Wilberforce Healthcare UK Limited

Wilberforce Healthcare

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

Wilberforce Healthcare is registered to provide a service to people living in the community who are over the age of 18 who may have dementia care needs, a learning disability, mental health needs or a physical disability. The office is based in Hull city centre and is accessible to people with physical or mobility difficulties.

This inspection took place on 19 January 2017 and was carried out by an adult social care inspector. This inspection was announced because the service was suspended at the time of the inspection and we needed to ensure the registered provider would be available to talk with us.

At the last inspection of the service on 10 and 13 October 2016, the service was noncompliant with regulations pertaining to person centred care, safe care and treatment, safeguarding vulnerable adults, staffing, complaints, good governance and submitting notifications. Due to the level of risk we identified we followed our enforcement policy and used our enforcement powers to urgently suspend the provider's registration. This meant they could deliver the regulated activity of personal care for a three month period.

The service had a registered manager which is a requirement if their registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

During this focused inspection we spoke with the registered provider who described the changes and improvements at the service. Due to the suspension of their registration at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described. We did review policies, procedures, and supporting documents that had been developed to ensure the service could be managed effectively.

We have assessed the actions of the registered provider and have followed our enforcement policy which has led to the suspension of this service being removed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

This domain was inspected but not rated because at the time of our inspection the registered provider's registration was suspended and they were not delivering the regulated activity personal care.

Is the service effective?

Inspected but not rated

This domain was inspected but not rated because at the time of our inspection the registered provider's registration was suspended and they were not delivering the regulated activity personal care.

Is the service caring?

Inspected but not rated

This domain was inspected but not rated because at the time of our inspection the registered provider's registration was suspended and they were not delivering the regulated activity personal care.

Is the service responsive?

Inspected but not rated

This domain was inspected but not rated because at the time of our inspection the registered provider's registration was suspended and they were not delivering the regulated activity personal care.

Is the service well-led?

Inspected but not rated

This domain was inspected but not rated because at the time of our inspection the registered provider's registration was suspended and they were not delivering the regulated activity personal care.

Wilberforce Healthcare

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 registered provider was 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 review the urgent suspension we issued following our focused inspection on 10 and 13 October 2016.

This announced inspection took place on 19 January 2017. The inspection was completed by one adult social care inspector.

Before the inspection, we reviewed all of the information we held regarding the service including the enforcement action, notifications and previous inspection reports.

During the inspection, we spoke with the registered provider and two members of administration staff. The registered provider described the changes and improvements since our last inspection.

We reviewed policies, procedures, and supporting documents that had been developed to ensure the service could be managed effectively.

Inspected but not rated

Is the service safe?

Our findings

At our comprehensive inspection on 10 and 13 October 2016, we found the service could not deploy suitable numbers of staff to meet the needs of the people who used the service. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On 7 October 2016 the Care Quality Commission were notified by the local authority commissioners, Kingston upon Hull City Council, of the service's inability to deliver care and support to 17 people during the weekend of 8 and 9 October 2016, which equated to over 100 care calls. Due to staffing issues experienced by the service and their failure to provide assurance of their on-going ability to deliver safe and effective care to the aforementioned 17 people, the local authority commissioners, Kingston upon Hull City Council made the decision to permanently reallocate them to other domiciliary care providers.

During this focused inspection we discussed how the registered provider would ensure they ensure suitable numbers of staff could be deployed to meet the needs of the people who used the service. The registered provider informed us how they would recruit and retain staff. The registered provider's registration was suspended at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described.

The registered provider told us they would recruit staff on an on-going basis to ensure they had prospective staff that could be trained and deployed as the service took on new packages of care. They told us they would conduct spot checks, supervisions and annual appraisals to support the staff team and provide team meetings so that staff felt valued and understood they were part of a team. We saw that polices were in place that were in line with the registered provider's explanation and we saw documentation had been developed to aid the processes.

At our comprehensive inspection on 10 and 13 October 2016, we found people did not receive safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider failed to ensure the service had effectively assessed the risks to the health and safety of people who used the service and failed to do all that was reasonably practicable to mitigate risks. We found that assessments of people's needs had been undertaken care plans and risk assessments had not been developed to ensure staff had the information they required to deliver safe care and treatment consistently and effectively. Staff told us that care plans did not reflect people's current level of needs and lacked pertinent information they needed to deliver the care people required safely.

During this focused inspection we discussed how the registered provider would ensure people received safe care and treatment. The registered provider informed us how they would ensure care plans reflected people's current care and support needs and how known risks would be recorded and mitigated. The registered provider's registration was suspended at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described.

The registered provider told us that an initial assessments of people's needs would be undertaken which would be used to develop a number of care plans and risk assessments. The known risks identified in the initial assessment would be clearly documented along with the action staff were required to mitigate the risk.

We were told by the registered provider that staff's abilities would be monitored through spot checks and supervision would be conducted on a quarterly basis to ensure care was delivered safely in line with people's needs as documented in their care plans and risk assessments. The time staff arrived to deliver care, the call duration and the time staff left would be monitored using the registered provider's call monitoring systems so that any issues were highlighted and could be rectified. We saw that polices were in place that were in line with the registered provider's explanation and we saw documentation had been developed to aid the processes.

At our comprehensive inspection on 10 and 13 October 2016, we found people were exposed to the risk of abuse by way of neglect. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were exposed to the risk of neglect and suffered from neglectful practices because staff failed to deliver care at agreed times and stay for the allotted amount of time to safely and effectively deliver the care and supported people required. From a sample of 561 calls delivered over 14, 15 and 16 October 2016, 81 calls were delivered in less than half of the time staff would need to deliver the care the person required. 52 calls were completed in less than 10 minutes and 19 were completed in less than five minutes. Records also showed staff arrived up to 179 minutes late and up to 177 minutes early to care calls. 21 people did not suffer abuse by way of neglect the local authority commissioners, Kingston upon Hull City Council were able to reallocate [to other services] care calls that the registered provider could not deliver.

During this focused inspection we discussed how the registered provider would ensure people who used the service were safeguarded from abuse and avoidable harm. The registered provider informed us they would use a call monitoring systems to ensure staff delivered care at agreed times and did not leave calls early. The registered provider's registration was suspended at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described.

The registered provider told us the call monitoring system they would utilise recorded the time when a member of staff entered a person's home and the time that they left. They told us that the service would receive a report on a weekly basis from the call monitoring system, which would be scrutinised and staff who had left calls early would be asked to explain the reason why. Staff would be held accountable for their actions and if they had been neglectful the registered provider would take disciplinary action in line with their internal policies.

The registered provider showed us the spot check documentation that had been developed to assess staff abilities to deliver safe and effective care. Each member of staff would receive a spot check on a three monthly basis unless concerns were identified which would trigger more frequent spot checks until the staff member's practice improved. The registered provider explained that if concerns were highlighted during spot checks staff would receive further training or be asked to a one to one meeting where the practices could be discussed. We saw that polices were in place that were in line with the registered provider's explanation and we saw documentation had been developed to aid the processes.

At our comprehensive inspection on 10 and 13 October 2016, we found suitable checks had not been

completed before staff worked with vulnerable people. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider failed to assure themselves that staff had not been deemed unsuitable to work with vulnerable adults or posed a risk to the people who used the service. When checks were completed as required appropriate action was not taken to ensure people's safety when concerns had been highlighted. We reviewed seven staff files and found suitable references and confirmation that Disclosure and Barring Service (DBS) checks had been completed in six members of staff. However, one of the DBS checks showed the person had a number of recent convictions. There was no risk assessment or record of any conversation with the staff member to support the registered provider's decision making regarding why they had deemed the person to be suitable to provide care and support to vulnerable people in their own homes. The seventh staff file did not contain a DBS check or references.

During this focused inspection we discussed the how the registered provider would ensure staff were recruited safely. The registered provider informed us that relevant checks would be completed before staff were allowed to support people and how they would ensure this took place. The registered provider's registration was suspended at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described.

The registered provider told us that that documentation had been created that had to be completed and signed off before staff could commence delivering care and support. We reviewed the document and saw that the date references were returned had to be recorded as did DBS check date. If any convictions were highlighted in a DBS check a risk assessment was to be completed, which stated additional checks were to be carried out. The document needed to be checked by the registered manager to ensure all of the required information had been received. We saw that polices were in place that were in line with the registered provider's explanation and we saw documentation had been developed to aid the processes.

Inspected but not rated

Is the service effective?

Our findings

At our comprehensive inspection on 10 and 13 October 2016, we found staff had not completed relevant training and were not supported in their roles. This was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff practice was not reviewed to ensure an effective level of care and support was delivered. None of the staff files we looked at contained an annual appraisal, even though staff had worked for the registered provider since 2013. There were no supervision records available in any of the staff files we looked at. The registered provider failed to assure themselves that staff had completed relevant training when they had previously worked in the care industry. We checked the file for a newly recruited member of staff and saw it contained an email from their previous employer stating the training they had completed and the year it was undertaken. There was no evidence available to support this such as certificates and there was no evidence to show that the registered provider had taken any action to assure themselves of the staff member's skills and abilities such as spot checks or monitoring.

During this focused inspection we discussed how the registered provider would ensure staff had completed relevant training and received appropriate support and guidance. The registered provider informed us how they would ensure staff had the necessary skills and abilities to deliver effective care and described the support and mentorship they would receive. The registered provider's registration was suspended at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described.

The registered provider told us they would utilise IT systems to record when staff required a spot check, supervision and annual appraisal. They told us they IT system would send an alert to the service's office manager who would then have the responsibility to ensure it was carried out. The registered provider's policy stated staff would receive a spot check and a supervision every three months and an appraisal annually.

The registered provider told us that all staff would have to complete an in-house induction to ensure they were aware of the values of the service and understood its policies and procedures. Any staff new to the care industry would be trained in a range of subjects deemed to be mandatory by the registered provider. Any staff who had previously worked in the industry would have to provide evidence of the training they had completed and their skills would be assessed before they could deliver care independently. The IT systems used by the registered provider would send an alert to the service's office manager when staff required their training updating.

Inspected but not rated

Is the service caring?

Our findings

At our comprehensive inspection on 10 and 13 October 2016, we found people did not receive person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service did not receive care that met their needs and reflected their preferences. Staff did not always know the people they were caring for and supporting, because people's care plans lacked relevant information. The care plans we saw did not contain personal information about people such as their hobbies and interests, their family lives or the previous occupations, which would have enabled staff to engage people in meaningful conversations. One care plan contained no information about the person's needs so staff delivering care would not have known what the person required assistance with or their preferences in relation to their care.

During this focused inspection we discussed how the registered provider would ensure people received person centred care. The registered provider informed us care plans would contain relevant information including people's preferences for how care and support was to be delivered. The registered provider's registration was suspended at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described.

The registered provider told us that people's needs would be assessed before the service agreed to support people. The initial assessment would be used to develop personalised care plans that documented people's preferences. The devised care plans would be shared with the person who would use the service or an appointed person to ensure their accuracy. A telephone review would be completed after one week, one month and after three months to enable the person to provide feedback on the service and to ensure their needs were being met, consistently and in line with their preferences. Further reviews would be undertaken on a six monthly basis. We saw that polices were in place that were in line with the registered provider's explanation and we saw documentation had been developed to aid the processes.

Inspected but not rated

Is the service responsive?

Our findings

At our comprehensive inspection on 10 and 13 October 2016, we found complaints were not recorded and investigated as required. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider failed to appropriately record and respond to complaints. The service's complaints file contained seven complaints but due to the poor record keeping and lack of information in the service we could not conclusively determine when or how the complaints were received. Internal investigations had not taken place and subsequently the service had failed to learn from any of the concerns raised which would have enabled them to improve the service and prevent future complaints.

During this focused inspection we discussed the breach of regulation 16 with the registered provider. The registered provider informed us how they would ensure complaints were recorded, investigated, used to develop areas of the service and staff practices. The registered provider's registration was suspended at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described.

The registered provider told us that they would ensure people understood how to complain by providing the complaints policy to people when their care and support commenced. They told us that people would receive a one week, one month, three month and then six monthly reviews were they would be asked if they had any concerns or issues they wanted to raise. They confirmed that all complaints would be taken seriously, recorded accurately and investigated. A letter would be produced that had to be signed off by the registered provider to ensure it covered all relevant points and provided an apology when required.

We reviewed the registered provider's complaints policy and saw that it contained adequate information such as how to make a complaint, acknowledgement, investigation and response times as well as the action a complainant could take if they found the registered provider's response inadequate.

Inspected but not rated

Is the service well-led?

Our findings

At our comprehensive inspection on 10 and 13 October 2016, we found the registered provider's quality assurance systems were ineffective; they failed to highlight shortfalls and drive improvement across the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider failed to monitor the care and support delivered to people who used the service. They did not operate effective governance systems and relied upon ad-hoc checks to monitor the quality of service delivery. The registered provider explained, "When we got the contract [The local authority commissioners, Kingston upon Hull, City Council preferred provider's contract] we doubled in size, we went from about 700 hours to nearly 1400. Our processes are just not good enough." The registered manager told us, "No one is at fault here except us, I have taken my foot off the pedal and I know that."

The care plans that we reviewed contained obvious contradictions and lacked sufficient detail to enable staff to deliver safe and effective care. The registered manager admitted, "Since we got the contract with Hull it's been too much for us, we have been skipping our own processes, not doing care plans properly and not checking on things."

We raised concerns regarding the lack of relevant information in staff files such as references and risk assessments regarding particular pieces of recruitment. The registered provider explained, "We have a risk assessment form and that should be filled in when we find something on a DBS check, I don't know why it hasn't been done" and "No one can be checking the files because they would have seen there was no risk assessment."

When we asked the registered provider how they monitored the level of care and support delivered by staff they told us that spot checks and telephone reviews were conducted regularly. When we checked the staff files where the registered provider told us spot checks were stored, there was minimal evidence that spot checks had occurred, we saw in two staff files spot checks that were undertaken in 2014 and 2015.

During this focused inspection we discussed how the registered provider would ensure good governance systems were operated. The registered provider informed us how they would ensure the quality monitoring systems would be used effectively to ensure people received safe and effective care from caring staff who understood their roles. The registered provider's registration was suspended at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described.

The registered provider told us they would utilise IT systems to highlight when specific tasks needed to be completed. For example, when staff inputted a person's detail on to the IT system, such as the date their care and support commenced, the IT system would send alerts to the office manager to ensure reviews were completed at specific intervals. The call monitoring system would be reviewed weekly to ensure staff failing to attend calls at agreed times or leaving calls early would be highlighted.

The IT system would also be used to highlight when staff required supervision, a spot check or training updates. Spot checks would be used to assess staff's abilities to deliver care and support in line with people's preferences.

The registered provider told us care reviews and questionnaires would be used to capture feedback from the people who used the service, their appointed representative, family members and relevant healthcare professionals.

At our comprehensive inspection on 10 and 13 October 2016, we found the registered provider had failed to notify the Commission of an event that prevented the service provider's ability to continue with the regulated activity safely. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

On Friday 7 October 2016 the registered provider informed the local authority commissioners, Kingston upon Hull, City Council of their inability to deliver care calls to 17 people who used the service on 8 and 9 October 2016 which equated to over 100 care calls. The registered provider failed to inform the Commission as required.

During this focused inspection we discussed how the registered provider would ensure incidents were reported in a timely and safe way and in accordance with legal requirements. The registered provider informed us how they would ensure they fully complied and with registration regulations. The registered provider's registration was suspended at the time of this focused inspection so we could not check that the methods described by the registered provider were being operated as described.

However, the registered provider told us they would educate the administration and office based staff so they knew what events the Commission required to be notified of.