Carepath Recruitment Limited

Carepath Recruitment Ltd

Inspection report

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25 August 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection of this service took place across two dates; 18 and 25 August 2016, this was the first time the home had been inspected under the comprehensive methodology. The registered manager was given 24 hours' notice prior to the inspection so that we could be sure they would be available to provide us with the information we required.

Carepath Recruitment Ltd is a domiciliary care agency, which provides personal care to both children and adults in their own homes. The service is available to people of all ages, with support needs ranging from mild to moderate, to complex and profound support needs. The agency is situated in the town centre area of Preston. The agency, although having a separate office, shares office space with the company's staff recruitment business.

The service is registered to provide personal care, on the day of our inspection there were 5 people using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We looked at how the service protected people from avoidable harm. We found that risk assessments were not always up to date. Where risks had been identified, care planning around the associated risk was not recorded. In some examples, no action had been taken to manage the risks, which meant people had not been protected by the service. The availability of parents and relatives meant that people's safety was protected.

Accidents and incidents were not held centrally and therefore we could see no evidence that they were analysed to identify patterns and learn from them.

We asked staff if they felt there were sufficient numbers of care workers to provide care and support for people and found that this was not always the case.

We looked at people's care plans at this inspection and found gaps in information regarding people's medicine regimes.

We checked how staff had been recruited we saw records which showed the provider had undertaken checks to ensure staff had the required knowledge and skills, and were of good character before they were employed at the service. Staff told us they knew how to report safeguarding concerns and felt confident in doing so.

We looked at how the service gained people's consent to care and treatment in line with the MCA. We found that the principles of the MCA were not consistently embedded in practice.

We found staff were not being supported by way of regular and effective supervision and appraisals. We found that staffing had not always received adequate training to care for the people they support.

We received some positive comments about the staff and about the care that people received. Care plans for adults were of very poor quality and did not have enough detail considering the complex needs of the adults cared for. We observed staff providing support for one person and the staff member approached the person in a caring, kind and friendly manner.

We checked whether the service was well led. Evidence we found showed there was a lack of management oversight and leadership for care staff. We found the service had no clear lines of responsibility and accountability. We found leadership of the organisation was not engaged with the delivery of registered activities. We found that the service did not have a robust quality auditing system in place, and no checks were completed for care staff.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of safe care and treatment, need for consent, good governance, dignity and respect, person-centred care and staffing.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not appropriate or effective systems in place to identify the possibility of risk and to prevent harm to people who used the service.

Policies and procedures were in place to guide staff in how to safeguard people from abuse and staff had received training in this area.

We looked at people's care plans and found gaps in information regarding people's medicine regimes.

Is the service effective?

Inadequate

The service was not effective.

People's rights were not always protected, in accordance with the Mental Capacity Act 2005.

Supervision and appraisals for staff were not always completed and staff were not well supported in their work performance.

Staff training was ineffective in ensuring that staff were competent and had sufficient skills to meet the needs of people they cared for.

Is the service caring?

Requires Improvement

The service was not consistently caring.

There was lack of consistence with care planning. Some people's files were well organised however some were poorly developed and lacked detail.

People were not always involved in care planning.

People's privacy and dignity was not always protected due to staffing.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples' needs were not reviewed when they had experienced a change in circumstances.

People and their relatives said they knew how to raise a complaint.

Not all care plan information was available on the day of inspection.

Is the service well-led?

Inadequate

The service was not well led.

People were put at risk because systems for monitoring quality and safety were not in place.

The information from risk assessments was not always used to manage the risk effectively.

Policies and procedures were in place but were not always adhered to.

Carepath Recruitment Ltd

Detailed findings

Background to this inspection

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

The inspection team comprised of two adult social care inspectors, one of which was the lead inspector for the service.

Prior to this inspection, we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us. We received feedback from social work professionals.

At the time of our inspection of this location, five people used the service. We spoke to one person who used the service and four relatives. This enabled us to determine if people received the care and support they needed and if any identified risks to people's health and wellbeing were appropriately managed.

We observed how staff interacted with one person who used the service and viewed four people's care records. We spoke to six care workers and the registered manager.

We also looked at a wide range of records. These included; the personnel records of five staff members, a variety of policies and procedures, training records, medicines records and quality monitoring systems.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt their children were safe supported by Carepath Recruitment Ltd care staff. One parent told us, "They are very good people". A relative of an adult supported by the service said: "They always check things with me first if they are unsure".

We looked in detail at written plans of care and associated documentation for four people who used the service. We looked at how the service protected people from avoidable harm. We found that risk assessments were not always up to date. Where risks had been identified, care planning around the associated risk was not recorded. In some examples, no action had been taken to manage the risks, which meant people were not safe.

An example of this was for an adult who was at risk of choking when eating and drinking. We could find no care documentation to help guide staff around how to care for the person to ensure that they were safe from avoidable harm.

Another example we found for the same person, was where they were putting themselves at risk due to their aggressive behaviour. There was no documentation in place to guide or inform staff of how to manage this, in order to protect the individual and staff members.

We found that a risk assessment for this same person who was diagnosed as having diabetes was missing. There were no plans in place to guide staff around what the person could and could not eat or the recommended quantities of food intake. The staff told us that they support with blood sugar monitoring however, there was no guide for staff around the procedure. This put the person at possible risk, as there was a lack of clear guidelines for staff around how this person's diabetes was managed.

These failings were present for the adult however children's files contained risk assessments and plans to mitigate the risks.

Accidents and incidents were not held centrally and therefore we could see no evidence that they were analysed to identify patterns and learn from them. We asked the registered manager about this during the inspection and were told there were no accidents to report. However, we found documentation, which stated that one person had a fall and had sustained an injury. There was no information about what had been done about this and no risk assessment for falls.This demonstrates that appropriate information and documents are not kept to protect service users against the risks of unsafe or inappropriate care and treatment

The risk management issues identified amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff if they felt there were sufficient numbers of care workers to provide care and support for people. Staff told us that there are not always two members on at the time one person requires hoisting. At

these times, staff are hoisting this person independently. This is against best practice for hoisting. In addition, there was no specific manual handling care plan for this person. This put the service user and staff at risk of potential avoidable injury.
We spoke with the registered manager who confirmed that the person had been starting the shift later in the day. We were told this was still within the funded time for the adult to be supported. However, this was against the personal preference for this person and staff had confirmed that the practice of independent hoisting was taking place.

We found that one person was left with no support overnight on one occasion as there was no staff available to cover the shift.

The issues identified with staffing levels amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's care plans at this inspection and found gaps in information regarding people's medicine regimes. Staff were pre potting seven days' worth of medications for one person and then signing the Medication Administration Records (MARs) at the time of administration when they could not be certain they had given the correct medication.

We looked at how the service supports people to apply their prescribed topical treatments such as creams and ointments. Staff told us they applied topical treatments for people; however, clear directions of where this should be applied were not recorded.

The provider was not following their own policy and procedure with regards to medications. The lack of protocols for medication increases the risk of medicines overdose and misuse. This put people who used the service at risk of harm through unsafe medication administration.

No audits or checks of medication or MARs were being completed. We viewed MARs charts for one person and found six omissions of signatures for the medications, between the dates 1 July 2016 and 8 August 2016. We did not find any significant impact for those people whose medicine records suggested omissions had been made. However, due to insufficient monitoring the potential to cause serious harm was high.

These shortfalls in medication arrangements amounted to a breach of breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had all completed the appropriate training in medicines management and the staff files and training documentation supported this.

We checked how staff had been recruited we saw records which showed the provider had undertaken checks to ensure staff had the required knowledge and skills, and were of good character before they were employed at the service. The checks included written references from previous employers, a check with the Disclosure and Barring Service (DBS), formerly the Criminal Records Bureau (CRB) and interviews with staff, a record of which was kept in their personnel files. These checks helped to keep people safe by ensuring only suitable candidates were employed to deliver care to people who they support.

Staff told us they knew how to report safeguarding concerns and felt confident in doing so. We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns. We saw evidence that staff had attended training in safeguarding for vulnerable adults and children.

Staff told us they followed infection control measures and people told us they wear protective personal equipment and dispose of this appropriately after use.

Inadequate

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA).

The 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 make 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.

We looked at how the service gained people's consent to care and treatment in line with the MCA. We found that the principles of the MCA were not consistently embedded in practice. We found that people's capacity to consent to care had not been assessed and decisions had not always been recorded. An example of this was for the adult who was supported to take insulin by the staff. We were told by the staff and a relative that the person can forget that they have taken this and request it again. When staff deny this the person can become aggressive. There was no documentation to support this decision.

The registered manager and staff told us that they had not received training around the MCA; and they did not demonstrate a satisfactory level of understanding of the MCA. They lacked awareness of how to complete the appropriate assessments and whose responsibility this was

This failure to follow the code of practice amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found staff were not being supported by way of regular and effective supervision and appraisals. The provider's appraisal policy stipulated staff would receive annual appraisals. However, records demonstrated that none of the staff had received an annual appraisal. Records of supervisions demonstrated that supervision was not consistent.

We looked at five staff files and for one person they had last had supervision in September 2015. Another example was for another staff member who last had supervision in December 2015. We spoke to the registered manager who said that he spoke to staff over the phone but did not record this. Staff had relied on parents or relatives to provide them guidance and supervision. We asked staff if they were able to tell us when they last had supervision. Staff told us: "I have never had supervision". And: "I have not had one since beginning working for the company".

We asked staff if they received training to help them understand their role and responsibilities. One staff member told us: "Yes I have had lots of training I have done my NVQ level 2".

However, we found that training was not considered for key areas. One staff member told us: "I have had

some training but just basic, I support people with complex needs and have to get information from the families". Another said: "I have the knowledge to care for [name removed] as I have done my own research at home".

Two relatives we spoke to confirmed that this was the case. One told us: "The carers are coming blind without knowledge and I have to tell them". Another said: "I have staff asking me what to do and I have to help guide them about [name removed] needs and how best to meet them".

We asked about the services induction programme and staff responses were varied. One staff member told us: "I did not have a proper induction I picked it up on my own". Another said: "I had a one day induction and completed shadow shifts".

Staff were not consistently supported in their work performance. These shortfalls in supervision, appraisals and training of staff amounted to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were supported to eat and drink, in order to maintain good health and we found that where concerns about people's abilities to eat and drink were identified, referrals had not always been made to external professionals for support and guidance.

Requires Improvement

Is the service caring?

Our findings

We received some positive comments about the staff and about the care that people received. Parents we spoke with told us care staff treated their children with kindness and the staff were caring towards them. People told us: "Carers are respectful and treat my son with dignity and respect". And: "The carers are perfect, they are really good people". Another person told us: "The staff are fantastic

Care plans for the adult were of very poor quality and did not have enough detail considering the complex needs of the adult cared for. Information was not arranged in an easy to find manner and in one file, there was minimal information.

We looked at care plans and checked if people were involved in planning for their care. We found no evidence adults or their relatives had been involved in planning their care so it was unclear if people had a say in the care they received. One person told us: "I have not been involved in any review, because there hasn't been one". All care plans should clearly detail how the person and / or their designated representative had been involved (or not) in the care planning and review process.

This amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke to understood how to respect people's privacy, dignity and rights. One person told us: "They [the staff] show respect for the family home". However, staff told us that they could not always ensure that people's dignity was protected. We were made aware that one person is being denied access to use the toilet in the evening. This is due to only one member of staff being at the property and the person requires two staff to support with hoisting. We spoke to the registered manager about this and were told that the evenings are not funded for two staff members. We did not see evidence that that a review of the persons needs had been requested to rectify this.

It is the responsibility of the registered manager to highlight to the commissioners of the care package if they can no longer meet the needs of an individual. We asked the registered manager if this had been highlighted and were told that an email had been sent to the social worker. However, we did not see evidence of this on the day of inspection.

This amounted to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff providing support for one person and the staff member approached the person in a caring, kind and friendly manner.

We saw instances where things had not worked well between carers and people they supported. In these instances, one person told us how the registered manager had attempted to resolve the issues ensuring carers and people were both listened to. For example, there was a mismatch between one carer and a

person, consideration was made to change the carers and this appeared to have resolved the issues.

Requires Improvement

Is the service responsive?

Our findings

In children's files, objectives and desires had been identified as part of the plan of care. However, we could not find the same level of detail in the files of adults supported by the service. This meant that there was no consistence in the care planning across the services.

We found there was a clear assessment process in place, which helped to ensure staff had a good understanding of people's needs before they started to support them. We noted that the assessment process always involved a visit to the service user's home and included the views of other professionals involved in their care. However, there was no consistence, as this was only in relation to children's records and support plans. There was no evidence of this in an adult support plan.

We looked at care records of four people. Three of the care records were informative and enabled us to identify how staff supported people with their daily routines and personal care needs. However, some records did not have enough details and guidance for staff.

Care plan information was not available on the day of inspection for one person; documentation held at the home address was not an accurate, complete and contemporaneous record. The documentation did not include a record of the care and treatment provided to the person or any decisions taken in relation to the care and treatment provided. One care plan we viewed was dated 2012 and another 2014 with no documented evidence of review. One example we found stated that the person could still shave without support, when this was no longer the case. The person's health had deteriorated and staff were doing much more for them.

These shortfalls in maintaining accurate and complete records amounted to a breach of breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints procedure which was made available to people they supported and their family members. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and the Care Quality Commission (CQC) were available.

People we spoke with said they would know how to make a complaint in the belief it would be addressed. One relative told us: "I can call the company with any concerns".

Inadequate

Is the service well-led?

Our findings

We checked whether the service was well led. Evidence we found showed there was a lack of management oversight and leadership for care staff. Staff had relied on parents or relatives to provide them guidance and supervision. Staff told us: "I would ask other people for support rather than ring the manager". And: "I have one to one briefings from the parents".

We asked staff if they felt supported by the registered manager. Staff responses were varied. Staff told us: "He puts pressure on us to work shifts": "He is not understanding and can be belittling": "If we can't do a shift he tells us to leave". Other responses were: "I try to resolve issues on my own as the manager is hard to get hold of he's so busy". One person told us: "I can go to the manager he is helpful".

Relatives of people who use the service told us: "We are happy with the carers and not with the provider." They told us they felt the provider did not provide contingency in the event staff went off sick or could not cover the shift. We spoke to the registered manager who informed us, if a staff member cannot continue they would attempt to cover using staff from other parts of their business.

We found the service had no clear lines of responsibility and accountability. We found leadership of the organisation was not engaged with the delivery of registered activities. We found due to the complexity of the needs of people supported and the risks associated, the service required robust leadership to ensure staff are regularly supervised and monitored.

We looked at how staff worked as a team and how effective communication between staff members was maintained and found that this was not robust. We found no evidence of staff meetings. Staff told us they did not have regular meetings and we found no evidence of ways in which best practice was shared for example when new guidance is introduced.

We were informed supervision was done on the phone, however this was not formally recorded. We did not find this to be an effective way of supporting staff who were involved in delivery of complex care. The registered manager could not demonstrate how staff were involved in discussions about improving the service

We found that the service did not have a robust quality auditing system in place. There were no audits for care files and medication administration records. We found issues that could have been identified by audits.

Spot checks to observe staff's competency had not been carried out. The purpose of spot checks is to check whether staff were punctual, stayed for the correct amount of time allocated and people supported were happy with the service. They also help identify if staff had continued to be competent in various care tasks.

We did not see evidence that the views of stakeholders, including people who use the service, staff, visiting professionals, professional bodies, commissioners, local groups, members of the public and other bodies, had been sought and acted on for the purposes of continually evaluating and improving the service.

These shortfalls in leadership, quality assurance, amounted to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

A wide range of written policies and procedures provided staff with clear guidance about current legislation and up to date good practice guidelines. These were reviewed and updated regularly by an outside company and covered areas, such as The Mental Capacity Act, Deprivation of Liberty Safeguarding, medicines, appraisal, staff supervision, individual planning and review and health and safety. However, our finding throughout the inspection demonstrated that the service were not always following their own policies and procedures. The registered manager was not always aware of the content of the policies. An example of this was when we asked him how often appraisals should be completed and he told us these were two yearly however, the policy states annually.

We spoke to the registered manager about the issues with staff not following the medication policy and procedure for one person. He was unaware that this practice was going on in the person's home, as he had not had any oversight in the home. The registered manager had never met the person who was receiving support.

Since our inspection the registered manager has informed us of progress he has made as a result of our feedback and recommendations made, which is considered to be good practice.

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 have effective arrangements in place to ensure that people they support were involved in the care planning process Regulation 9 (3) (a)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not have suitable arrangements in place to ensure that people are treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. Regulation 11(1) (2) (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe

care and treatment

The provider did not have suitable arrangements in place to ensure that medicines were managed in a safe way.
Regulation 12 (2) (g)

The provider did not have suitable risk management arrangements in place to make sure that care and treatment was provided in a safe way for service users.
Regulation 12 (2) (a) (b)

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 17 HSCA RA Regulations 2014 Good governance The provider did not ensure sufficient numbers of staff were deployed to meet peoples care and treatment needs Regulation 18 (1)

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.