The Waverley Care Group Ltd

Waverley Community Care (Guildford & South West Surrey)

Inspection report

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Ratings

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

Overall summary

Waverley Community Care is a domiciliary care agency which provides care to people living in their homes. The agency provides a range of services, but at the time of this inspection it was primarily to older people with physical health needs and adults who require mental health support. The agency is registered to provide both personal and nursing care, but was not providing the latter at the time of our visit.

Summary of findings

The inspection took place on 05 October 2015 and was unannounced. Following the inspection we made telephone calls to people who used and were involved with this agency.

The agency had a registered manager. 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.

Whilst people experienced some good care that enabled them to remain in their own homes, the management of this agency was described as "Chaotic" and communication between the agency and people who used the service required improvement. The agency was not well led and the systems in place to monitor and improve quality and safety were inadequate.

The quality of record keeping across the agency was poor and the provider's systems to identify and manage the risks associated with this had failed. As such we identified multiple concerns about the way information was gathered, stored and used.

People could not be assured that only suitable staff were employed because the agency had failed to follow appropriate procedures in the recruitment of new staff. Staff had access to a range of training opportunities, but new learning was not routinely checked to ensure it improved staff's practice and that staff were competent to carry out their roles.

Care staff were knowledgeable about people's needs and provided flexible and responsive support. Information however was not accurately documented to ensure new staff had guidelines to follow and enable care to be provided consistently. People were not sufficiently involved in the formal planning and reviewing of the care which meant that they did not have always have the opportunity to discuss issues which would improve the support they received. For example, people shared frustrations with us about not knowing which care staff was coming and call times and lengths not always suiting them.

Whilst risks to people and staff were identified and taken seriously, appropriate action had not always been taken to ensure people were fully protected from the risk of harm. Staff had a good understanding about safeguarding, but the agency's duty to refer concerns to the local authority had not always been done in a timely way.

People appreciated the regularity of a small team of care staff to support them. They consistently described care staff as "Excellent", "Very kind" and told us that they would frequently "Go above and beyond what was expected." People liked the fact the new staff were usually introduced to them before they provided support alone.

Other community professionals praised the creative approach to support that the agency provided to people with complex needs or who were resistant to receiving care. Care staff were described as "Genuinely caring" and "Good advocates of people." We were repeatedly told that the recent employment of a Community Psychiatric Nurse (CPN) to work with people with mental health needs had "Bridged the gap" and really improved the lives of some people who needed a lot of support to live in the community.

The agency supported people in a holistic way and had good links with other healthcare professionals, such as GPs, district nurses and local community teams which helped people to maintain good health.

Staff supported people to retain their independence and lead their lives with choice and control. People said care staff always treated them with dignity and respect. Care staff were able to tell us how they protected people's privacy and maintained dignity during the provision of care.

We found a number of breaches of regulations. You can see what action we asked the provider to take at the back of this report.

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?

Requires improvement

The service was not always safe.

The agency did not always follow appropriate recruitment procedures when employing new staff.

The agency did not have effective systems to ensure the support provided to people with their medicines was managed safely and appropriately.

Risks to people were not always adequately assessed and monitored.

Staff had knowledge about their role in safeguarding people, but the agency had not always reported safeguarding concerns in a timely way.

Is the service effective?

Good

The service was effective.

Staff had recently begun to receive the necessary training to perform their roles.

People were supported to maintain good health and had access to health care professionals when they needed them.

Staff understood the importance of gaining consent from people, but written consent was not always obtained.

Where necessary staff supported people to receive adequate food and drink and highlight the benefits of maintaining a healthy diet.

Is the service caring?

Good

The service was caring.

People spoke highly of the staff who supported them.

People appreciated the regularity of the care staff who supported them and the fact that new staff were mostly introduced to them before providing care.

The agency was creative in the way it provided support for people with complex needs.

People's privacy and dignity were well respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

Staff were knowledgeable about people's support needs, their interests and personal preferences, but this information was not routinely available in care records.

Summary of findings

People were not sufficiently involved in the formal reviewing and monitoring of their care and felt that call lengths were not always appropriate for their needs.

People felt that care staff listened to their concerns but that the agency was not responsive in dealing with their frustrations about organisational issues.

Staff supported people to retain their independence and enabled people to lead their lives as they wished.

Is the service well-led?

Requires improvement

The service was not well led.

People felt that the management of the agency was chaotic.

Communication between the office and care staff was not always effective.

Provider auditing and quality monitoring was not robust enough to identify shortfalls in the service.

People and their relatives were not routinely asked for feedback about their care experiences.

Whilst people experienced some good care, there were risks associated with the way the agency was being managed.

The quality of record keeping was poor and people's personal information was not always stored appropriately.

Waverley Community Care (Guildford & South West Surrey)

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 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 provide a rating for the service under the Care Act 2014.

This inspection took place on 5 October 2015 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection.

This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we carried out this inspection in relation to concerns that had been raised with us.

During our inspection we went to the agency's office and spoke to the provider, the registered manager and two members of care staff. After the inspection we conducted telephone interviews with four people that used the service, four relatives and five care staff. We reviewed a variety of documents which included six people's care plans, four staff files and other records relating to the management of the service.

We also spoke with three other health and social care professionals who were involved in the care provided to people who used the service.

Waverley Community Care (Guildford & South West Surrey) was first registered with the Care Quality Commission (CQC) on 15 April 2015. This was the first time the agency had been inspected.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe with staff and that the agency took appropriate steps to maintain their safety. We found however, that the agency had not always taken appropriate steps to ensure this was always the case.

People were not adequately protected by the agency's recruitment practices. The agency had policies and procedures in place which outlined how new staff should be recruited. The agency's own policy stated that a risk assessment would be completed if a staff member had convictions identified on their check with the Disclosure and Barring Service (DBS). DBS enables employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with children or adults who are vulnerable. We found that this policy had not always been followed. In one case the registered manager said that she had completed this risk assessment, but it could not be located. In two other cases there was no evidence that this had been undertaken and the registered manager was unaware that staff convictions existed. We also identified that some staff did not have references in place and gaps in employment histories had not been explored by the agency.

Failing to follow appropriate systems recruitment procedures when employing new staff was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that these staff had been recruited by an external body, but acknowledged that they had failed to have oversight of this process. We saw that more recent staff who had been recruited by the agency themselves had appropriate information detailing their fitness to work.

The agency failed to ensure the proper and safe management of medicines. Whilst the agency had limited involvement in supporting people with their medicines, their systems for ensuring safe practice in this area were not sufficient. Staff told us that they completed an on-line training course about medicines and those spoken with were able to demonstrate they knew the correct practices. There was no system in place for verifying that staff were competent in this area. No routine checks were done on new staff to ensure that they were following correct guidelines and there was no evidence that staff had read the agency's policies and procedures in this area. During an interview with us, one staff member mentioned that a person's prescribed food supplement was running low, but had not recognised their responsibility in ensuring people's medicines were available in sufficient supply.

We saw that care staff completed Medication Administration Records (MAR) for people whose care plan identified they required support with their medicines. The agency had no system in place for regularly auditing these records. Details about people's medicines were not included on the MAR charts and as such it was not possible to check that medicines had been taken in accordance with the prescription.

Failing to have systems in place to ensure people's medicines were managed safely and properly was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from community professionals and social work teams told us that where risks for people had increased, these were well managed by the agency. We found that the recording and risk assessments of these issues however, were poor. Discussion with staff highlighted that they were aware of the risks both to people and themselves and took appropriate steps to mitigate these. There was however, no record that the agency had appropriate oversight of how risks were managed. For example, we read how some people had complex mental health needs which presented risks to them and others. Yet, there were no risk management plans in respect of these needs. Another person had been identified as exhibiting inappropriate behaviour to female staff and whilst the registered manager was able to describe how this was being managed, there was no documentation in respect of it to guide staff.

We saw evidence that the agency conducted an assessment of people's needs before the agency commenced their care. This assessment included a risk assessment of both the person and their environment. Whilst this process identified risks, it did not highlight what action had been taken to mitigate the risks. For example, the assessment of one person's home highlighted a high risk in respect of trip hazards in the house and yet there was no record as to how the risk was reduced or managed. Staff stated how they managed these risks in practice, but again this was not reflected in the documentation.

Requires improvement

Is the service safe?

We read in incident and accident records that two staff had previously been injured whilst supporting people to move. The agency told us that all staff had now received practical moving and handling training. There was however no evidence that the agency had investigated these accidents. The relevant guidelines in place were insufficient to demonstrate how people were supported to be moved safely and without causing injury to staff.

Failing to appropriately assess and where possible, mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that they had no concerns about the way people were treated by staff. Other community professionals told us that they felt the people they were involved with were better safeguarded since they received services from the agency. We found that whilst staff demonstrated an understanding of their responsibilities in respect of safeguarding people, they were not clear how to report such concerns beyond informing the registered manager.

The agency had policies and procedures in place, but these were not compliant with the Care Act 2014. It was clear that care staff recognised where people may be at risk of harm and that the agency took these concerns seriously. Action however was not always taken in accordance with multi-agency policies and procedures. For example, concerns had been raised in respect of one person and whilst the agency had taken steps to address these concerns, they had not reported the issues to the local safeguarding team. As a result of this inspection, an appropriate safeguarding referral was made but this should have been done before this.

We read that a person had requested that their information was not shared with the police. There was no clarity about the circumstances around this nor detail about when information may need to be shared to safeguard the person.

Failing to have systems which effectively prevent abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The agency had sufficient staff to meet the needs the people that they were currently providing support to, although call times did not meet the expectations of some people. We saw that the agency had a system of matching staff to work with people and that this was based on a combination of skills and geography. Only one person told us that they had experienced a missed call and this was as a result of miscommunication rather than staffing shortages.

Good

Is the service effective?

Our findings

People described care staff as being "Excellent, first class" and "Very adaptable." People and their relatives told us that they felt they were able to "Train staff to their way." Community professionals commented that they were particularly impressed with the agency's recent recruitment of a qualified Community Psychiatric Nurse (CPN) to support the team of staff working with people living with mental health needs.

Appropriate steps had not always been taken to record people's consent to the care plan in place. For example, we noticed that one person had not signed their care plan and the registered manager said that this was because the person was blind and English was not their first language. No steps had been taken to facilitate this person understanding and signing their care plan.

People told us that care staff respected their wishes and acted in accordance with their decisions. Care staff were clear about how they obtained consent from people and what they should do if people refused to consent to their care. For example one staff member talked to us about times when people had refused them entry to provide support. Staff demonstrated an understanding of how to ensure they worked in people's best interests. Where people repeatedly refused their care, we saw that the agency involved other professionals. One social worker told us that the agency had been creative in providing support to a person who had refused the package of care they were assessed as needing. It was evident from talking with the CPN that they and care staff had a good relationship with people living with mental health needs and took appropriate steps to ensure they were fully involved in decisions about their care.

From conversations with people and professionals, it was evident that the agency liaised with other healthcare professionals to support people to maintain good health. As such the agency made referrals on behalf of people where they needed support from doctors, district nurses or other community services. For those people who the agency supported with their mental health, one social worker described staff as being a "Good advocate for their mental health needs." Staff from the Drugs and Alcohol Access team said that the agency also engaged effectively when people were in crisis.

The agency had recently developed a good clinical team to assist staff working with people with specialist needs. The registered manager was a Registered Nurse and as such took the lead on assessing and supporting people with physical health needs. The CPN provided direct support to people with mental health needs. We found that since the team had been split in this way, staff had received specialist training and learning relevant to their bespoke roles.

Prior to the recent appointment of the CPN, staff training had mostly been online generic and mandatory training. Staff told us that they had welcomed recent face to face training on topics such as palliative care and leg ulcer care, along with practical training in moving and handling.

Staff said that they felt confident and competent to carry out their jobs. For those staff supporting people with mental health needs, they said they had benefitted from the close support of the CPN.

The agency had also made recent improvements to the induction programme for new staff. As such, we saw that newly recruited staff were completing the Care Certificate. The Care Certificate is a set of standards introduced by Skills for Care. Existing staff said that their induction had included time in the office reading policies and shadowing other staff. We saw that the agency had a plan to ensure those staff would also now complete the Care Certificate.

Where necessary staff supported people to receive adequate food and drink and highlight the benefits of maintaining a healthy diet. We read that people's support needs with regards to eating and drinking were assessed at the start of the service. Staff gave examples of the type of support they provided in this respect. For example, for some people staff provided gentle encouragement to maintain a healthy lifestyle. Again, the records in this area were not reflective of the support provided.

Good

Is the service caring?

Our findings

People described care staff as “Excellent”, “Lovely” and “Very kind”. Relatives praised care staff for being “Thoughtful” and “Caring”. One relative voluntarily contacted us to praise the agency and told us “The care was so good, kind and caring. They were very respectful [to my husband] and didn’t rush him and listened to his wishes.”

We found that staff were split into geographical teams which meant that people mostly received care from the same small number of staff. People told us that they really appreciated having the same care staff because it meant that the care they received was consistent and they didn’t have to keep explaining how they wanted to be helped. With only a few exceptions, people told us that new care staff were introduced to them and shadowed their regular care staff before providing care alone. This was again highlighted as a real benefit of the agency.

People told us that care staff would “Go above and beyond” what they expected in terms of the care they provided. During the inspection we heard how the CPN was re-arranging their time in order to support a person who had to go to hospital to ensure they were accompanied on arrival and then supported back home afterwards. From discussion with the CPN it was also clear that a lot of support had been provided to this person previously to prepare them for their hospital stay and ensure the treatment was successful.

Other professionals told us that the agency had been really caring towards people with complex needs and creative in the way they offered support for people who were reluctant to accept help. They said that they felt both care staff and management really cared about the individuals they supported and genuinely wanted to find a solution to difficult situations.

People’s privacy and dignity were protected. People told us that staff always treated them with respect and that their privacy was never compromised. People said that where they had specific choices about the gender of care staff this was always respected. Relatives re-iterated that personal care was provided sensitively and discreetly. Staff were able to describe the steps they took to ensure this was always the case. For example closing doors when care was provided, keeping people covered and allowing people private time to use the toilet or commode.

People’s religious and cultural beliefs were respected with staff promoting their individual differences and preferences. Staff described how they respected people’s cultural beliefs in the food they prepared for people. For one person who could not speak English, staff explained that they had a set routine so the person knew what to expect. We also read that the registered manager had contacted the person’s relative when they did not appear themselves so that the reason could be explored sensitively.

Requires improvement

Is the service responsive?

Our findings

People said that they received care that met their needs, but were frustrated that care staff were sometimes late and they were not told in advance who would be supporting them. One relative told us that call times were a "Mystery" and on one occasion no staff member arrived at all.

Poor communication was people's main complaint about the agency. People had a regular team of care staff but could not understand why they could not be advised who was coming each day in the same way staff were. Similarly, some people were unhappy that they were not always informed if care staff were running late or the time of their call had been changed. We heard that some care staff contacted people directly in these situations, whilst others informed the office. In the latter case, we were told the office did not pass this message on.

People said that they had no complaints about the quality of care they received. They said that they felt able to raise any issues with care staff. Some people felt that the agency would not be responsive in dealing with their frustrations about organisational issues such as call times or when invoices were issued. At the office we saw that the agency had a complaints policy, but there were no records of any complaints that had been made.

People were not sufficiently involved in the formal planning and reviewing of their care. Either the registered manager or CPN completed an initial assessment of people's needs at the commencement of the service. Whilst people were clear that this visit had taken place, they did not feel that they were involved in the compilation of their care plan and felt that this assessment was only for the agency's own purposes. They said that once care staff were allocated to them they discussed how they wanted to be supported with them. This subsequent discussion was not recorded. As such the records maintained did not reflect the person centred care that people described and did not provide new care staff with the information required to provide appropriate care.

From discussion with the CPN it was evident that people with mental health needs were being effectively supported their social, housing and medical needs but this was again not reflected in the people's care plans.

People did not believe their care had been reviewed, although did say that the registered manager had visited them and sometimes things had changed as a result. The registered manager said that she reviewed people's needs continuously and that changes were ongoing. She described that she would provide hands on care herself and used this opportunity to reassess people's care. Again we could see that practically things were being done, but people did not have the opportunity to review their care in a formal way. As such issues about call times and lengths were not being addressed.

Failing to plan and review care collaboratively with people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from people and their relatives indicated that on most occasions they received the care they needed and expected. People felt that care staff were responsive to their needs and provided good care to them. We found that staff were knowledgeable about people's support needs, their interests and personal preferences, but this information was not routinely available in care records. The impact of this poor record keeping was mitigated by the local arrangements of regular care staff and new staff shadowing the usual staff member, but staff would be better prepared if they had a clear plan of care to follow.

Some people raised the issue that care staff did not always stay the required length of the call, although stressed that they did provide the care required before leaving. We read in feedback questionnaires from people who used the agency in 2014 comments such as "Some carers have skimmed on hours". The care staff we spoke with said that they felt some call lengths were too long for what people required. In these cases they said that they would always offer to do cleaning or shopping for people before leaving.

Staff supported people to retain their independence and enabled people to lead their lives as they wished. People praised the practical care they received and said that staff could not do enough for them, especially at times of difficulty or crisis. One relative told us that the registered manager had visited their husband in hospital and talked to him about his end of life care. They went on to say that the person was able to die at home how they wished because of the care provided.

Community professionals said that the agency had enabled people to remain in their own homes because the care provided was responsive and flexible to their needs.

Requires improvement

Is the service well-led?

Our findings

People described the management of the agency as "Chaotic" and "A mystery." Some people said that their queries were not answered if they rang the office or that their calls were not returned. Other people said that they had not experienced any problems, but that they tended to talk with care staff rather than contact the office. Whilst people experienced some good care, there were risks associated with the way the agency was being managed.

Communication between the office and people and care staff was not always effective. Care staff told us that sometimes the office had failed to share important information about people with them. One staff member said that they had once arrived at a person's house after they had died because the office had not informed them. Some professionals highlighted in their feedback that the management did not always effectively engage with them about business issues. We experienced issues with communication as part of this inspection process. We asked that people who used the service be informed that we might contact them and yet many people we spoke with said that this had not happened.

The quality of record keeping across the agency was poor and people's personal information was not always stored securely. For example we had concerns the way information about entry to people's property was stored. Information was recorded in too many different places and as such was not used effectively.

Care records were not appropriately maintained and did not reflect the support that the agency provided. For example, none of the work undertaken by the CPN had been documented in the people's care plans. Similarly whilst the agency had been liaising with the district nursing team about a person's leg wound, the conversations and subsequent actions were not detailed in the person's care records.

Recent organisational issues had meant that the agency had created a backlog with invoicing people for their care. People who paid privately were frustrated by this, as were the local funding authority. At the inspection, we found that insufficient records had contributed to the delay in these invoices being sent.

Failing to maintain complete and contemporaneous records about the care and treatment provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider informed us that record keeping had been affected by problems with a new electronic system. Whilst it was evident that this had created some difficulties, the issues were known and a better solution should have been sought in the interim.

The agency's systems for auditing and monitoring quality were inadequate. The agency lacked a robust system for identifying and improving the quality and safety of the service provided. The agency had failed to identify and act upon the shortfalls in areas such as recruitment, risk assessment and record keeping.

Processes that were in place were informal and ad hoc. For example, some spot checks on care staff had been completed, but these were not always documented and there was no system that determined the frequency and follow-up for these. Competencies of new staff were not tested and where training had been completed there was no assessment of this knowledge in practice. There had been a heavy reliance on e-learning without checks to ensure that this improved practice. Despite identified issues with manual handling, there were no observations undertaken to ensure staff were operating safe practice.

Feedback systems were not used to generate improvements. The agency conducted an annual survey, but the results from these questionnaires had not been collated and analysed. As a result no actions had been set to ensure the feedback was used reflectively to improve the service. For example in November 2014, people raised the issue of call times not being adhered to and 11 months later the feedback we received was the same. People did not feel that the agency listened to their frustrations about organisational issues and as such stopped sharing it.

This failure to have effective systems to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person failed to have effective recruitment procedures in place.**

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person failed to have systems in place to ensure the safe and proper management of medicines.**

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person failed to have systems in place to appropriately assess and where practicable, mitigate risks.**

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person failed to have systems in place to effectively protect people from abuse.**

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

The registered person failed to collaboratively assess, plan and review care with people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person failed to have effective systems to assess, monitor and improve the quality and safety of services. The registered person failed to maintain complete and contemporaneous and secure records in respect of the care and treatment provided.