Smithfield Health & Social Care Ltd

Smithfield Health & Social Care Limited t/a Verilife

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Smithfield Health & Social Care Limited t/a Verilife is a domiciliary care service, which provides personal care for people in their own home in two London boroughs. At the time of the inspection there were 152 people using the service.

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

We carried out an announced comprehensive inspection of this service on 30 November 2016 and the service was meeting all the requirements we inspected. After that inspection, we received concerns in relation to staff rotas being planned by the service with no allocated travel time. As a result, we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic. You can read the report form our last comprehensive inspection, by selecting the 'all reports' link for Smithfield Health & Social Care Limited t/a Verilife on our website at www.cqc.org.uk.

At this inspection on 25 January 2017, we found that staff were not deployed in a way that met people's needs. People and their relatives told us that staff were often late for visits. Two people we spoke with told us late visits had a negative impact on them, specifically when visits were two and a half hours later than agreed in their care package. The service did not provide staff with adequate travel time between visits. Rotas identified instances where visits were scheduled back to back. People were not always informed by the office when staff would be arriving late for their scheduled visit.

The service did not have robust systems in place to monitor and address late visits. The service used an electronic system to monitor visits and late and missed visits were highlighted on the system. The information about visits was difficult to interpret without further analysis. The service was not analysing this information to enable them to clearly understand the extent of late visits. After the last inspection on 30 November 2016, the provider sent us an action plan to address concerns identified in the inspection, including being late for visits. However, at this inspection we found back-to-back visits were still being scheduled and people continued to receive late visits.

People who raised complaints about staff lateness did not always have their complaints acknowledged in a timely manner. After this inspection, the provider sent us confirmation complaints had been acknowledged and were under investigation.

You can see what action we have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People did not always receive support as arranged. Rotas did not give staff adequate travel time to enable people's care to be delivered in accordance with their needs and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always have their concerns and complaints acknowledged and addressed in a timely manner in line with good practice.

Is the service well-led?

Requires Improvement

The service was not always well-led. The systems in place to monitor and address late visits were ineffective.

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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 following concerns we were made aware of and to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. This inspection took place on 25 January 2017 and was unannounced. The inspection was carried out by four inspectors. One inspector carried out the site visit. Three inspectors made telephone calls to people and their relatives.

Before the inspection, we reviewed the information we held about the service. We looked at statutory notifications the service had sent to us, previous inspection reports, safeguarding concerns and other information shared with us by health professionals. We also used the action plan sent to us by the provider following the previous inspection in November 2016 to help us plan the current inspection. During the inspection, we spoke to three care staff, one team leader, one team coordinator, the training officer, the registered manager and the Chief Executive Officer (CEO). We looked at 11 staff rotas, service user rotas, electronic call monitoring system (ECMS) records, late visit logs, the complaints file, confidentiality policy and staff induction handbook.

After the inspection, we spoke with 11 people using the service, five relatives and four care workers. We also reviewed staff supervision records, records of completed complaints and audits of late visits which the provider sent us.

Requires Improvement

Is the service safe?

Our findings

We received mixed views about the care that people received with two people stating late visits had a negative impact on them. People we spoke with made negative comments about timing of visits to people and how the service dealt with their concerns about this. Nine out of the eleven people and all five relatives we spoke with told us they had experienced late visits. One person told us, "They [staff] are no more than half an hour late. They aren't normally late, but when they are late no one rings to let you know." Another person said, "There are times they [staff] don't arrive on time. This is not a problem in the morning but in the evening it is a problem as the call which is meant to be at 18:00, they [staff] can arrive at 20:00-20:30." A third person told us, "It's not always the staff's fault; they [staff] have to go where they are told to go. Sometimes they are short staffed." A relative said, "There are times when they [staff] are late. If it's a big delay the office rings to let me know. On average when they [staff] are late they may be late by 30 minutes, but it does vary. It doesn't have an impact on us when they [staff] are late but only when they are early. We are quite flexible with the time. And we are quite happy."

Staff were not always deployed in a way that met people's needs. Visits to people were arranged in a way that meant that people did not always receive care and treatment as agreed and in line with their preferences. People received visits from staff outside of their agreed allocated schedule, which meant people did not always know when care was going to delivered. Staff members provided a mixed response in relation to travelling time and late visits. One care worker told us, "Sometimes because of the way the rota is we [staff] are behind on our visits. We [staff] may have to spend a bit more time with a person and that can put us behind. It could be better if we got travel time." Another care worker said, "Sometimes I have a call in one area then go to another area and the time allowed isn't possible. We tell the office all the time and the client complains that we will be late. We aren't given travel time and that's not fair, so we are sometimes late and that can make people anxious. We report this to the office but they don't listen to us." A third care worker said, "Yes, the rotas are back-to-back but everything runs smoothly."

On reviewing staffing rotas we found that staff were not given sufficient time to travel between visits to ensure they arrived on time. Of the 11 rotas over a one-week period that we reviewed, we found they all had visits which were scheduled without any designated travel time allocated.

We examined staff rotas to ascertain the distance between visits that were not allocated travel time. On six rotas, visits were situated one mile or less between each other. On four rotas, the distance between visits was three miles or less. Although the distances between visits were not necessarily significant, by not allocating travel time between visits, staff would either be late or have to cut visit times in order to be on time for each visit. As a result, people's preferred visit times were not always met by staff.

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

Requires Improvement

Is the service responsive?

Our findings

People did not always have their concerns and complaints acknowledged in a timely manner. People were dissatisfied with how their complaints were dealt with. We received mixed responses in relation to complaints raised to the service. For example, one person told us, "I have complained. I have sent in letters but they have not responded." Another person said, "I did raise a complaint recently as the carer was very late, three to four times. I did receive a call from the service providing assurance that staff will not be late and things have improved." At the time of the inspection the registered manager did not have an up to date complaint folder and did not have the necessary information available. During the inspection, we requested to see the complaints folder and found one recorded complaint since the previous inspection. The complaint clearly identified concerns around staff arriving late for visits. After the inspection, the provider sent us an updated copy of the complaints file and we noted they had responded to the complaint identified in the inspection. We requested further information which the provider submitted, however found records did not demonstrate complaints were dealt with in a timely manner.

We recommend that the service seek advice and guidance from a reputable source, about the management and learning from complaints.

Requires Improvement

Is the service well-led?

Our findings

People received support from a service that did not have effective systems in place to monitor and address late visits and was not taking sufficient action to improve the service.

During the inspection, office staff showed us an example of the record of late visits identified by the electronic call monitoring system (ECMS) on a given day. We that found between 06:30 and 15:30 on the day of inspection there were 115 systems generated late visits. We raised our concerns with the registered manager who informed us the ECMS sends an email alert if the staff member has signed in either 20 minutes early or 20 minutes late of the agreed start time. We were told that staff attendance was monitored. We were also told that the information about late visits on ECMS was not accurate. The registered manager told us, "There are various reasons, as to why visits are logged as late visits, for example, if people do not have a phone in their homes, then staff are unable to log in electronically, this would then be recorded as a late or missed visit. A person may wish to have a later or earlier visit than originally planned or a staff may need to cover visits as someone is off sick. The ECMS isn't always accurate. It doesn't always accept changes to visit times we make and will then still record visits as late visits."

After the inspection the registered manager sent us a break down of the 115 late visit alerts and the reasons for the alerts which included, for example, 17% which were either late or early visits. However, the service could not produce any evidence to show that analysis of late visit alerts routinely took place.

We reviewed staff work sheets for the period of one week for nine staff members. These rotas showed travel time was not allocated between visits to people on over 800 occasions. We asked the registered manager and the chief executive officer why the majority visits were allocated without a designated travel time. The registered manager told us, "There are times on the rota where there are three visits back-to-back then no visits scheduled and this enables staff flexibility with visits. It also enables them to catch up on their travel time." However, we also found 13 instances where there were four or more visits back-to-back, without a break. Staff were not provided with travel time between visits and this meant staff were consequently late in arriving for visits. A number of people who used the service and their relatives told us that staff were late and, sometimes, this had an impact on them.

At this inspection we went through the action plan dated 6 December 2016 with the registered manager and found the service had taken some action to address issues with staff deployment in two geographical areas and as a result reduced the number of visits to ensure they were able to meet people's needs. The registered manager demonstrated enthusiasm to complete 're-patching' in all areas as quickly as possible. The registered manager told us, "We have completed a large piece of work in re-patching the two areas. Unfortunately, we have not been able to complete this due to staff sickness and the Christmas and New Year period. We are committed to getting this work completed." Since this inspection, the registered manager told us they had successfully recruited additional office staff to support on the completion of the action plan. The registered manager also informed us they had sent all staff a letter explaining the practices around travel time and rotas. It stated, "We will shortly be 're-patching' and adjusting the rosters to give a realistic gap between each visit instead of a block after a series of visits." However, at the time of this inspection,

visits were still being scheduled back-to-back, people were receiving late visits and the system to monitor late or missed visits was not effective.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 18 HSCA RA Regulations 2014 Staffing Staff were not always deployed in a way that met people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People received support from a service that did not have effective systems in place to monitor and address late visits and was not taking sufficient action to improve the service.

The enforcement action we took:

Warning notice.