Care Quality Commission

Care 1st Limited

Care 1st Homecare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We carried out an announced inspection of this service on 7 January 2015. 48 hours notice was given of this inspection. This was to ensure that the registered manager was available. The last full inspection took place in May 2014 when two breaches of regulations were found. We returned to the agency in September 2014 and found that action had been taken and the regulations were being met.

Care 1st is a large domiciliary care agency that operates in Bristol and South Gloucestershire. The agency provides a service to approximately 300 people in the region who require personal care.

A registered manager was in post at the time of the 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

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People received effective support from staff who were trained and whose performance was monitored. Staff worked with other healthcare professionals when required to ensure that people were supported in a way that met their needs. However people reported that communication was inconsistent when care staff were running late. The impact of this varied for people, but for some this led to anxiety and worry.

People told us they felt safe in the company of staff from the agency. Staff had received training to help them identify the signs of potential abuse and told us they would feel confident and able to report any concerns.

There were risk assessments in place to ensure that people were cared for in a safe way. These included guidance for staff on people who may be a risk of self neglect or malnutrition.

There were systems in place to support people with their medicines safely. Changes had recently been made to improve how medicines were administered. A member of staff had been recruited with specific responsibility to review people's support in relation to medicines.

Where people required support with their meals, information about their likes and preferences were included in their support plans.

Staff recorded in daily notes when meals had been provided for the person. Staff were aware of the Mental Capacity Act 2005 and received training in this. Procedures were in place to make best interests decisions on behalf of a person who lacked capacity when necessary.

People reported that staff were kind and caring. People had opportunity to contribute and voice their opinions about the care they received. People told us that they were treated with dignity and respect.

Support plans were in place to guide staff in meeting people's needs. These were regularly reviewed to ensure they were up to date and amended when a person's needs changed. People were positive about the care they received.

There were systems in place to respond to complaints. We saw examples of formal complaints that had been responded to with transparency and promptly.

The service was well led, however improvements could be made. There were systems in place to monitor the quality of the service, however these did not always give accurate information about the number of missed visits and the impact they had on people. There were clear expectations in place about the standards expected of staff. Disciplinary procedures were in place to manage staff who had fallen short of the standards expected of them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff had training in safeguarding adults and felt confident in identifying and reporting signs of potential abuse.

Risk assessments were in place to guide staff in providing support that was safe.

People received appropriate support with their medicines and procedures were currently being reviewed to improve this aspect of the service further.

Good

Is the service effective?
The service was not always effective.

Some people reported visits that had been missed or were late. Communication from the office wasn't always consistent at these times which led to some people experiencing anxiety.

People who had support with meals received this in ways which took account of their individual preferences.

Staff were aware of the Mental Capacity Act 2005 and how this may impact on people who used the service.

Staff worked with other healthcare professionals when required to.

Requires Improvement

Is the service caring?
The service was caring.

People reported that staff treated them with kindness, dignity and respect.

People were given opportunity to express their views about the care they received.

Good

Is the service responsive?
The service was responsive.

There was a complaints procedure in place. Formal complaints were responded to with openness and transparency.

People reported that their needs were met. Support plans were reviewed regularly to ensure they were up to date.

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Good

Is the service well-led?
The service was well led. However improvements could be made.

Requires Improvement

Summary of findings

There were clear expectations in relation to the standards staff needed to meet.

There were systems in place to monitor the service and take action when necessary to respond to shortfalls. However, the system for monitoring missed calls was not fully effective.

Care 1st Homecare

Detailed findings

Background to this inspection

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

This inspection took place on 7 January 2015 and was an announced inspection. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

As part of our inspection, we spoke with 16 people who use the service, six relatives of people who use the service, 10 care staff (including supervisors and coordinators), and the registered manager. We reviewed six care files, and other documentation relating to staff recruitment and training.

Good

Is the service safe?

Our findings

People told us they felt safe with the care staff that attended to them. Comments included "They fill in the book when they have finished and make sure that I'm safe and happy." and "When hoisting my relative it's done safely and carefully."

There were sufficient numbers of suitably qualified staff to ensure that people's needs were met. We spoke with two staff who were responsible for rotas in particular geographical areas. We were told that at the present time, staffing levels were balanced with the care hours provided so that all visits were able to be covered. At times of unexpectedly high levels of staff absence, supervisors and care coordinators were able to cover visits.

The agency had a range of policies and procedures to help support safe recruitment and selection. Applicants had completed an application form which requested an employment history with start and finish dates and the reasons for leaving. At least two references were required and if they did not provide enough detail additional references were requested. The registered manager told us that if a reference was inaccurate or lacked essential information they would seek further information.

Staff references provided information about their personal qualities and previous experience to help provide assurances that they were honest, trustworthy and that they would treat people well. Relevant checks had been completed before staff commenced employment, including those with the Disclosure and Barring Service (DBS).These checks helped to ensure that staff were safe to support vulnerable people.

All staff we spoke with told us they had completed safeguarding adults training. Staff we spoke with understood their individual responsibility to safeguard people from the risk of abuse and they were clear that if they witnessed or were told about abuse, they would report it to staff in the office. Staff were able to tell us about the actions they would take if they felt their concerns were not being addressed appropriately. For example one staff member commented "I'd speak to someone higher up if I had to, I wouldn't leave it, I'd go to CQC if it wasn't being dealt with."

Staff told us they felt people were safe and said, "I was worried about one person and there's been a review, I've spoken with the family who feel there is a lot of improvement" and "We keep people under review and speak with families if necessary."

Leading up to our inspection, we were aware of a number of medicines errors made by care staff at the agency. In response to this, a supervisor had recently been appointed whose role included reviewing medicines. At the time of our inspection, care packages for people who received support with their medicines were being reviewed to ensure that the correct support was in place. Part of this work included ensuring that the support provided was defined correctly, for example as 'prompting' or 'administration' so that accurate and clear guidance was in place for staff. Where verbal prompts to take medicines were given, this was recorded in the daily records.

Where staff were administering medicines, Medication Administration Record (MAR) sheets were in place in people's homes. These records had recently been updated so they were easier for staff to use. The MAR sheets gave space to record any medicines that had been administered from a monitored dosage system and additional space to record separate medicines, such as short term antibiotics. Staff were under instruction to contact the office if they came across medicines that weren't specified in a person's care plan. MAR charts were reviewed by a supervisor when they were returned to the office. They would also be checked in people's homes as part of spot checking staff performance. This meant that there were systems in place to ensure that people received safe support with their medicines. People were satisfied with the support they received with their medicines. Comments included "They remind me to take my medication and fill in the folder when they have done their work" and "They ask me to take my medication and stop with me until I have taken it." Staff received training in administering medicines as part of their induction. This training was redone if any concerns about their performance arose.

Risks to people's health and wellbeing were recorded in their support files so that staff had guidance in how to support them safely. For example, this included any environmental risks in the home as well as risks associated with the individual's care such as the risk of falls and risk of self neglect. The measures in place to support the person were described, such as the equipment they used and the

Good

Is the service safe?

kind of issues that needed to be reported to the office. We also noted that there were assessments in order to help staff prioritise people in the event of adverse incidents that affected the service, such as inclement weather.

Requires Improvement

Is the service effective?

Our findings

Prior to our inspection and as part of the feedback from people, we received concerns about how well staff were able to communicate with people and the impact this had on people's care. For example, one person told us "My relative is a little deaf so if the carer has a strong accent my relative doesn't understand". We spoke with the registered manager about this and were told that as part of their recruitment procedures, the communications skills of potential care staff were assessed. This was introduced as a result of feedback from people about the communication skills of staff.

We also received information from several people who experienced visits that were late or missed. The impact of visits running late varied for people; some were not concerned, however other people found it difficult when staff did not arrive on time. Comments included "Staff are rarely on time and it can be as much as an hour late which isn't that good." and "They are late quite frequently and they don't call to say why". In addition to this, people found that communication was inconsistent when visits were running late or the rota had changed. One person commented; "One thing is that the communication from the office is poor; things get changed and they don't tell you who the carers going to be. It would be good if carers are going to be late they could let me know." Another person said "they e-mail me my rota and its changed within hours of getting it".

People were supported by staff who received effective training and support. All staff had completed a three day induction course. Staff told us they had completed first aid, health and safety, moving and handling, infection control and medicines awareness. The registered manager informed us the induction course will be changing in March 2015, when more topics will be covered. Staff told us the content of the induction course was good and it helped give them the skills they needed to be able to provide appropriate care. Staff said, "I had three days training in the office, then worked double with another care assistant for a while" and "We actually got into the hoists, it was good because we know how the clients are feeling." Staff told us, "We can come into the office or someone will come out if we're unsure."

Staff received specialist training when necessary; this included training in Percutaneous Endoscopic Gastrostomy (PEG) feeding; a particular method of delivering nutrition for people who are unable to take food orally. Staff also confirmed they were observed when supporting people with medicines until they felt confident and competent to do this unsupervised. Staff were supported to attend specialist training such as dementia awareness, epilepsy and challenging behaviour.

We saw records in staff files of regular supervisions and observations of practice. This included 'spot checks', whereby a senior member of staff attended a call without warning to observe the performance of care staff.

People's right to consent to care and treatment was acknowledged. There were arrangements in place to ensure that people gave consent to the plan of care held in their support plans. In the sample of care files that we viewed, the individual themselves had been able to give their consent. However, there was space on the consent form to record a best interest discussion if the person lacked mental capacity to make decisions about their own care and support. This showed that staff were aware of the Mental Capacity Act 2005 (MCA) and how it may need to be applied when planning care. The MCA is legislation that protects the rights of people who lack the capacity to make decisions about their own care and treatment. All staff confirmed that they had received training in the MCA. Staff said, "I always read the care plan and be aware they can make decisions for themselves" and "I had a client who was making unsafe decisions so I phoned the office. They spoke with the person's family and the person's care plan was updated, we now do welfare checks."

In the case of one person, we saw there was information about the person's power of attorney. This is an individual who has been appointed to make decisions on behalf of someone who lacks mental capacity. There was a copy of the documentation on file so that staff could refer to it and were aware the specific powers that had been granted to the person.

Not everyone received, required or wished to have support from the agency with meals. However we saw that information about their nutritional needs was recorded so that care staff were alerted if the person was at risk nutritionally. There was guidance for staff to report any concerns about a person to the office if they were concerned about them nutritionally so that relevant healthcare professionals could be informed. Where a

Requires Improvement

Is the service effective?

person's care routine did include meal preparation, their preferences were included in their support plans. Information was recorded in the daily records about the meals that had been provided.

Records showed that staff liaised with other healthcare professionals when it was appropriate to do so. In one person's file, we saw that there was information from the occupational therapist about a person's moving and handling needs and staff were clearly guided to refer to this plan. In another care file we saw that handover information was included from the re-ablement team. One person told us "If I'm not well staff call the office and they will arrange for my GP to attend."

Good

Is the service caring?

Our findings

People gave positive feedback about the care they received from staff. Comments included "The staff are lovely, nice and caring.", "Yes, staff are kind and caring and help us with the things that we need." and "Yes, it's dignified, caring and they respond to my needs very well."

Staff were aware of the importance of treating people with dignity and respect and gave examples of how they achieved this. For example, staff told us they closed doors and curtains and made sure people were covered when providing personal care. People confirmed that staff treated them with dignity and respect. One person said "They treat me with gentleness and dignity". Another person said "When they do my personal care its dignified and they respect my privacy and I feel respected."

People confirmed that staff were respectful of their homes, for example by disposing of gloves and aprons appropriately and ensuring that their property was left clean and tidy. One person told us "they leave my home tidy and clean" and "on the way out they put their gloves and aprons in the bin." Another person told us "They leave my home clean and tidy making sure the bathroom and bedroom have been cleared of clothes and towels. I'm pleased with the service."

Where possible, people received care from a consistent team of staff to enable them to build positive relationships. One person told us "Staff socialise with me and I do enjoy that time." People could choose to have a staffing rota emailed to them in advance each week if they chose to so that they were prepared. People that we spoke with confirmed this, but commented that changes were frequently made to it.

Support plans identified where people were able to be carry out aspects of their care routine for themselves. This helped ensure their independence was promoted. For example, in one plan we viewed, it described the aspects of care that the person was able to carry out themself such as shaving and washing their face. One person told us "When they help with my personal care they will only do the things that I can't."

There was documentation within people's care files to show they had been involved in planning their care. People confirmed they had been consulted about their care needs. One person said "I have been asked about my care needs and it's written down", another person said "I feel valued for what I say to the carers and they listen to me".

There was evidence of regular reviews of people's support, and this was an opportunity for the person or their relatives to give their views and opinions. We were also told that people had been given opportunity to provide feedback on the service they received through a questionnaire; however we were told that the response to this had been poor so it hadn't been possible to draw any conclusions from the data. Plans had been put in place to improve the questionnaire and encourage greater participation.

Good

Is the service responsive?

Our findings

People we spoke with told us they would feel able to raise complaints when necessary. Comments included "If there was something wrong I would complain to the manager." and "I'm involved in care plan changes and staff approach me with respect and listen to what I have to say. If I had any concerns about the care I would chat to the manager." Another person told us "when I have complained they listen to me and responded in a positive manner."

One person told us how their relative had complained about the service and as result things had improved "Things did get really bad, they missed coming to see me two weeks ago this has happened on two occasions, the housework wasn't been done very well so my brother had words with the manager and things have now improved." There were systems in place to respond to complaints and this was set out in a written policy. A record of complaints was kept and we viewed two formal complaints in detail. We saw that the concerns outlined in the complaint had been responded to comprehensively and with openness and transparency, with apologies made where appropriate when the service had not performed as expected.

Before people commenced a care package with the agency, a full assessment of their needs was carried out. This included gathering full information about the person's needs and their views on the kind of support they wished to receive. This included details about their medicines needs, an environmental risk assessment, daily routine and various other risk assessments relating to the person's care.

There was evidence of this assessment in each of the six care files we reviewed. The initial assessment recorded information about people's cultural and religious needs. In one example, we saw that a person had been asked whether they wished for staff to support them with attending a local church or day centre.

Following this initial assessment, support plans were created to guide staff in providing the right support. These were reviewed regularly to ensure that they were current and updated when people's needs changed. People were positive about the care they received. We were told "yes, it's dignified, caring and they respond to my needs very well", and "they are good at what they do when they put my creams on they talk and chat and I feel that they treat me nicely and I feel happy with what they do for me."

The care assistants had feedback forms about the support they provided, which were used to develop care plans. Care assistants were encouraged to identify aspects of people's care that were important to them, such as when someone liked to have a glass of water by their bed at night or liked to have the radio on when taking a bath. This showed that people were treated and valued as individuals with their own unique needs and preferences.

We saw that their were systems in place to ensure that staff with the right skills were matched to the needs of the person they supported. On the computer systems used to allocate staff to visits, it was flagged up where people had a particular need so that only staff with the right skills and training were allocated.

Requires Improvement

Is the service well-led?

Our findings

We saw that staff were each provided with a handbook that contained important policies and procedures so that they were easily accessible when required. The handbook contained a 'mission statement' so all staff were clear on what the expectations of them were. There was also a code of conduct set out, which described how people receiving care from the agency should be treated. The code of conduct made reference to 'acting with honesty and integrity' and 'respecting the dignity and value of each person'. This meant that staff had clear guidance on the behaviours that were expected of them in performing their duties. One member of staff commented “If you haven’t got trust you haven’t got anything. I love my job”.

Staff performance was monitored and where there was evidence that the standards expected of them were not being met, disciplinary procedures were followed. The registered manager gave us a specific example of when this process had been put in to practice following concerns about misconduct. There was also a capability procedure in place for staff whose performance was under question.

There were systems in place to monitor the quality of the service provided by the agency. This included a system to check that calls to people were being made as scheduled. We observed in the office that a member of staff was designated to carrying out this duty.

When attending a call, staff were required to log their visit by phone which was then recorded on the computer system. This allowed reports to be created, to see what percentage of calls had been completed within the allocated time. We viewed a report for the period May 2014 - October 2014 and this showed that 98.5% of scheduled visits had been made. 89.6% of visits were made within half an hour of the designated time and 74% within 15 minutes of designated time. This report included all visits that were missed for reasons outside of the agency's control, such as the individual being in hospital. We therefore asked for further information to identify whether any visits had been missed by the agency. We were shown information from the rostering database for a period of two months which gave further explanations of why the call was missed. We were told that a missed call could not be closed on the system until an explanation was provided. The database showed that in the majority of cases, there was a reasonable explanation for the call being missed. For example, in one case, we saw that a carer had experienced difficulties with a car breaking down. The agency had called the person and they had then cancelled the visit. In another case, a call was missed due to their being no reply at the home. There were occasions when a call had been missed by the agency and it was recorded that an apology had been sent afterwards. It was not clear from the data what the impact of these missed calls were and whether they represented a risk to the person concerned. Therefore there wasn’t clear and easily accessible information on which to inform better practice or make improvements to the service.

We saw that the registered manager was proactive in acting on concerns that were identified in the performance of the agency. For example, it had been noted that there had been a number of medicines errors in the last six months. The registered manager had responded to this by employing a further supervisor, who as part of their role had a specific responsibility to review practice around the administration of medicines.

We recommend that the process for monitoring the service is reviewed to ensure that it is fully effective in identifying areas for improvement.