UK Star Care Ltd

Sceptre House

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We undertook an announced inspection of Sceptre House on 24 and 25 July 2017. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people and we wanted to be sure someone would be available to assist with the inspection.

Sceptre House is a domiciliary care agency that provides personal care for people in their own homes. At the time of the inspection eight people had their care funded by a local authority with four people funding their own care.

This was the first inspection of the service since it registered with the Care Quality Commission in August 2016.

At the time of the inspection a registered manager was 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.

Risk assessments were not developed to ensure specific risks related to each person were identified and guidance was not provided as to how to reduce any possible associated risks.

The provider had an administration of medicines policy but care workers were not always provided with information on the MAR charts or in the care plans to ensure medicines were being applied in an appropriate and safe way.

The provider had a recruitment process but this was not always followed therefore not providing appropriate information regarding applicants to ensure they were suitable for the role.

The provider had a policy in relation to the Mental Capacity Act 2005 but was not always working within the principles of the Act. Records did not clearly indicate if the person using the service had the capacity to make informed decisions in relation to their care.

The competency of new care workers to complete care tasks was not assessed appropriately during the induction period. Some care workers had completed their induction training a number of months before starting work. This meant the provider could not ensure the new care workers had the appropriate knowledge and skills required to meet people's care needs safely.

Records relating to care and people using the service did not provide an accurate and complete picture of their support needs.

Regular audits had not been carried out to identify aspects of the service requiring improvement and action had not always been taken to address issues.

People told us they felt safe when they received care in their own home. The provider had processes to respond to any reported safeguarding concerns as well as incident and accidents.

People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care.

An assessment of people's support needs was carried out before home care started and care plans identified how people wanted their care provided.

The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

The person and relative we spoke with felt the service was well-led.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to the safe care and treatment of people using the service (Regulation 12), safeguarding service users from abuse and improper treatment (Regulation 13), good governance of the service (Regulation 17), staffing (Regulation 18) and fit and proper persons employed (Regulation 19). Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Some aspects of the service were not safe.

Risk assessments were not developed to ensure where specific issues related to each person were identified, guidance was provided as to how to reduce any possible associated risks.

The provider had an administration of medicines policy but information was not provided to ensure medicines were being administered in an appropriate and safe way.

The provider had a recruitment process in place but this was not always followed therefore not providing appropriate information regarding applicants to ensure they were suitable for the role.

People told us they felt safe when they received care in their own home. The provider had processes in place to respond to any reported safeguarding concerns as well as incident and accidents.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider did not always work within the principles of the Mental Capacity Act 2005.

The competency of new care workers to complete care tasks was not assessed appropriately during the induction period. Some care workers had completed their induction training a number of months before starting work.

Care workers did not complete training in relation to the administration of medicines.

Care plans identified when people required support from care workers to prepare and/or eat meals.

Is the service caring?

Good

The service was caring.

Care plans identified the person's cultural and religious needs as well as their preferences for gender of the care worker.

People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care.

Is the service responsive?

Good

The service was responsive.

An assessment of a person's support needs was carried out before home care started.

Care plans identified how people wanted their care provided.

The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Records relating to care and people using the service did not provide an accurate and complete picture of their support needs.

Regular audits had not been carried out to identify aspects of the service requiring improvement and action had not always been taken to address issues.

People felt the service was well-led.

Sceptre House

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.

This inspection took place on the 24 and 25 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

One inspector undertook the inspection and before the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

Before the inspection, the provider completed a Provider Information Return (PIR). 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.

During the inspection we spoke with the registered manager, deputy manager and quality assurance manager. We reviewed the care records for five people using the service, the employment folders and training records for four care workers and records relating to the management of the service. We also contacted by telephone one person who used the service and one relative. We sent emails for feedback to four care workers and received comments from one care worker.

Requires Improvement

Is the service safe?

Our findings

The provider had general risk assessments in place in relation to each person receiving care and the care workers visiting them but they did not have risk assessments for specific risks which were identified during each person's needs assessment. These risks included developing pressure ulcers, diabetes, managing incontinence and increased risk of infections due to a medical condition.

As risk assessments had not been completed in relation to the specific risks identified for each person, guidance had not been provided for care workers as to how to reduce any possible associated risks when providing care.

The care plans of some people indicated when care workers should apply cream but it did not state if this cream had been prescribed and if it should be recorded on a Medicines Administration Record (MAR) chart. During the inspection we reviewed the communication books for one person used by care workers to record the care and support provided during each visit. We saw the care workers had recorded they had applied a cream during each visit but the type of cream had not been identified in the care plan. We then saw a care worker had referred to the cream by brand name and this indicated it was a non-steroidal anti-inflammatory pain relief cream which had been purchased from a pharmacy. This cream had not been prescribed and any possible impact on other prescribed medicines or medical conditions had not been identified or assessed. This meant the person was at risk as suitable checks, guidance and monitoring were not in place in relation to the application of this cream.

We looked at the records for another person and saw the rota used by the care workers indicated the administration of a pain relief patch was to be carried out at each visit but the care plan stated it should be weekly. This meant the person was at risk of receiving the medicine more frequently than prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had a recruitment process in place but we found this was not always followed and therefore the provider did not have the appropriate information regarding applicants to ensure they were suitable for the role. The registered manager told us they would request references from at least two previous employers or one previous employer and a character reference. The applicant was also asked to provide a full employment history and proof of identification and their right to work. However, these checks were not always requested as described by the manager

We looked at the records for four care workers and we saw the application form for one applicant did not include the dates they worked for previous employers including other care providers. The character reference provided for this person did not identify the relationship between the person and the applicant to determine if this was a suitable reference. There was no record that the missing information was discussed during the interview process. One reference for another applicant had not been obtained from their most recent employer and no reason for this was recorded with the application.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw all the applicants had a criminal record check carried out before they started working in the service as well as checks of their identity and right to work in the UK. The issues identified were discussed with the registered manager during the inspection and they agreed to review their recruitment processes.

The person we spoke with told us they felt safe when they received care in their home and the relative told us they were happy with the care their family member received and felt they were safe. We saw the provider had policies and procedures in place so if any concerns regarding the care being identified the registered manager would respond to them appropriately. At the time of the inspection no safeguarding issues had been reported.

We asked the person using the service and a relative if care workers usually arrived at the agreed time for their visit. They told us "If they are going to be on time it is OK and if they are held up they call me and arrive the time they tell me they are going to me here by" and "Yes, sometimes they are held up due to delays or traffic. They are pretty good as they call and tell us." We also asked if the care workers stayed for the agreed length of time. Their comments included "I am not a great person for timekeeping so as long as they do what they are supposed to do. If it takes five minutes less or more I don't mind" and "They do what they are supposed to do when they are here and stay the time."

The deputy manager explained care workers completed a time sheet which was also used as their rota. It included information about the name of the person being visited, if a second care worker was scheduled to attend as the person required the assistance of two care workers and the type of care to be provided.

The provider had a process in place to record and investigate when an incident and accident was reported. At the time of the inspection the registered manager confirmed no incidents and accidents had occurred since the service was registered.

The provider had appropriate processes in relation to infection control. The care workers were provided with appropriate equipment including aprons and gloves to use when providing support. There was an infection control procedure in place, care workers completed training as part of their induction and checks were made on the use of equipment during spot checks.

The registered manager told us the number of care workers allocated for each visit to a person using the service was based on the referral information received from the local authority and following their visit to the person's home to complete the needs assessment.

Requires Improvement

Is the service effective?

Our findings

The provider had a procedure in place to assess the capacity of people using the service to make decisions in relation to their care and to meet the requirements of the Mental Capacity Act 2005 (MCA) but this was not always followed.

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 take 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The deputy manager explained that if following a mental capacity assessment a person was identified as not having capacity to make decisions relating to their care they would ask the family to agree the care plan and make decisions.

During the inspection we saw a mental capacity assessment had been completed for one person but contained inconsistent information. We asked the deputy manager about the assessment and she confirmed it had been completed by the person's relative and not a member of staff with MCA training. The capacity assessment had identified that the person lacked capacity to make certain decisions but did not identify how the care workers should best support the person to make decisions in relation to specific aspects of their care. The person's records indicated a Lasting Power of Attorney was not in place in relation to health and wellbeing to identify who could make decisions on their behalf. A Lasting Power of Attorney in health and care matters legally enables a relative or representative to make decisions in the person's best interest as well as sign documents such as the support plan on the person's behalf. The care plan indicated the person had given verbal consent for a relative to sign their documents but the mental capacity assessment was not clear if the person was able to give their informed consent.

This meant the provider did not have suitable arrangements to help ensure people's rights in line with the principles of the MCA were always protected, whilst care was being delivered to them.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

As part of the one week induction process new care workers completed one day of training with an external provider. The training was based upon the requirements of the Care Certificate. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to care for staff new to health and social care. During the inspection we looked at the records for four care workers. We saw care workers had completed their induction training up to seven months before they started to provide care for people

using this service. One care worker had completed their induction training in September 2016 but did not start working for the service until April 2017. The records for another care worker showed they completed their induction training seven months before they submitted their application form to apply for the role of care worker with this service.

This meant there was a gap between the care workers completing their training and starting to provide care and no refresher training was provided to remind them of the procedures or best practice they had previously learnt to ensure they could provide safe and appropriate care to people.

The registered manager explained, as part of the induction, new care workers completed a minimum of one day shadowing an experienced care worker and their competency in relation to a range of care tasks was assessed before they could attend visits on their own. During the inspection we saw the induction records for four care workers and we saw they had been identified as competent in relation to tasks not required during the visits at which they were assessed. This included being assessed as competent in relation to catheter care when the person they were visiting did not use a catheter and they safely supported a person to eat but were not required to assist the person they visited with food and drink. We asked the registered manager how the competency of the new care worker was assessed and they explained there would be observation of the tasks carried out during the shadowing visits. For any tasks that were not required to be completed as part of the shadowing visits the new care worker would be asked if they felt competent to complete those tasks which would be recorded on the form. Therefore these checks were not robust enough to ensure the new care workers were competent enough to complete practical and more complex tasks, such as catheter care, required during visits to people receiving support.

We also saw that new care workers completed as little as one 30 minute visit as part of their shadowing visits during induction. The registered manager explained the visits were to people who they may be providing care for in the future so were limited to the number they could attend during the one day. This meant the new care worker may not have enough time to get to know the person and understand how they wanted their care to be provided before they started the care visits on their own.

The registered manager explained all care workers had three supervision meetings with their manager each year and an annual appraisal. We saw records of supervision meetings which had not been dated and had a standard list of areas to be discussed during the meeting but there was no record of what had been discussed with the care worker or any identified actions that might have been required following the meeting.

Care workers did not receive training in relation to the administration of medicines as part of the training identified by the provider. The deputy manager informed us she carried out competency checks on the care workers but they had not received any training. We saw the competency of the new care worker at administering medicines was also identified on the shadowing visit record. The record for one care worker indicated they were assessed as competent in relation to administration of medicines but the people visited did not require the care worker to administer their medicines. This meant care workers had not received the appropriate training in relation to the administration of medicines.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked the registered manager what refresher training care workers would receive and they told us they aimed for care workers to complete the one day training course, which was part of their induction, on an annual basis. This had not yet started as care workers had not been working for the provider for more than

one year. Appraisals had not been completed for the same reason.

The care plans included the contact details of the person's GP and any other healthcare professional involved in their care. This included the district nurse, physiotherapist and pharmacist. If care workers identified the person's health needs had changed it would be recorded in the record of care completed at each visit and the provider would inform the person's relatives so they could contact the relevant healthcare professional.

We saw care plans indicated if the person required support from the care worker to prepare and/or eat their food. Where care workers supported people with the preparation of food information was included in the care plan relating to their preferences for food and drink. The care worker would also record what the person had eaten in the records completed for each visit.

Good

Is the service caring?

Our findings

The person using the service and a relative were asked if care workers were kind and caring when they provided support. Comments included "I think so. They are very kind and they talk to my family member while they provide support" and "Yes, they are very nice and lovely."

We also asked them if care workers treated people with dignity and respect when they were providing care. They told us "I consider they do. No complaints at all. They are very polite" and "Oh yes. They are very good to my family member." We also asked the care workers how they maintained a person's privacy and dignity when providing support. The care worker told us "By closing the door and knocking on the door."

We asked if the same care worker or if they regularly changed, the person using the service told us "More or less, they always tell me if there is going to be a change. I have had the same care worker for a while now." The relative of a person using the service said "Oh yes. I know who will be turning up there as they tell me."

The person we spoke with and the relative of a person using the service told us care workers helped maintain their independence while providing care. The care plans we looked at indicated when the person could complete an activity independently and when a care worker needed to provide additional support.

The care plans included information in relation to the person's religious and cultural needs. It also included their personal preferences relating to the name they preferred to be called by and the gender of the care worker who would be providing support. The person's main language was also identified. This meant care workers were provided with information so they were aware of any cultural or religious issues that could affect the way care should be provided. We saw from the rotas that the person's preference for the gender of care worker was respected.

We saw some of the care plans provided care workers with information about the personal history for the person they were supporting where the information was available. The care worker could use this information to identify any areas of interest when talking with the person during visits.

Good

Is the service responsive?

Our findings

The person we spoke with and a relative of a person using the service both confirmed they met with a member of staff from the service when they started to use the service to discuss how they wanted their care provided. One person said "They sat down with me and my family member and discussed everything before they started."

The registered manager explained a detailed assessment of the person's care and support needs was completed before home care started. If the person was being discharged from hospital and was funding their own care an initial assessment visit would be carried out before the discharge to ensure the level of care required could be provided. If the person had their care funded they would review the referral information provided by the local authority which identified the person's health and care needs. They would then meet with the person to discuss their care need to ensure the referral information was accurate. A care plan and risk assessments were then developed from the information obtained. The care plan identified how the person wished their care to be provided and the activities to be completed by the care workers during each visit. The care plan and risk assessments were then reviewed every six months or earlier if the person's support needs had changed. The care plans and risk assessment we looked at were up to date.

Care workers completed a record for each visit to the person they provided care for. Some of the communication records we looked at during the inspection were focused on the care tasks completed during each visit. We asked the person using the service and the relative we spoke with if the care workers completed all the care tasks identified in the care plan during each visit. They confirmed they did.

The provider had a complaints policy and procedure in place. We asked the person using the service if they knew how to raise a complaint with the provider and if they had ever made a complaint. The person explained they have never had to make a complaint but they knew they needed to contact the provider's office. They told us "I have a list of all the office contact numbers if I have a problem." The relative we spoke with also confirmed they would contact the office if they had any concerns or complaints. Information on how to make a complaint was included in the information booklet given to people when they started to receive care from the service. During the inspection we looked at the records for one complaint related to a missed visit. The records included details of the complaint, a record of the investigation and outcome with any actions that have been taken to resolve the issue.

The registered manager confirmed people and relatives can provide feedback on the quality of the care they received through monthly telephone calls made by staff in the office. Information from these telephone calls was recorded. At the time of the inspection they were planning to send a questionnaire to people using the service.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we found records relating to the care offered to people did not provide an accurate, complete and contemporaneous record for each person using the service

The health assessment for one person stated they took pain medication for the effects of arthritis but the registered manager confirmed this information did not relate to this person but to another person using the service. The care plan and risk assessment for this person identified that they spoke English but in the communication section of the records it stated the person would speak in their birth language 'most of the time' and care workers should encourage them to speak English. There was no guidance for care workers as to how to communicate with the person in their original language.

The care plans and risk assessment for another person had the name of another person using the service at the top of each page. This information had been placed in the person's own home which meant the name of another person using the service had been disclosed. The health assessment for this person stated there were no issues with skin integrity but the person had a history of pressure ulcers and was at an increased risk.

Care workers had recorded the person using the service was unable to sign the timesheets but there was no indication in the care plan or risk assessment that this was the case. The deputy manager confirmed that there was no reason why the person could not sign the time sheet for the care worker.

The planned visit times recorded on the care plans did not match the planned times on the timesheets completed by care workers. We saw the information had not been amended between the various documents. One person's care plan indicated their morning visit was to take place at 9am but the time sheet stated it should start at 10am. This meant care workers would not carry out the visit at the time agreed with the person so they would not know when the care worker would arrive.

Information about how the person should be supported to move was not always consistent in their care plan and assessments. The moving and handling risk assessment for one person identified that a hoist and hospital bed should be used but this was not recorded in the care plan. This could result in the person being moved in an unsafe manner as care workers may not be aware of the equipment that should be used.

The issue with the accuracy of the records meant the provider could not ensure people received the appropriate care they required.
We could not confirm with the care workers how well they knew the support needs of the people using the service.

The provider did not have a robust system of audits and checks in place to review the quality of the care and support provided. The registered manager confirmed that at the time of inspection no formal audits were carried out in relation to MAR charts, care plans, timesheets, recruitment processes and other records relating to the care provided to people using the service. As a result the provider had not identified the

shortfalls we identified at this inspection, so they could make the necessary improvements.

The registered manager explained spot checks were carried out on the quality of the care received by people using the service but these were not recorded so any issues could be identified and required actions taken.

The deputy manager informed us an audit of the communication sheets completed by care workers should be carried out monthly but it had only been carried out in relation to one person using the service. This meant the communication sheets of the other people using the service had not been reviewed to ensure information relating to the care provided was recorded accurately and the apporiate care was provided in line with the care plan.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the time of the inspection a registered manager was in post for the service. We asked the person using the service if they felt the service was well-led. They told us "Seems to me it is very well run but I have nothing to compare it with. It is very satisfactory." We also asked the relative of a person using the service for their views on the service. They commented "I should think so. I asked the hospital if they were good people and they said yes. It seems to be well-run. I am satisfied with the way they treat my family member. The company is well run." The care worker who responded told us they felt supported by their manager. They also felt the service had an open culture and was well-led.

The registered manager explained they were members of the United Kingdom Homecare Association and received information in relation to new practice and requirements so they were kept up to date with developments in the domiciliary care sector. They also told us they attended any courses for providers arranged by the local authority.

People using the service were given a guide book which included the provider's mission statement with the aims and objectives of the service and the rights of the person using the service. Care workers received a handbook which also included the mission statement but also provided information on standards of behaviour expected from care workers as well as dress code and processes and procedures. This meant both people using the service and care workers were made aware of the provider's aims and objectives as to how care should be provided.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure that people employed for the purpose of carrying on a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate training and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users of receiving the care or treatment and did not do all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (a) (b) The provider did not ensure the proper and safe management of medicines. Regulation 12 (2) (g)

The enforcement action we took:

We have issued a warning notice to the provider telling them they must make improvements by 22 November 2017.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those service) Regulation 17 (2) (a) The provider did not have a process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. Regulation 17 (2) (b)

The provider did not have a system in place to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulation 17 (2) (c)

The enforcement action we took:

We have issued a warning notice to the provider telling them they must make improvements by 22 November 2017.