Carers Sitting Service

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

Summary of findings

Overall summary

This inspection took place on 26 and 28 April 2016 and was announced. Carers Sitting Service is registered to provide personal care to people living in their own homes. At the time of our inspection, 12 people were receiving personal care. Carers Sitting Service also provides a short respite service for family and friends who care for people in their own homes. For example, by cleaning, support with shopping, and sitting with a person so that family carers can attend appointments. These activities are not regulated, and are not inspected by the Care Quality Commission.

The service had a registered manager in post at the time of our inspection. 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.

People's needs were assessed, but risks associated with personal care were not adequately identified. Appropriate protective measures were not put in place to minimise the risk of avoidable harm. Care plans were not reviewed and updated regularly to reflect people's changing needs.

The provider could not assure themselves that medicines were being managed in accordance with current regulations and guidance. Care plans were unclear about the level of support people needed with medicines, and there was no system in place to ensure that people received medicines as prescribed.

The provider could not demonstrate that all staff received training to ensure they had up to date skills and knowledge to provide effective care. Staff felt supported but they had not received regular one to one supervision. Most staff had not had one-to-one supervision with their manager in the last year, and over half the staff had not had an annual appraisal in the last year. The registered manager and deputy manager had received training in the Mental Capacity Act 2005 (MCA), but care staff had not undertaken any training in relation to capacity and consent.

The provider did not have adequate systems in place to monitor and review the quality of care people received. The local authority had identified concerns about risk assessments, quality of information in care plans, training and staff supervision and medication auditing. The provider was aware of these concerns, but had not undertaken the work required to resolve the issues.

Safe recruitment procedures were followed and appropriate pre-employment checks were made. Checks were undertaken to ensure new staff were safe to work in the care sector.

People were able to make their own choices about their personal care, and were involved in planning and reviewing their care. There were enough staff to meet people's personal care needs at the time when they needed support.

People were happy and comfortable with staff and said they felt safe. Staff were trained and understood how to recognise abuse, and were confident to raise concerns.

There was a complaints process in place, and people were encouraged to express their views about the service. People and relatives felt confident to make suggestions for improvement of care or raise concerns.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 safe.

Risks associated with people's personal care had not been undertaken. Medicines were not managed safely. People's care plans did not contain relevant information about their health conditions and support needs.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not always have up to date training in key areas of care. Staff did not always have one-to-one supervision in line with the provider's policy. People were provided with personal care in accordance with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People felt supported by staff who were kind and caring. People were involved in making decision about their care, and felt supported to remain as independent as possible. Staff understood and demonstrated the importance of treating people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always contain up to date relevant information about their needs. The provider did not review people's care in accordance with their policy. People and their relatives knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider did not have adequate systems in place to monitor and review the quality of care. The registered manager did not always understand or follow their responsibilities in relation to

the regulations. People, relatives and staff felt able to make suggestions to improve the service.

Carers Sitting Service

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 26 and 28 April 2016 and was announced. The provider was given 48 hours' notice because the location is a domiciliary care service which provides personal care to twelve people; we needed to be sure that someone would be in.

The inspection team consisted of one 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.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, a notification of serious injury to a person or any allegation of their abuse.

We spoke with local care commissioners and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

We spoke with four people, two relatives and three care staff. We also spoke with the registered manager and deputy manager. We reviewed four people's care records, including medication administration records (MAR charts) for two of those people where these were available. We looked at three staff files and records relating to the management of the service. These included training records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People did not have appropriate risk assessments in place. Where people received support with personal care activities no risk assessments had been carried out in relation to these activities to ensure their safety. The assessments that were in place did not identify what risks might arise from providing personal care to people. There was no information for staff to follow to reduce risks associated with the provision of personal care. This put people at risk of avoidable harm.

Staff and records told us about one person who was experiencing episodes of anxious and agitated behaviour following changes in their health condition. We looked at their records and saw there was no assessment in place to consider risks and measures to minimise harm. The person's care plan did not contain any guidance for staff to support the person when they became agitated or distressed. The registered manager and deputy manager confirmed that no risk assessment had been undertaken in relation to this. This person had also received a short package of 24 hour support for a period of four days in April 2016. The provider did not undertake any additional care planning or risk assessment with this person in relation to this period of 24 hour support. This meant any additional risks involved in providing personal care over four days, including night time care, had not been considered. The provider had failed to assess the risks to the health and safety of this person.

The same person's recent care plan review recorded that they needed to use equipment to support them bathing, as their needs had changed. Staff told us that they had not received any training in how to support the person to use the equipment safely. There was no recorded risk assessment in place for this activity, and the registered manager confirmed this had not been undertaken. The provider had failed to take actions to mitigate this risk.

Records showed another person needed support to help maintain their continence. The registered manager confirmed that this was the case, and said that staff had received training regarding this. Staff we spoke with confirmed this. There was no risk assessment in place for providing the person with support around their continence care. This put the person at risk of skin problems if care was not provided correctly.

Staff and records told us that a third person needed support from staff to use stairs. The registered manager confirmed that there was no specific assessment of the risks involved in supporting the person to do this, or consideration of protective measures to reduce risk. This showed that the person was at risk of harm whilst undertaking an activity which could result in falling.

We could not be assured that people received their medicines as prescribed. People told us they were responsible for their own medicines, but that, where necessary, staff would remind them, or check that medication had been taken and then sign their medicines administration record (MAR). One person said that that staff helped them on a daily basis by applying their prescribed skin cream. The person said that a MAR was used and they were happy with how the system worked. We looked at the person's MAR and noted that there were no specific instructions about how or where the prescribed cream should be applied. Another person's care plan stated that they had medicines administered in the form of skin patches, and

that staff needed to support the person to put these on. The registered manager told us that the person was no longer taking this type of medicine, but their care plan had not been updated to reflect this. There was a risk that staff would follow care plans that were not up to date and did not reflect people's current medicine prescriptions.

People's care plans were unclear about the role of staff in supporting, prompting or supervising people with medicines. For example, one person said staff prompted them (on one day a week) to take their medicine that was prescribed for them. The person's daily care records for 2 October and 30 October 2015 stated, "Tablets given." The MAR sheets did not have any information about tablet medication for this person. The registered manager told us that staff did not do medicine prompts for anyone. However, it was clear from people, staff, and records that people did receive prompting and support from staff to take their medicines. There was no consistent approach to recording what type of help people received to ensure that they received their medicines as prescribed. The provider's arrangements did not consistently account for the safe management or administration of people's medicines and did not meet with nationally recognised guidance. People were at risk of not being supported to have their medicines as prescribed.

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

The provider undertook pre-employment checks to ensure prospective staff were suitable to care for people in their own homes. This included checking references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people.

People and their relatives were confident staff would respond appropriately in an emergency situation. One person said, 'They [staff] would know what to do.' One relative said staff would contact them in an emergency, as well as taking other appropriate action. Staff were knowledgeable about what action to take in an emergency, for example, if they found a person had fallen. One staff member described finding a person who had a fall, calling the emergency services and contacting the registered manager. The telephone call log records confirmed this. However there was no corresponding accident or incident form for this or for other similar occurrences. For example, the telephone log records from 7 April 2016 indicated that staff had found a person to have had a suspected fall, and they had called emergency services. There was no associated accident or incident form completed by staff, and the last entry in the accident book was dated 3 June 2013. We could not be assured that staff understood their responsibilities to record accidents and incidents so the provider could look for trends or identify preventative measures to reduce the risk of avoidable harm.

People and their relatives told us they felt safe using the service. Staff were trained and knew how to recognise abuse or suspected abuse. They understood the provider's policies and guidance on keeping safe from the risk of abuse and felt confident to raise concerns. They understood how to report concerns to the registered manager, and felt confident to raise concerns with the Local Authority or CQC if this was necessary.

The provider had a policy in place detailing what action staff were expected to take in an emergency, and had a plan in place to deal with events that could affect the service, like adverse weather. Staff knew about this and knew what was expected of them to ensure that people continued to receive care.

People said there were enough staff to provide them with support when they wanted or needed it. One person said, "They are very flexible in how they provide the support." The registered manager said that they provided a minimum care call of 30 minutes. As the service was small, they arranged the rota based on

people's assessed needs and staff availability. The registered manager was clear that the service would offer people personal care after assessing their needs and establishing that there were the staff available to meet those needs. The local authority care commissioners we spoke with confirmed that this was the case. This meant that the provider had enough staff to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

The provider could not demonstrate that staff received training to ensure they had up to date skills and knowledge to provide effective care. Records showed that staff undertook a range of training to support their role and responsibilities for people's care. This included dementia awareness, moving and handling, medicines and safeguarding. However, there were areas of care where the provider could not demonstrate that staff had undertaken refresher training in a timely manner. For example, three staff had not had medication awareness training for over three years. One of these staff members had not had this training since February 2011. The registered manager assured us that they were booked to do the training soon, but at the time of our inspection this had not taken place. Nine staff had not undertaken any health and safety training in the last three years (including the registered manager and deputy manager), and the training matrix indicated that nine staff had not received any health and safety training.

Staff told us and records showed they received an induction in a range of skills the provider felt necessary. One staff member said that they worked alongside a colleague as part of their induction. Records of staff induction for their employment at the service did not indicate whether staff had received training that covered the common induction standards or their replacement, the new Care Certificate. This sets the national minimum recommended training standards that all new non-regulated care staff should achieve before they provide care. The registered manager confirmed that the cost of the Care Certificate was a barrier to a small organisation, so they were currently not supporting staff to obtain this. However, the provider's induction training arrangements did not cover all of the key areas set out in the Care Certificate. For example, working in a person centred way, promoting people's privacy and dignity, and in relation to infection prevention and control (IPC). Thirteen staff were documented as having had no IPC training. This meant that the provider's arrangements for staff induction training were less than the nationally recommended standard for this, which could place people at risk from receiving ineffective or inappropriate personal care.

Staff told us they had an annual appraisal and had regular individual supervision meetings from the registered manager. Staff also told us that the registered manager carried out unannounced spot checks to monitor their care skills. Records confirmed these checks took place. The registered manager said that all staff would have had an annual appraisal. Records showed that eight staff had not had an annual appraisal in the last year. Records also showed staff did not receive supervision every three months, as stated in the provider's supervision policy. Fourteen staff had not received supervision in the last year. The provider could not assure us that staff received supervision relating to their skills and performance in a timely manner.

People and their relatives felt staff would get them medical help if needed, as they had confidence in the service and the staff. Staff also told us they knew when to seek medical help. One staff member described how they had requested medical help for one person after they had fallen. Staff told us that they did not always have specific care plans to help them support people with their healthcare. This meant that staff did not have clear and consistent information about people's health conditions and how to support them. This put people at risk because staff would not know how to identify concerns or deterioration in health, and there was no agreed plan of what action staff should take.

The staff members we spoke with were knowledgeable about people's care needs and preferences, but we noted that the care records did not always contain sufficient details about people's health conditions and the support they may need. For example, one person had an acquired brain injury, but there was no information on the care plan about how this might affect the person or what additional support they may need. Another person had a diagnosis of dementia, but there was no documented information about how the diagnosis affected the person or guidance on how staff should best support them. This meant there was a risk that all staff would not have sufficient information to help them support people in a consistent way.

People were provided with personal care in line with legislation and guidance in relation to consent. 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. 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. If people living in their own homes are receiving restrictive care that may amount to a deprivation of their liberty, an application must be made to the Court of Protection to ensure that restrictive care is lawful and in a person's best interests. No-one receiving personal care from the Carers Sitting Service was subject to restrictive care that would require a court application.

The registered manager and deputy manager had received training in the MCA and demonstrated they understood what the law required them to do if a person lacked the capacity to make a specific decision about their care. One staff member said they needed to check out why someone was refusing care and work with them, rather than just assuming the person lacked capacity. Staff understood they needed to seek people's consent for their personal care, and were clear they would talk with the registered manager if they had concerns that people might lack capacity to give consent to their care. This meant people's rights were being upheld, and their consent to care was sought.

People who received support to maintain a balanced diet told us they were happy with the assistance staff provided. One relative said, "They check things to make sure she's got enough to eat and enough fluids, etc." Not everyone receiving personal care needed support in relation to eating and drinking.

Good

Is the service caring?

Our findings

People felt supported by staff who were kind, considerate of their needs and feelings, and caring. One person said, "They are fantastic. I could not wish for better." Another person said, "We have a little chat and he is a nice person." A relative told us that staff listened to the person and provided support in a caring manner. For example, "They ask for [my relative's] opinion and give her choices."

Staff we spoke with felt that they cared for people and wanted to be able to make a difference to their quality of life. One staff member said, "I love my job. Being with people and supporting them is absolutely brilliant." Another staff member said, "I love talking with people and being able to support them to remain in their own homes."

People were involved in making decisions about their care. Some people had chosen their preferred staff. We saw that one person had said they no longer wished a particular staff member to support them, and the registered manager arranged for them to have alternative staff. Another person commented that, "We talk to each other so things are clear." People's care plans contained information about their wishes and preferences for personal care. For example, one person's care plan detailed the way in which they liked staff to wash them. Another person's care plan had specific information about the way they liked their breakfast prepared.

Staff preferred to work with people to provide consistent and regular care, and said that the registered manager tried to ensure that people received care from the staff they wanted. The registered manager confirmed that this was the case and records supported this. People were supported by familiar staff who listened to them and tried to ensure that care was provided in the way people wanted.

People felt that staff supported them to remain as independent as possible. One person said, "They help with the things I can't do, but don't do the things I can do for myself." People's care plans recorded details about their personal preferences for their support. This included information about what people were able to do for themselves, and what staff needed to support them with. For example, one person's records had information about their preferred routine when getting up and being supported to have a shower.

People said that staff did their personal care in a respectful way that upheld their dignity. One person said, "For example, they put a towel down so I don't get wet." Another person commented that staff always ensured their curtains were closed when providing care. Staff treated people with dignity and respect, and understood how important this was for people. One staff member said that it was important to pay attention to small actions, "Such as making sure the door is closed and curtains drawn." The provider had been awarded the local authority's Dignity Award campaign. Derbyshire County Council states, "A key test is if you're treating people with the same dignity and respect as you would want for yourself or your family."

Staff respected people's right to confidentiality, but were also clear about balancing this with passing on information about risk or concerns appropriately. One staff member said, "I would share information if I was concerned. I would talk with [registered manager]."

Requires Improvement

Is the service responsive?

Our findings

The care plans we looked at did not always contain relevant information about people's needs and preferences for care, and they were not reviewed in a timely manner. Records showed the provider had identified what people's support needs were and how they liked staff to support them. One staff member said that the registered manager or deputy manager took them to meet people before they started working with them, saying, "I think this is brilliant. We get introduced to the new person. We talk to them and go through what they want, and we look at the care plan with the person." People's views about their personal care were sought and recorded in their care plans. For example, one person's records had detailed information about how they liked to be supported to wash and dry themselves. However, we identified one person, whose care plan said they had mild difficulty in both expressing themselves and understanding others, but did not provide any guidance for staff on how to ensure effective communication. Staff who knew the person well were able to describe how the person communicated, and how best to communicate with them, but acknowledged there was no written guidance. This meant there was a risk that new staff may not respond appropriately to the person's communications needs. We spoke with the registered manager about this and received assurance that this information would be added to the person's care plan. This demonstrated that people's care plans did not always have relevant information for staff to respond promptly and or appropriately to people's needs.

We saw that people had recently had their personal care packages reviewed by the provider. The registered manager confirmed that care reviews were done every year, but the evidence in people's care files did not support this. For example, records showed that one person had their care plan put together in December 2013, but not reviewed from then until February 2016. Another person's records showed their care plan was drawn up on November 2013 but not reviewed until November 2015. The registered manager told us that every person had a telephone call from them three weeks after starting to receive care, which was designed to seek people's views about their experience of this so far. However, we established that these calls were not documented, so the provider could not demonstrate how they resolved any issues with care at this stage.

People and relatives felt they had regular opportunities to provide feedback about the service, including questionnaires, reviews of their care, and by talking with staff. One person said, "We chat about things as they know I don't like filling in forms." The annual quality monitoring forms we viewed from November 2015 were all positive about the service and did not identify any areas for improvement.

People and their relatives knew how to raise concerns or make a complaint. Everyone we spoke with said that they had never needed to do this as they were satisfied with the care provided. Everyone felt confident they would be listened to if they had to raise concerns or make a complaint, as they felt the provider was responsive. One person said, "If ever I contact them and leave a message they get always get back to me," and a relative said, "If I wasn't happy I'd let them know." People and their relatives were provided with a copy of the provider's complaints policy and procedure and staff understood how to support people to make a complaint. We saw that complaints had been resolved in accordance with the provider's policy and procedure and action taken to improve the quality of care. For example, a relative complained about how

staff were disposing of a person's continence pad. This was investigated and action taken in relation to a member of staff.

Requires Improvement

Is the service well-led?

Our findings

The provider's statement of purpose stated that they would, "Monitor and regularly review the performance of our service for quality assurance." The provider information return (PIR) said the registered manager and deputy manager would, "Ensure through spot checks and the quality assurance information that care is being delivered to a high standard and is always person centred." However, at our inspection we found the provider did not have adequate systems in place to monitor and review the quality and safety of people's care.

The local care commissioners' report from their contract and quality monitoring visit of 13 August 2015 identified that, 'All necessary person specific risk assessments must be implemented immediately.' A report of their follow-up visit on 10 December 2015 identified that there were still no task-specific risk assessments in place in relation to people's personal care. The provider information return (PIR) stated that they, 'Carry out risk assessments of the property and moving and handling and these are reviewed periodically and all staff informed of changes.' However, the PIR did not mention carrying out risk assessments relating to the personal care that people received. We spoke with the registered manager and deputy manager about our findings regarding lack of risk assessments for personal care activities. They acknowledged that this had been identified by the local authority, and that they had not carried out risk assessments in relation to personal care. This put people at risk of avoidable harm whilst receiving personal care. The provider had failed to act on feedback they had been provided with to ensure people's safety.

The provider's policy on medicines stated that they would, 'Enable people to take their medication in a safe and supportive environment,' and that people would, 'Receive assistance with the administration of medication only where necessary, subject to a person specific medication risk assessment.' We did not find any recorded risk assessments or guidance for staff to follow relating to people's individually prescribed medicines. This meant there was no information about what action staff should take if they found that people did not take their medicines as prescribed. The provider had failed to ensure that they had followed their own policy to assess, monitor and mitigate risks.

The provider did not audit the record keeping arrangements for the administration of people's medicines. Instead, they relied on staff to report any issues or concerns relating to the management of people's medicines. Poor practice around medicines could not be identified or remedied quickly. The provider information return (PIR) stated that there had been no medicine errors in the last 12 months from submission of the PIR, but their management systems and related records could not account for this statement. This put people at risk of harm from the unsafe management and administration of medicines as the provider could not assure us that people were supported to have their medicines as prescribed. There were not adequate systems in place to ensure that the administration of medicines was done so safely.

The provider did not have a system in place for auditing daily care records, so there was a risk that poor care or gaps in planned care could not be identified and remedied. Reviews of people's care were not carried out and recorded in a timely manner.

The provider's records did not demonstrate that staff supervision was consistently in place on a three monthly basis in accordance with their policy. For example, one staff member last had an annual appraisal in April 2014. The system in place for monitoring training identified gaps in training or areas for refresher training. However, there was no evidence action had been taken to ensure staff had up to date training. The system in place had failed to improve the quality of the service as no action had been taken to address the identified concern.

We spoke with the registered manager about these issues, and they acknowledged the concerns we raised. They agreed to address this and take steps to improve management systems at the service to better assure that good quality care was delivered by staff who were regularly supervised.

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

The registered manager did not always understand or follow their duties and responsibilities in relation to the requirements and provisions placed on them by the Health and Social Care Act (HSCA) 2008. We found that notifications about important events that happened at the service had not consistently been made to CQC when required. The manager told us about a recent safeguarding incident relating to a person's care, which they had reported to the local authority as a safeguarding concern. Records confirmed this. CQC did not receive any notification relating to this.

People and their relatives felt the service was managed well and knew who the registered manager was. One person said, "I think it is very well managed." A relative commented, "I met them [registered manager] when they came and did the assessment. Any contact I've had has been positive."

People and their relatives felt confident to make suggestions about improving the service, or to raise concerns. They also felt that any feedback they gave was taken seriously and acted on by the provider. One person said, "They find out what I need and use it to improve how they do things." A relative said, "We have a dialogue, which has helped the service improve as it has gone on."

Staff told us they felt supported by the registered manager and their peers. They felt able to raise concerns about care or suggest improvements to the service. One staff member said, "[The registered manager] is very fair. She will pick up on issues and tell me straight away; she's very fair about this." Staff told us that the registered manager did unannounced checks on their care skills, and records showed that this was the case.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and safe treatment was not being provided in a safe way, as the provider was not assessing the risks to the health and safety of service users receiving personal care, or doing all that is reasonably practicable to mitigate and such risks. The provider was not ensuring the proper and safe management of medicines. Regulation 12 (1) and (2)(a), (b) and (g).

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems established or operated effectively to assess, monitor and improve the quality of the services or to assess, monitor and mitigate the risks relating the health, safety and welfare of service users and others who may be at risk in relation to providing personal care. The provider did not act on feedback from relevant persons and other persons for the purposes of continually evaluating and improving the service. Regulation 17 (1) and (2) (a), (b) and (e).

The enforcement action we took:

Warning Notice