

Joyce Darfoor Ltd

CarePlus 24

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

We undertook an announced inspection of Care Plus 24 Agency Domiciliary Care Agency (DCA) on the 24, 29 and 30 April 2015.

Care Plus 24 provides personal care services to people in their own homes. At the time of our inspection six people were receiving a personal care service. Three people received care from a member of staff who lived-in at their home. Three people received a number of care visits throughout the day according to their assessed needs. CarePlus 24 provides support for people who require a

range of personal and care support related to personal hygiene, mobility, nutrition and continence. Some people were living with early stages of a dementia type illness or other long-term health related condition. People lived reasonably independent lives but required support to maintain this level of independence.

In addition to the DCA the provider also provided care staff to work in local care and nursing homes on a temporary basis. These staff are often referred to as

Summary of findings

‘agency staff.’ This type of agency is not regulated by the Care Quality Commission (CQC) therefore was not included in our inspection although it is referred to in this report.

The registered manager at CarePlus 24 is also the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are ‘registered persons’. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by staff who had a good understanding of their individual needs and choices. People told us they received the care they needed by regular staff who they knew well. They told us they were involved and able to make decisions about their day to day care. However, people’s care records did not always reflect the care they required. Care plans were not detailed and did not include all information staff may need to provide care. Care plans were not updated when people’s care needs changed.

Medicines were not always managed safely. There was limited guidance for staff about ‘as required’ (PRN) medicines. There were no risk assessments in place to support staff. Medicine Administration Record (MAR) charts were not in place for some people who required support with medicines or topical creams.

Safe recruitment practices were not in place. Criminal record checks had taken place however there was not a

full employment history in place for each member of staff. This meant the provider could not demonstrate staff were of a good character and suitable to work with people who used the service.

Staff received training and support although this was not always documented. It was not clear how the provider identified what training staff required. Staff had an understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) however, not all staff had received DoLS training

There were enough staff to meet people’s needs. Staff had a good understanding of safeguarding

procedures and what steps they would take if they believed someone was at risk of abuse of harm.

Risk assessments were in place and these identified both personal and environmental risks.

People were supported to maintain their own health. People were referred to their GP and supported to attend other healthcare appointments as needed.

There was a complaints policy in place, people told us their concerns were addressed appropriately but this was not recorded.

There was not an effective system in place to assess, monitor and improve the quality of the service provided; therefore the provider was not aware of all the shortfalls we found.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version 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?

CarePlus 24 was not consistently safe.

People's medicines were not always managed safely. Not all medicines administered had been recorded, risk assessments were not in place for the use of 'as required' medicines and there was a lack of guidance for staff.

Recruitment procedures were not safe; they did not contain a full employment history for each member of staff.

Risk assessments were in place and these identified both personal and environmental risks. Staff understood what to do to protect people from the risk of abuse. There were enough staff to meet people's needs.

Requires improvement



Is the service effective?

CarePlus 24 was not consistently effective.

Staff received training however it was not clear how the provider identified what training staff required.

Staff had an understanding of MCA and DoLS although not all staff had received DoLS training.

People's nutritional needs were met and they were supported to receive enough to eat and drink.

Staff knew people well and recognised when they may need to be referred to an appropriate healthcare professional for example the GP or district nurse.

Requires improvement



Is the service caring?

CarePlus 24 is caring.

Staff had a good understanding of people as individuals. This enabled them to provide good, person centred care.

People were supported to make decisions about their daily care and remain independent.

Good



Is the service responsive?

CarePlus 24 was not consistently responsive.

People received care and support that was responsive to their needs because staff knew them well. However, care records did not reflect the care people required. This meant there was no guidance for staff to ensure consistency or demonstrate that people's care needs were being identified and met.

Complaints were handled appropriately however these were not recorded.

Requires improvement



Summary of findings

Is the service well-led?

CarePlus 24 was not consistently well-led.

There was not an effective system in place to assess, monitor and improve the quality of the service provided; therefore the provider was not aware of all the shortfalls we found.

People and staff told us the registered manager was approachable and responded to concerns appropriately.

Requires improvement



CarePlus 24

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 of Care Plus 24 took place on 24, 29, 30 April 2015 and was announced. We told the provider two days before our visit that we would be coming. We did this because they were also the manager and were sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be in. One inspector undertook the inspection.

Before the inspection visit we reviewed the information we held about the service, including the Provider Information Return (PIR) which the provider completed before the inspection. The PIR 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. We also reviewed information we received since the last inspection.

At the last inspection on 19 November 2013 we found the service met the regulations we inspected.

During our inspection we went to the office and spoke to the registered manager, a staff member, two further managers who worked within the company. We reviewed the care records of five people that used the service.

We looked at six staff recruitment files, supervision and training records, and spoke with the registered manager about the systems in place for monitoring the quality of care people received. We looked at a variety of the service's policies such as those relating to safeguarding, medicines, complaints and quality assurance.

Following the inspection visit we undertook phone calls to three care workers, three people that used the service and relatives of two people that used the service to get their feedback about what it was like to receive care from the staff. We also spoke with two social care professionals to get their views on the service.

At our last inspection of 19 November 2013 the service was meeting the regulations inspected.

Is the service safe?

Our findings

People told us they felt safe with the staff that looked after them. They told us if staff had any concerns about their welfare these would be reported and action taken straight away. People who received support with their medicines told us they received them when they needed them.

Systems in place did not ensure safe recruitment practice. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with people.

However, application forms did not include a full employment history and there was no evidence of interview notes to demonstrate this had been discussed. References were in place but due to the lack of employment history it was not clear if these references were professional or character references. This could leave people at risk of receiving care from staff who were not of good character or suitable to work with people who used the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people required support to take their medicines. Medicine administration record (MAR) charts were in place and these had been signed by staff when medicines had been taken. If medicines were not taken, for example if the person declined, the chart was completed using a coded system to indicate why. We saw two occasions where the MAR chart had not been completed and on other occasions a code was used which was not included on the MAR chart so it was not clear why this medicine had not been given. Some medicines had been prescribed to be taken 'as required' (PRN), for example pain killers when someone had pain. There was some guidance in place for example how many tablets the person could take in 24 hours but there was no information about the frequency these could be taken. We looked at the medicine policy but this did not include any PRN guidance. This could leave people at risk of harm by receiving more medication than they required.

Daily notes included information that had not been included in people's care plans. For example staff had recorded they had applied people's creams. It was not clear if these creams were prescribed or cosmetic. There was no information on MAR charts or in care plans about people

needing or choosing to have cream applied. One person told us how staff supported them to take their medicines by putting tablets out for them to take. We had looked at this person's care plan and there was no risk assessment or guidance for staff to follow to ensure consistency. There was no MAR chart in place for staff to know what medicines had been prescribed and when these should be taken. This could leave people at risk of harm from receiving incorrect medicines or creams that had not been prescribed.

There were no risk assessments in place for people who required support with their medicines. There was no information about where to store medicines to ensure they were stored both safely and at the correct temperature. Medicines may not be effective if they are not stored correctly.

People had not been protected against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a good understanding of why people needed their medicines and how to administer them safely. Currently staff were not responsible for ordering or disposal of people's medicines. This was undertaken by people or their family members.

Staff had an understanding of different types of abuse and how to identify and protect people from the risk of abuse or harm. Staff told us all concerns would be reported to the registered manager. If concerns related to the registered manager they would report to the appropriate local safeguarding authority.

Risk assessments were in place and these identified both personal and environmental risks. Some people had been identified as having poor mobility and were at heightened risk of falls. Risk assessments included information about how people mobilised safely. This included the use of mobility aids for support when walking, or the use of a stair lift to get upstairs. Environmental risk assessments identified, for example, rugs and mats which may present a trip hazard and as a result one person had removed their rugs. The registered manager had identified a number of risks which were specific to people's individual life choices. These had been discussed with individuals and although no actions had been taken this meant staff were aware of

Is the service safe?

the concerns and risks to people. Staff told us people were supported to keep as safe as possible whilst maintaining their independence and lifestyle choices. People we spoke with told us they were able to live their lives as they chose.

There were enough staff to provide safe care to people. The registered manager told us before assessing people to use the service she ensured there were enough staff to meet their needs and provide a good standard of care and support.

Two staff provided live-in care for people and other staff were available to provide support if these staff were not available. One member of staff provided care to people who lived at home. If this staff member was not able to

work the care would be provided by the registered manager or other staff. The registered manager had identified further staff who worked within residential care homes through the agency who were suitably skilled and qualified to provide care for people at home. The registered manager explained staff who provided home care were also able to support people who required live-in care if the regular staff member or back-up support were not available. The registered manager explained because she had a good knowledge of staff ability in both parts of the organisation she was able to ensure suitable staff were always available to provide appropriate care and support. People told us they had support from regular staff who they knew.

Is the service effective?

Our findings

People and their relatives told us staff had a good knowledge of the care they provided. They told us staff identified when people were not well or needed further support. One relative told us, “She, (staff) always notices if things aren’t right, and she tells me when things are getting better.” People told us how staff supported them to attend GP and hospital appointments.

The registered manager told us when staff commenced work they completed an induction and period of time shadowing other staff. We were shown an induction book that had been completed by a member of staff who no longer worked at the DCA. The registered manager explained staff kept their own books to enable them to refer to them in the future as they needed to. We were told staff training included moving and handling, infection control, first aid, medicines and safeguarding which included mental capacity. There were certificates in staff files to show what training staff had completed. These were confusing as they did not demonstrate staff had received all the training we were told they had.

We were shown workbooks staff were given to complete in relation to medicine training however there were no certificates or other evidence to demonstrate any staff had completed medicine training. Staff we spoke with told us they received regular training and updates and confirmed they had received medicine training. Staff received on-going supervision. This was recorded on a tick sheet and showed when the staff member had been observed providing care for example personal care, moving and handling and diet and nutrition. It also identified if staff required further training or support. However, there was no evidence of observations in relation to the administration of medicines or any check of staff competencies in relation to medicines. We have identified this as an area of practice that needs to be improved.

In addition to recorded supervision, staff regularly spoke with the registered manager when they visited the office. They discussed issues related to the people they looked after and areas of development they had identified for themselves. Staff told us they were well supported by the registered manager.

Staff told us they had received training in the Mental Capacity Act 2005 (MCA) when they received their adult

safeguarding training. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. Staff demonstrated an understanding of mental capacity in relation to the people they looked after. They told us everybody was able to make their own choices in relation to what they did each day. One staff member said, “People may have the start of dementia but they can make their own choices, they know what they like and what they want to do.” There were no formal mental capacity assessments however care assessments contained information about people’s memory and whether they were subject to periods of confusion. There was also information about the choices people were able to make for example in relation to their choice of what to wear and what to eat. This provided staff with information about what choices people were able to make and where they needed support. One member of staff understood Deprivation of Liberty Safeguards (DoLS). These safeguards concern decisions about depriving people of their liberty, so that they get the care and treatment they need, where there is no less restrictive way of achieving this. Other staff told us they had not yet received DoLS training. It is important that staff are aware of DoLS so that people are not restricted illegally. This is an area that needs to be improved.

People received appropriate support to help them meet their nutritional needs. There was information about people’s nutritional needs in their assessments. This included whether people required support to prepare and eat their meals and whether they had any special dietary needs for example a soft or pureed diet or help cutting their food. There was further information about any particular likes, dislikes and where people liked to eat their meals. Staff told us how they supported people with meals. They said people themselves or their relatives shopped for food, this ensured there was always enough available. Staff discussed with people what they would like to eat and prepared it according to people’s preferences. For people who had support from live-in staff, mealtimes were flexible to suit the individuals. Where people had support specific to help them with their meals the visit times had been agreed when people started using the service.

One person told us how staff supported them to prepare the meals of their choice. They said staff knew how and

Is the service effective?

when they liked to eat their meals and knew where they required support with. The person said, “We have a good routine, it works well, much better than I ever thought it would.”

People’s health and well-being was monitored at each care visit. One relative told us how staff were quick to recognise when their loved one was unwell or was concerned about their well-being. Staff knew people well and recognised when they may need to be referred to an appropriate healthcare professional for example the GP or district nurse. Where appropriate, staff would inform people’s relatives if the person became unwell or contact the GP on the person’s behalf. Staff told us they would always report healthcare concerns to the registered manager to ensure she was aware. The registered manager told us she would liaise with people’s GP’s if necessary and discuss for example changes in medicines such as a course of antibiotics.

People received care and support from familiar and consistent care staff. Visit times were agreed when people started using the service and people told us these were flexible to suit them. If staff were going to be late for a visit they would tell the registered manager who would then inform the person. People told us staff were not usually late but if they were it was nice to be informed. Before a new member of staff visited people they were introduced to the person usually by shadowing the regular member of staff. The registered manager explained this was a vital part of providing a good service. She said it was important people knew who was visiting them and it was equally important for staff to know about people they were looking after. She said, “I can tell staff what care people need but they need to know other things, like where are the tea-cups kept.”

Is the service caring?

Our findings

People told us they had a good relationship with the staff who looked after them. They told us staff were kind and caring and treated them with respect. They said they received care from staff who they knew and who knew them well. One person told us, "It takes time to get to know someone but we've done that, it works well now."

People told us about their anxieties in relation to having care at home. One person said, "I was really worried about it, but it's turned out very well, it's like it's always been." Another person told us they had taken a while to adjust but were now very happy with the arrangements. They explained it was the staff who had supported them. They said, "She put her arm round us and said, you're the boss, it's your home." They added, "That made all the difference that made it work."

It was clear staff knew people well, they had a good understanding of people's needs, choices, likes and dislikes. People received care from regular care staff and were introduced to them before they started to deliver care.

People were involved in decisions about their day to day care. People told us staff spoke with them about their care to ensure they received what they wanted. Staff told us they reminded people they had choices. One staff member explained people often had routines but would remind them they could change the routine if they wished. The registered manager regularly phoned people to ensure they were happy with the care or if people required any changes. One person told us how changes had been made to meet their specific needs. We were told, "They try to accommodate the unusual times I want them to visit." This person also told us this was not always possible. They added, "Where expectations can't be met compromise is reached."

Staff told us they prompted and encouraged people to remain independent. They told us although they knew what care people needed and they could read the care plans they asked people what they wanted at each visit. People told us by receiving support at home they had been able to remain independent. They told us although they needed some support they were able to live their lives as they chose.

We saw from daily notes how staff had recognised when people were distressed and supported them appropriately. Staff we spoke with had a good understanding of why some people may become distressed, how they showed distress and how they prevented or dealt with it. Staff demonstrated insight, sensitivity and understanding about people's individual worries and concerns.

Staff spoke about people with kindness, affection and respect. They all told us their aim was to deliver good care that people wanted to receive. They said, "I treat people how I would want my family treated, and for my family it's got to be top marks." They also told us they provided care which suited people not what suited them. One staff member said they reminded people, "We're working for you, you tell us what you want." They told us because they knew people well they were able to provide them with the care they wanted in the way they chose. Staff explained they respected people's individual choices and lifestyles. One staff member told us, "We're visitors in their homes, and people can live as they choose at home." People we spoke with told us staff treated them and their homes with respect.

We asked staff how they maintained people's dignity and privacy. They gave us examples which included maintaining people's privacy when delivering personal care. One staff member told us how they ensured people were appropriately covered and those who were able supported to undertake their own personal care.

Is the service responsive?

Our findings

People told us they had been involved in an assessment when they started using the service. They told us if they had any concerns or complaints they would tell staff or the registered manager and these would be addressed. One person said, “If you tell them they sort it out.”

Staff knew people well and understood their care and support needs, choices and preferences. However, records viewed did not always reflect the care and support people received. People’s needs were assessed when they started using the service and care plan reviews took place about every six months. There was no evidence people were involved in developing their own care plans and there was no records to demonstrate people had consented to receive care. Care plans contained basic information and did not contain information to provide staff with a picture of the person they were supporting. For people who received support from live-in staff, the care plans were very broad and stated people required help with personal care and meal preparation but this was at the person’s request. For people who lived at home, visit times were included but detailed information was limited. Care plans stated people required support with personal care or preparing meals however, there was no guidance about whether the person preferred a wash or a bath, or what toiletries they may like to use. Whilst we understand people’s care was provided as they chose there was no guidance for staff to ensure they were aware of what support may be required and how people liked this support delivered.

An assessment for a person who had recently started using the service had been completed on a different form to those seen in other care plans. This form offered the opportunity to include information about the person’s daily lifestyle, social needs and hobbies however this had not been completed. There was no information about people’s specific likes and dislikes, routines or rituals. The registered manager had a good knowledge of what this person liked but this had not been recorded. Staff told us about another person’s hobbies which were similar to their own; there was

no information about this in the person’s assessments or care plan. We saw from the daily notes people engaged in a range of outings and activities but this information had not been included in the care plan. This did not provide clear guidance for staff to ensure consistency or demonstrate evidence that people’s needs were met.

People’s risks had been assessed and identified. However there was no guidance for staff about actions to take to mitigate risks. For example where people had been identified at risk of falling and whether people they used mobility aids there was no guidance for staff of what actions to take to prevent people from falling.

Changes in people’s care needs were not consistently recorded. One care plan that had been reviewed when the person’s needs had increased and the care plan reflected this change. We were told about other changes which had not been updated within care plans. For example one person no longer required support with their medicines but the care plan informed staff medicines were still required. This had not been recorded and did not provide clear guidance for staff to ensure consistency or demonstrate evidence that people’s needs were met.

Personal records were not accurate, complete and contemporaneous. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy in place however this did not include the correct information if people were not satisfied with how their complaint had been handled. Everybody who used the service had a copy of the statement of purpose. A statement of purpose informs people what the service does and how it achieves this. This included information for people about how they could make a complaint or raise a concern. The registered manager told us they had not received any official complaints. People we spoke with told us any concerns raised were addressed promptly and appropriately however these were not recorded.

Is the service well-led?

Our findings

People we spoke with told us the registered manager and staff were approachable and they were able to raise any concerns they had. One person said, “We have an open relationship, I can say what I want.” Another person told us the registered manager was, “Keen to sort out any issues.” This person also said the registered manager wanted to learn what would work for them.

The registered manager had an overview of the service, she knew people and staff well and had an understanding of their needs and capabilities. However, there was no system in place to assess, monitor and improve the quality and safety of the service.

The registered manager told us she regularly telephoned people to ensure they had no concerns and to get feedback about the service. People confirmed this and told us they spoke with the registered manager regularly to discuss changes to their care provision and any other issues that may arise. However, there was no record that people had been asked for their views about their care or the service. This meant the provider was unable to demonstrate how feedback from people was used to evaluate and improve the service.

There was no audit system in place. MAR charts were not audited therefore occasions when medicines had not been given were not identified or action taken to prevent a reoccurrence. There were no audits of care plans and associated documentation to identify any areas which needed to be addressed. For example where assessments had not been fully completed and care plans had not been updated to reflect peoples changed needs. We saw from the daily notes one person had fallen and although the appropriate action had been taken at the time there was no evidence the registered manager was aware. There were no records of any accidents or incidents. This meant that there was a risk that patterns of concern could be missed.

There was a reliance on verbal communication and records in relation to the day to day running of the service were not well kept. There was no evidence of action being taken to address issues identified in assessments for example environmental risk assessments identified if smoke detectors were in place in people’s homes. There were instructions for staff to check these six monthly but no evidence this had been done.

Policies were in place but these were generic and not individualised to the service. The safeguarding policy contained information about abuse and actions to take but did not include contact details of who to report concerns to for example local authority safeguarding telephone numbers.

The training policy stated training updates took place ‘as required’; the registered manager stated these took place according to the original certificate or 1 to 2 yearly. There was no overview of what training staff had undertaken and it was not clear how the registered manager identified when staff required further training. Staff told us they completed induction and medicine training however there was no evidence this had been done.

Observational supervision took place and this was recorded. Staff told us they often discussed training and development needs or issues related to people’s changing needs with the registered manager. These had not been recorded.

There was not an effective system in place to monitor and improve the quality and safety of the services provided. There was no evidence to demonstrate how information received was processed and used to evaluate and improve the service.

Due to the above concerns, we have identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was also the provider of CarePlus 24 although there are two other senior managers within the service these managers were not involved in the provision of care services. This meant the provider was not engaged with any external adult social care support networks which would enable sharing of best practice and provide professional support for them.

However, the registered manager had a good overview of the service. People and staff told us she was approachable, they were able to discuss any concerns and these would be addressed appropriately. Staff had a clear understanding of their roles and responsibilities and who they would report their concerns to. One staff member told us, “It’s like family, we can say anything and it will be sorted.”

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People were not protected against the risks associated with the unsafe use and management of medicines.

Regulation 12(1)(2)(g)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

People's personal records were not accurate and up to date.

The provider did not have an effective system to regularly assess, monitor and improve the quality of service that people receive.

Regulation 17(1)(2)(a)(b)(c)(e)(f)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The provider had not ensured staff were of good character and suitable to work with people who used the service.

Regulation 19(2)(a)(3)(a)