Concept Care Solutions Limited

Concept Care Solutions - 1st Floor Middlesex House

Inspection report

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Ratings

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

Overall summary

We inspected Concept Care Solutions – 1st Floor Middlesex House on 28 October 2014. 48 hours' notice of the inspection was given to ensure that the registered manager could be present. We also visited the service on 13 November 2014 in order to attend a staff meeting and talk with staff.

Concept Care Solutions – 1st Floor Middlesex House is a medium sized domiciliary care service. It provides personal care to people in their own homes in south and west Hertfordshire. At the time of this inspection a service including personal care was provided to 105 people.

At our last inspection in May 2013 the service was meeting the regulations we inspected.

Summary of findings

There was a registered manager at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered 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 had differing views on the quality of the services they received. People told us that their regular care workers knew their needs and provided a good service. One person said, "My carer is brilliant. They know what they're doing." However all the people we spoke with told us that there were too many changes of care worker and they did not always know who was coming to assist them. When their regular care worker was not available the service did not let them know of changes and care workers were frequently late. One person told us that they used to have a good care worker who was reliable and very helpful, but, "Since they left I don't know who is coming and when. Sometimes I get people I've never seen before, who don't know what they're doing and don't know how I need to be helped." People felt that care workers did not have information on their specific needs and wishes. One person said that they did not have a regular care worker and, "they don't know my requirements before they come." This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not follow the Code of Practice of the Mental Capacity Act 2005 (MCA) to make sure that people who did not have the capacity to make decisions for themselves had their legal rights protected. Care plans did not include assessments of people's capacity for making decisions about their care and treatment. People did not sign care plans to show that they had been involved in planning their care. The registered manager was not able to give us information about people whose affairs were dealt with by the Court of Protection, or who had restrictions on their liberty because they did not have capacity to make decisions about their care and support. We have made a recommendation about following the MCA Code of Practice.

Complaints were not recorded and responded to effectively. A representative of the local authority which commissioned care for the majority of people using the service told us that they had received 17 complaints about the service between June and October 2014, and eight of these had not been responded to. When we looked at the complaints records we found that only six complaints had been recorded during this period. Most people we spoke with told us that the service did not listen to any concerns and did not respond to complaints. One person said, "I complain to the office, but nothing seems to happen. I don't believe they listen to my concerns." This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities).

Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The process of quality monitoring did accurately monitor and address areas where improvement was needed. The provider sent quality questionnaires to people regularly and told us that they took actions as a result of this feedback to improve communication with people using the service. However seven of the ten people we spoke with commented on poor communication with the office. Records of concerns such as late and missed calls were not accurate and care plans were not up to date and accurate. The provider did not have accurate information on actions that were required to improve the quality of the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe and trusted their regular care workers. Staff were knowledgeable in recognising signs of potential abuse and how to report any concerns. They also told us how they would deal with any emergency in order to keep people safe. During the previous 12 months three allegations of abuse were investigated and substantiated. The provider took actions to discipline the staff involved and established a system for regular staff supervision to ensure that staff were aware of procedures to keep people safe.

Staff told us that they received regular training so that they knew how to meet people's needs and support them appropriately. They said that care plans provided them

Summary of findings

with information on each person's needs. A representative of the NHS clinical commissioning group (CCG) for Hertfordshire told us that they had reviewed the care provided for people they referred, and everyone they commissioned care for was happy with the care they received.

Care plans provided information for people who needed assistance with preparing meals and with eating and drinking. However one person told us that care workers did not know how to prepare basic food or to use a microwave oven. We have made a recommendation about training on basic food preparation.

The service did not have a consistent and effective management team. There had been four care managers in post since our last inspection in May 2013. People told us that they did not have confidence in the management of the service. Seven of the ten people we spoke with commented on poor communication with the office. One relative said, "The agency is just not good at organisation, which is where a lot of the problems are." Another person said, "I don't know who to talk to at the office, I don't know who is in charge." However most staff members told us that they had good support from the managers. For example one person said, "You ask and they do help, they will always call you back."

The Statement of Purpose for the service did not provide clear information on the services provided and the provider's aims and objectives. We have made a recommendation about revising the information that the Statement of Purpose contains.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and corresponding regulations 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 the 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?

Good

The service was safe. The provider took actions following safeguarding investigations to ensure the safety of people using the service.

Recruitment and selection processes ensured that staff were fit to work with people who used the service.

The service had procedures for administering medicines, and people received their prescribed medicines safely.

Is the service effective?

Requires improvement

The service was not effective. The provider did not follow the Code of Practice of the Mental Capacity Act 2005 (MCA) to make sure that people who did not have the capacity to make decisions for themselves had their legal rights protected.

Staff received training and support to ensure they could meet the needs of people who used the service.

Staff had the information they needed to meet people's healthcare needs.

Is the service caring?

Requires improvement

Some aspects of the service were not caring. The provider did not ask people for their views about the service they received, and people were not involved in preparing their care plans. Some staff did not have skills for basic food preparation and use of kitchen equipment.

People told us that their regular care workers were caring and treated them with respect. Staff knew their individual needs and wishes.

Is the service responsive?

Requires improvement

The service was not responsive. People did not receive a consistent service that met their individual needs and preferences.

The service did not record and respond to complaints effectively. People said that the service did not respond to any complaints they made. Complaints were not recorded accurately.

Is the service well-led?

Requires improvement

The service was not well-led. The day to day management of the service was not consistent and the Statement of Purpose did not provide the required information about the service.

Processes were in place to monitor the quality of the service but these checks did not accurately monitor and record areas where the service was failing.

Concept Care Solutions - 1st Floor Middlesex 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 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.

The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with seven people who used the service and with five relatives of people who were not able to speak with us. We attended a meeting with 35 care staff and discussed their views of the service. We also spoke separately with two members of the care staff, three senior staff and the registered manager. We looked at two people's care plans and five staff recruitment files, as well as training records and a range of records about how the service was managed.

Before we visited the service we checked information we held about the service, including notifications of significant events the provider had sent to us and comments and concerns about the service that we received from members of the public. We received information about the service from the contracts monitoring team and adults safeguarding officers of the local authority which commissioned the service for the majority of people using the service. We also spoke with a representative of the NHS clinical commissioning group.

Before the inspection we asked the provider to complete 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. They did not return a PIR and we took this into account when we made judgements in this report.

Good

Is the service safe?

Our findings

People told us that they felt safe and trusted their regular care workers. One person said that they felt safe using the services of the agency and that the support they provided, “is all good, I couldn’t ask for more.” Two people who had three or four visits a day said that they felt safe and trusted their regular care workers. One person told us that they did not feel safe with one care worker following an incident with preparing food incorrectly. They had asked the service not to send this care worker to them again. Most of the care workers lived in London and the provider arranged transport for them to travel to visits in Hertfordshire. One person told us that they did not feel safe because the car and driver remained outside their house while they were receiving care.

Staff were trained in safeguarding adults from abuse and staff we spoke with were knowledgeable in recognising signs of potential abuse and how to report any concerns. They also told us how they would deal with any emergency in order to keep people safe. The provider followed the commissioning local authority’s protocol for reporting and investigating any allegations of abuse. However during the previous twelve months three allegations of abuse were investigated and substantiated. The provider took actions to discipline the staff involved and established a system for regular staff supervision to ensure that staff were aware of procedures to keep people safe.

Assessments were undertaken to assess any risks to the person using the service. Risk assessments included the measures for staff to take to reduce the risk of harm, such as treating a person gently to avoid causing pain. Assessments for moving people with restricted mobility specified the equipment required to assist them and whether one or two people should assist them with transfers.

Checks were undertaken before staff were employed to show that they were fit to work in a care setting. We looked at five staff files. They held evidence to confirm that appropriate checks were carried out, including written references, criminal record disclosures and proof of identity.

Staff told us that they received training in managing medicines. They demonstrated knowledge of procedures for administering and recording medicines safely. Care plans contained details of any medicines that the person required and when they should be administered. One care plan specified that medicines were required at set hours, and visits were scheduled to meet these requirements. A person who needed assistance with medicines told us that the care worker gave them the medicines as prescribed, and recorded the medicines. Care managers told us that they checked records of medicines when they visited people for reviews, to ensure that staff followed the procedures accurately and safely.

Requires improvement

Is the service effective?

Our findings

The provider did not follow the Code of Practice of the Mental Capacity Act 2005 (MCA) to make sure that people who did not have the capacity to make decisions for themselves had their legal rights protected. Care plans did not include assessments of people's capacity for making decisions about their care and treatment. Training records did not show that staff had received training on the Mental Capacity Act (MCA) 2005. The registered manager was not able to give us information about people whose affairs were dealt with by the Court of Protection. We found some examples where MCA assessments should be considered. For example one person's care plan was written with the involvement of a family member and stated that communication about the person's care was with another family member. There was no evidence of an assessment of the person's capacity to make decisions, and of who should make decisions in their best interests.

Staff received training to give them the skills to meet people's needs. The provider also managed a training organisation which provided training for staff of the agency. Staff told us that they received regular training so that they knew how to meet people's needs and support them appropriately. They said that specific training was provided when needed on specific medical conditions. Staff files contained records of the training that each staff member had completed. Induction training when staff started working for the service included person centred support, communicating effectively, and safeguarding. A new member of staff told us that the induction training was informative and gave them the skills they needed when they visited people in their homes. New staff who did not have English as a first language had tests of their spoken and written English to ensure that they would be able to communicate with the people they supported.

Staff received regular supervision and appraisals of their work, and the provider held monthly staff meetings which were well attended. 35 staff took part in the staff meeting that we attended. They told us that care plans provided them with information on each person's needs and they could ask for advice if they had any questions. One person said they had phoned the office to ask for specific guidance for one person and had received this. Care managers told us that they carried out spot checks of care workers to ensure that they knew how to provide care for each person.

People told us that care workers understood their health conditions. Care plans provided information on each person's health needs. The care plans for people referred by NHS included the NHS assessment for continuing care and provided a description of all physical symptoms and the care required. A representative of the NHS clinical commissioning group (CCG) for Hertfordshire told us that they had reviewed the care provided for people they referred, and everyone they commissioned care for was happy with the care they received.

Care plans provided information for people who needed assistance with preparing meals and with eating and drinking. One care plan we saw had been written with the involvement of the person's family carer and provided full details of how to assist the person so that they could swallow their food and drinks.

We recommend that the service seek advice and guidance from a reputable source about the application of the MCA Code of Practice to people using domiciliary care services.

Requires improvement

Is the service caring?

Our findings

People told us that their regular care workers provided good care and support and they developed good relationship with them. One person said that the support they received from the service was, "absolutely perfect. My carers are all very good and I get excellent care – I've got to know them all well." Another person said their care workers were "kindness itself – first class." "The help I get is all good. I couldn't ask for more." But others commented that sometimes the standards of service were not so good. People told us that if they did not have a regular care worker or their regular care worker was not available they did not receive a consistent and caring service. Care workers were often late and did not have information on how to meet people's needs. One person said, "The carers are sometimes in a rush and are in and out too fast." Another person told us that care workers did not know how to prepare basic food or to use a microwave oven. They said that one care worker had cooked a pizza without removing the plastic packaging, and another had left a meal in the microwave too long, and the microwave exploded.

Care plans provided only basic information on how to meet people's needs, but staff told us that they knew how people liked to be assisted, and respected their views. Training was provided on person centred support, the duty of care and how to communicate effectively. Staff said that they respected people's privacy and dignity when providing personal care.

The provider sent regular questionnaires to people about the quality of the service they received, but people were not asked about their specific care and support needs. Several people told us that managers did not contact them to ask their views. One care plan we saw had been written with the involvement of a family member, but people did not sign care plans to show that they had been involved in planning their care. One person told us that they were unaware of their care plan, and they had not been involved or consulted in developing one.

We recommend that the service provides training and guidance for care workers on basic food preparation and the use of kitchen equipment.

Requires improvement

Is the service responsive?

Our findings

The service had processes in place to provide personalised care that met people's individual needs. Staff we spoke with were knowledgeable about the individual needs and wishes of the people they supported. They told us that care plans were well written and provided them with information before they visited people for the first time. Care plans that we saw included information on healthcare and personal care needs, and any needs related to a specific medical condition or disability. However we did not see any assessments of other aspects of social and cultural diversity. One care plan had been written with the involvement of the person's family carer and contained full details of how they wished to receive their care including the procedure for washing and how to assist them to eat and drink. The care plans we saw had been reviewed and amended following the reviews.

People had differing views on how the service responded to their individual needs. People told us that their regular care workers knew their needs and provided a good service, but there were too many changes of care worker and they did not always know who was coming to assist them. Typical comments were, "My carer is brilliant. They know what they're doing." And, "The help I get is all good. I couldn't ask for more." Other people felt that care workers did not have information on their specific needs and wishes. One person said that they did not have a regular care worker and, "they don't know my requirements before they come." Another person said, "Some of the care workers have been coming for over two years and understand my needs very well. But the standard of service does fluctuate at weekends." A relative felt that care workers did not receive adequate training before they visited people in their homes. They said that they were "trained on the job" by shadowing more experienced care workers.

Everyone we spoke with said that if they did not have a regular care worker, or when their care worker was not available, the service did not let them know of changes, they did not know who was coming to help them, and care workers were frequently late. One relative said, "On the whole the quality of carers is mixed, but [my relative] had one excellent long term carer who was their main support. If the regular carer is not available there is too much change and carers are often up to 40 minutes late." Another person told us that they used to have a good care worker who was reliable and very helpful, but, "Since they left I don't know who is coming and when. Their punctuality is bad and they come at odd times, not the agreed times. They never ring up when they're going to be late. They don't know my requirements before they come. Sometimes I get people I've never seen before, who don't know what they're doing and don't know how I need to be helped." This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not record and respond to complaints effectively. Seven of the 12 people we spoke with told us they had raised concerns about the care they received. Two people were satisfied with the response they received to their complaint. One said, "If I do have a problem I just phone the office and the problem is fixed. I never get a call back, it's just fixed." Another person said they had raised issues in the past with the agency which were dealt with quickly. However five people told us that the service did not listen to any concerns and did not respond to complaints. One person said, "I complain to the office, but nothing seems to happen. I don't believe they listen to my concerns." Another person said, "I have phoned the office to complain but nothing happens." One person told us about a specific complaint they had made, and said that nothing had improved. Two people did not raise concerns with the service because they felt that managers would not address them and respond. A relative said that they had raised concerns about the service they received with the district nurse, and had no response from the managers of the service. A person said that they would discuss any concerns directly with the care worker rather than contact the managers of the service.

Complaints were not recorded accurately. The complaints file at the service had records of only ten complaints for this period. All these complaints were responded to, and the records showed that people were satisfied with the responses. The provider analysed the complaints received and recorded actions taken and learning points from the complaints.

However a representative of the local authority told us that they had received 17 complaints about the service in the six months before our inspection. They had passed all these complaints on to the provider, but eight had not been responded to. At least seven complaints were not recorded

Requires improvement

Is the service responsive?

and were not responded to. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

People told us that they did not have confidence in the management of the service. One relative had concerns about poor training for care workers. They said, "The agency is just not good at organisation, which is where a lot of the problems are." One person said that they had disputed the hours claimed on bills the agency sent to them. Two people told us that they did not see managers and no-one asked their opinion on the service they received. One person said, "I don't know who to talk to at the office, I don't know who is in charge."

The service did not have a consistent and effective management team. The provider was also the registered manager. The management structure included an area manager and a care manager with responsibility for the day to day organisation of the service. There had been three care managers in post since our last inspection in May 2013, and the current care manager was on extended leave. The local authority that commissioned services informed us that they had concerns about the quality of care provided and that the registered manager did not respond to complaints effectively.

Staff at the staff meeting told us that management had improved and that they had good support from the managers. One staff member said, "You ask and they do help, they will always call you back." However another member of staff contacted us and said that the agency did not provide good support for care workers and did not act when they raised concerns about specific people who used the service.

The service did not have a clear set of values. The managers at the team meeting we attended discussed practical aspects of the work, such as completing time sheets, wearing uniforms and how to deal with emergencies. Staff were aware of how they should act, and several staff spoke of putting the people they supported ahead of the organisation's requirements for logging in. We asked the registered manager for a copy of their current Statement of Purpose. The document we were given did not provide clear information on the services provided and the provider's aims and objectives. The Statement of Purpose stated that Concept Care Solutions was trading as Dolphin Care, and the aims were to provide healthcare staff and nurses and to deliver the highest standards of patient care. The Statement of Purpose did not provide specific information on providing care workers to people in their own homes. It mentioned that quality and equality were core values, but gave no further information on these.

The provider had systems in place to monitor the quality of the service they provided. However we found that the systems were not effective in monitoring areas of shortfall in the service and developing plans to address them. The provider sent quality assurance questionnaires to between ten and 20 people who used the service each month. The records of this contact showed that for 2014 80% of people rated the service good to acceptable, and 20% found aspects of the service bad or very bad. The provider told us that they took actions as a result of this to improve training and supervision for staff and communication with people using the service. We saw evidence that training and supervision were in place for staff. However seven of the ten people we spoke with commented on poor communication with the office.

The process of quality monitoring did accurately monitor and address areas where improvement was needed. The registered manager told us that they reviewed care plans to ensure that they were up to date, but they had not acted to ensure that all care plans were up to date and accurate.

The provider actively monitored late calls and missed calls through an electronic log-in process which the commissioning local authority also monitored. However there were discrepancies in the reports of late and missed calls from the service and the local authority. The records maintained at the service showed that there were no missed calls during 2014. The local authority told us that between April and September 2014 missed calls were alerted on the system and they had received complaints about missed calls. The registered manager said that if a person using the servicer cancelled the call because it was very late, they did not record this as a missed call. The local authority told us that they did record these cancelled calls as missed calls. The inaccuracy in monitoring of the service was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

We recommend that the service seek advice and guidance from a reputable source on producing a Statement of Purpose that provides information on the values of the organisation and the services it provides.

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 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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services This corresponds to regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care The provider did not provide consistent care for people using the service to meet their specific needs and preferences. Regulation 9 (1) (a) (b) (c) (3) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints This corresponds to regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints. People did not feel confident that their concerns would be listened to and acted on. The provider did not record and respond to complaints accurately. Regulation 16 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision This corresponds to regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have adequate systems in place to accurately monitor the quality of the services provided and to take actions where required.

Regulation 17 (2) (a) (e) (f)