationally recognised tool to provide staff with the basic knowledge and skills to undertake their roles within a care setting.

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.

Staff were aware of whether people had the capacity to make decisions about their care. Staff respected people's decisions and provided support in line with these. The senior care worker told us one of the people whose records we viewed did not have the capacity to consent to decisions about their care and that instead they discussed care decisions with relatives who had lasting power of attorney for that person. However, this information was not included in the person's care record and there was a risk that staff would not have this information. We spoke with the registered manager about this who told us they would ensure this information was included in the person's records.

When required, staff supported people with eating and drinking. Most people we spoke with had their meals provided by their family members or were able to independently prepare their meals. When people needed support from staff this was provided. People and staff told us care workers ensured people had access to drinks during their visits and left drinks within reach to ensure people had enough to drink and to minimise the risk of people developing urinary tract infections.

People and their relatives confirmed that staff supported them with their healthcare needs and worked with the other healthcare professionals involved in their care. This included liaising with and receiving training from occupational therapists in regards to equipment at the person's house to support with moving and handling. Staff told us they had the contact details of people's GPs and other healthcare professionals involved in their care, including their district nurse. They informed us they would contact the health professionals involved in a person's care if they had concerns a person's health was deteriorating and were confident in calling an ambulance in an emergency.

Requires Improvement

Is the service caring?

Our findings

One person told us, "[The care workers] have been brilliant. They're really friendly and nothing's too much trouble." A relative told us in regards to the care workers supporting their family member, "Previously [their family member] was happy. [The care workers] gave respect, they worked together. They talked and joked with him." However, they said the care worker that supported them recently, "came in and didn't say a dickie bird."

Most people told us they had the same care workers supporting them. However, one person said recently there had been lots of different care workers supporting them and they would prefer consistency in the staff supporting them. The recent changes in their regular care workers were impacting on the relationships and rapport people had built with their care workers. People and their relatives were complimentary about the permanent care workers who had been consistently supporting them, but informed us it was harder to build that rapport with the number of new care workers they had.

Some people using the service had limited communication. One person was visually impaired and another person was unable to communicate verbally. However, this information was not included in their care records meaning staff who were not familiar with the person may not have this information to communicate effectively with the people they were supporting.

People were generally supported by their preferred gender of care worker. We heard from one person they had initially requested not to be supported by male care workers with their personal care. However, due to problems relating to staffing levels they were supported by two male care workers. They were however, quite happy with the two male staff supporting them and the level of care provided. However, they had requested not to have any further male care workers support them. We discussed this with the registered manager and senior care worker who were aware of this person's request and informed us this would be taken into account if there were any further staffing changes. People were also able to express if they were unhappy with a particular care worker and no longer wanted support from them. The roster system enabled the senior care worker to put this preference in and stopped the care worker from being allocated to support that person.

People were involved in decisions about their care and how their support was provided. Most people funded their own care and were involved during the assessment phase in identifying the level of support they wanted and how this was to be provided. One staff member told us, "We ask them questions to find out what they like and don't like." People were involved in day to day decisions including what they wanted to wear, how they wanted to be supported with washing and what meals they would like to have.

People told us the care workers respected their privacy and dignity when supporting with their personal care. Staff said they were mindful to ensure people were comfortable when receiving care. This included ensuring their privacy by drawing curtains and closing doors, and ensuring their dignity through covering them as much as possible whilst personal care was delivered.

Requires Improvement

Is the service responsive?

Our findings

One person told us, "I'm still here and it's all thanks to the care workers."

However, people also told us the changes in their care workers impacted on the support provided to them. They told us their regular care workers were aware of their routines and preferences in regards to how their care was delivered. One staff member told us, "I know their needs as I've been with them a long time." However, the changes in care workers meant that some staff did not know people's preferences. They also said that due to the care workers not knowing their routine they were taking longer to support them and they told us they felt pressured to receive care the way the care worker wanted to support them. They said, "I've got to do what the care workers do quickest."

One person told us they had recently had a change in care worker. They told us this new care worker was not aware of all the duties they needed to complete at each appointment, which meant at times the care worker did not provide all the support the person required, for example with domestic tasks.

Prior to people receiving care the registered manager went to assess their needs and identify what support they required and at what level. We saw that initial support plans were developed but these did not cover all areas of support people required and they had not been reviewed meaning they did not reflect people's current needs. For example, one person's postural balance had deteriorated meaning they could no longer use a commode due to the risk of them falling but their support plan had not been updated to reflect this. One staff member told us the initial care plan was "sometimes a bit basic". They said care plans were updated as they got to know people with additional details about how support was to be delivered. Nevertheless, we did not see this level of detail or review in the care records we viewed.

We saw that care records did not provide sufficient detail about the support people required. One person's care record stated they were to be "repositioned". When speaking with the senior care worker we identified that this meant care workers were to support the person to move up the bed if they had slipped down during the day, rather than support the person to reposition to different sides during the day to relieve pressure to parts of their body. This lack of detail meant there was a risk that the person would not receive appropriate support for their individual needs.

Staff were required to complete communication logs detailing the care provided to people at each appointment. On the whole we saw that these provided detailed information about the care given. However, we also saw that some of the entries were not legible and the registered manager also could not read the entries meaning they could not be assured that staff were providing the support people required. We saw that quality of recording had been discussed at a recent team meeting but it continued to be an area requiring improvement.

The five paragraphs above show the provider was in breach of regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2014.

One person told us they had no concerns or complaints about the service. They said, "It's been amazing." The 'service user guide' contained information about complaints and encouraged people to make a complaint about any concerns they had. However, we saw that it did not explicitly say who to make a complaint to and we saw the old office address was still on the information, meaning there was a risk that written complaints may not be sent to the right person or place. Some of the people we spoke with were not aware of the formal complaints process but told us they would raise all concerns with the registered manager. Information was also provided to people in the 'service user guide' about other organisations they could raise their concerns with if they felt unable to raise them with the registered manager or were dissatisfied with how the complaints were handled by the registered manager.

Requires Improvement

Is the service well-led?

Our findings

One person told us, "The manager has never been out to visit." Another person said the manager had been to visit them several times since they starting receiving care in July 2015 to check on the care and support delivered and that the manager was available over the phone if you needed them. Staff told us the registered manager checked on the quality of care delivered but at times this was completed by speaking with people rather than observing care. This meant the registered manager was receiving feedback about the service but they were unable to directly observe the quality of care delivered and identify if any improvements were required.

The registered manager informed us they previously undertook spot checks on the quality of support provided. However, these had not been undertaken over the last three months. The previous spot checks were recorded on the provider's previous electronic system and therefore was unavailable for us to view. The registered manager informed they had plans to undertake quarterly spot checks but at the time of our inspection a system was not in place to manage this.

There was a system in place for staff to electronically record their arrival and leaving times for visits. This was meant to enable the management team to track whether staff were arriving to visits on time and staying the required length of time. We saw this system showed that staff were not consistently arriving at the times scheduled. For example one person's call was scheduled for 12.00pm and the system showed the staff arriving at 10.53am. We also saw the system recording that a staff member was at two different calls at the same time. Therefore this raised concerns as to whether the system could be relied upon. The registered manager informed us that concerns raised by people about their care worker being late were not recorded which meant there was no system to monitor the extent of these concerns, record the incidents and learn from this information.

A system was not in place to review key performance data, including information arising from incidents, accidents and complaints. This meant there was no system in place to review this data for key themes and trends and ensure improvements were made and lessons were learnt.

The registered manager informed us they checked the quality of communication logs and medicine administration records when they were returned to the office, but there was no system in place to check the quality of support plans or risk assessments. No other audits were completed to review the quality of care delivery. The registered manager had not ensured that accurate and complete care records were maintained in regards to people's care. A process was not in place to ensure regular review of people's care records and ensure they were updated as people's needs changed.

The five paragraphs above show the provider was in breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

A satisfaction questionnaire had been sent to people and their relatives to ask for their views about the service. At the time of our inspection the findings from these questionnaires had not yet been received. The

registered manager told us they would use the findings to review the quality of service delivery and make changes where needed.

Staff were complimentary about the registered manager. They said they were "accessible" and "approachable". There was an on call system in place which meant the manager was available for staff out of hours. One staff member told us they could "call [the registered manager] anytime." They also described the registered manager as "very, very good" and said "she's understanding." Staff felt able to have open conversations with the registered manager and felt well supported by them. There were regular staff meetings where staff felt able to raise any issues they wanted to discuss and they told us the registered manager was "willing to listen [to their ideas]."

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 The provider did not ensure that care and treatment of service users was appropriate to meet their preferences and ensure their needs were met. Regulation 9 (1) (3) (b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that care and treatment was provided in a safe way for service users, through an assessment of the risks to the health and safety of service users, mitigating such risks, and ensuring safe medicines management. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure that processes or systems were established to assess, monitor and improve the quality and safety of services provided. They did not assess, monitor and mitigate the risks relating to the health, safety and welfare of services users and they did not maintain securely an accurate, complete and contemporaneous record in respect of each service user.

	Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient numbers of staff deployed to meet people's needs. They did not ensure that staff received appropriate training and supervision. Regulation 18 (1) (2) (a)