Care UK Limited

Newmarket (Homecare) DCA

Inspection report

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Ratings

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

Overall summary

This inspection took place between 27 January and 19 February 2015. The initial visit was unannounced.

The service provides care to people who live in their own home. At the time of our inspection there were 152 people with a variety of care needs who used the service.

There was a manager in place but they were not registered with the Care Quality Commission.

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.

The provider had a safeguarding adults policy for staff that gave guidance on the identification and reporting of suspected abuse. Care workers were aware of how to report suspected abuse or concerns for people's welfare externally.

Risks were not always assessed prior to the service providing care. This included risks to the individual

Summary of findings

receiving care and environmental risks. Where risks had been assessed these were not reviewed regularly to ensure they were up to date and reflected the current situation.

There were insufficient care workers to support people safely. The service had regularly missed calls to provide care to people due to insufficient numbers of care workers. The manager told us that the service was recruiting care workers and using agency staff. However, we saw that this had not met the service's staffing needs and the service had not ensured that people's needs were met.

People's safety had been compromised in the management of their medicines. Care workers were observed to administer medicines and this was not recorded. Medicine administration records were not audited to check if people had received their medicines. The service was using two medicines policies and this was causing care workers to be confused as to their responsibilities.

People and their relatives gave some positive feedback about the care workers that provided care, however care workers had not received refresher training to ensure they could meet the needs of people who used the service.

Where care workers had been subject to an investigation into their care practice and behaviour this had not been recorded effectively and as a result we could not see that the appropriate actions had been taken.

Three people did not have care plans in place and this had resulted in them not receiving the care and support they required. For example not being supported with having sufficient to eat and drink and with access to other healthcare professionals.

People and their relatives told us they were not involved in the planning of their care and support. They did not feel that the service listened to their views. They told us that when they did contact the service their calls were not always returned. They also told us that they did not feel that if they raised concerns these would be responded to.

The service had some systems in place to monitor the quality of service. However, we saw that these were not always effective. We also saw that where audits had identified deficiencies these were not always addressed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in multiple regulations. 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?

Inadequate

The service was not safe.

In some cases care was provided to people without appropriate risk assessments in place. Where risk assessments had been carried out these were not reviewed regularly to ensure they reflected current risks.

Investigations into inappropriate conduct by staff were not fully recorded and carried out to the provider's policy.

Medicines were not managed safely. The administration of medicines was not always recorded appropriately. The service was using to two different medication policies which was causing confusion amongst staff.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were not always supported to have sufficient to eat and drink.

People were not always supported to access healthcare services when their health needs changed.

Care workers were trained in the requirements of the Mental Capacity (2005) Act and we observed them supporting people to make decisions when providing care.

Is the service caring?

Requires improvement

People were not involved in making decisions about their care. Care plans were not reviewed and updated or if a person's needs changed.

Care workers respected people's privacy and dignity and personal belongings when providing care in their home.

We observed care workers provide care with kindness and compassion.

Is the service responsive?

Inadequate

The service was not consistently responsive.

The service missed visits to people's homes to provide care.

Care plans were not always in place. When there was a care plan it was not always fully completed with a person's preferences.

People did not feel confident that their concerns and complaints would be listened to.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Summary of findings

There was no registered manager in place.

Regular auditing of care records and risk assessments did not take place.

Information from quality assurance processes was not used to improve the service.

Newmarket (Homecare) DCA

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 between 27 January and 19 February 2015. An unannounced visit to the offices of the service was made on 27 January with follow-up visits on 28 January and 17 February 2015. We visited 14 people in their homes on 3 February, 11 February and 13 February 2015. We also spoke with six people using the service or their relatives on the telephone. We spoke with nine members of care staff.

We looked at the care plans for eight of the people we had visited and compared these with the records held in the office. We looked at records relating to the management of the service including four staff files.

Prior to the inspection we spoke with Cambridgeshire County Council who commission services from the provider and who had raised concerns with us.

Inadequate

Is the service safe?

Our findings

People and carers were not provided with information about the risks associated with the provision of care. Three people we visited in their homes did not have risk assessments in place. One person we spoke with told us they had not been involved in any decisions relating to the management of risks associated with their care, for example transferring from bed to chair with the assistance of a carer.

We saw risk assessments for some risks associated with providing care to people. For example risks associated with moving and handling. However these risk assessments were generic in type and did not always address the risks relevant to providing care to a specific individual. For example no risk assessment were in place for a person who had a condition such as diabetes or used a medical device. Environmental risk had been assessed for example trip hazards and use of electrical equipment such as kettles and toasters. Again these were generic and not specific to the individual. For example it was recorded in one person's care plan that the care worker should put a car battery on charge. The manager told us that they believed this referred to the battery for the person's electric wheelchair. This was not clear in the care plan nor were any risks associated with this activity addressed.

Where risk assessments had been carried out these had not been reviewed. For example risk associated with providing care for one person had been assessed in June 2013. The assessment had not been reviewed. When visiting this person in their home we saw that the risk assessment did not address the issues which were current.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service did not ensure that it had sufficient staff to meet people's needs. Cambridgeshire County Council had raised concerns with us about the number of missed visits by the service. One person told us that their relative had been without food all day when a visit was missed. Another person told us that their relative had not received personal care when a visit was missed. The manager told us that the service was recruiting staff and was currently using agency staff. However, this had not addressed the shortfall. The service informed us that in December 2014, 36 visits were missed, in January 2015, 30 visits were missed and in the first three weeks of February 2015, 10 visits were missed. This meant that people did not get the care and support they required.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not managed so that people received them safely. While visiting a person living with dementia in their home we observed the care worker remove medicines from a dossett box filled by a chemist. These were handed to the person with a drink. This was not recorded. The care worker told us that medicines were stored on the top of a cupboard so that the person did not take them by mistake. There was no care plan or associated risk assessment in place relating to this person's medicines.

Care workers told us that they received training in the administration of medicines and yearly refresher training. Records we saw confirmed this. However, carers also told us that there was some confusion as the service had two different policies regarding medicines which they were required to follow. The service had its own policy and also that of Cambridgeshire County Council. They told us that policies had a number of differences. These included whether medicines could be administered from dossett boxes and whether eye drops could be administered. This confusion, along with the lack of care plans and risk assessments could mean that people received their medicines inappropriately or unsafely.

When we visited people in their homes we saw that medicines administration records (MAR) for previous months were still in people's care plans. The manager told us that the service policy was that these are returned to the office every month for auditing. MAR not being returned to the office meant that they could not be audited and the provider could not be sure that people were receiving their medicines appropriately.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People we spoke with told us that they felt safe when receiving care. They expressed particular appreciation of the fact that they had recently begun receiving the names of the care worker who would be providing their care meaning they knew who would be visiting them.

Inadequate

Is the service safe?

Care workers we spoke with demonstrated an understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Care workers had been provided with training in the safeguarding of adults from abuse. This demonstrated that care workers had the knowledge to protect people from avoidable harm and abuse.

However, we saw in two staff files that these members of staff had been the subject of disciplinary investigations. Records did not demonstrate that the allegations had been fully investigated or that the appropriate referrals made, for example to safeguarding. Actions taken to address the allegations were not fully recorded. We asked the manager if service policy had been followed with regard to these matters. They confirmed that it had not. Therefore, the provider could not be assured that unacceptable practice would not continue.

Recruitment records showed that the provider had carried out a number of checks on staff before they were employed to ensure that staff had appropriate experience and were fit to work with vulnerable adults in their own homes. These included checking their identification, health, conduct during previous employment and that they were safe to work with older adults.

Requires improvement

Is the service effective?

Our findings

The standard of support people received to access healthcare also varied across the service. For example one person we visited in their home had developed a pressure ulcer. There was no care plan in place detailing how this should be managed. Staff had recorded in the daily record that cream had been applied but there was no record of who had recommended this course of action or if any referrals had been made to the appropriate health care professional. The care worker we were accompanying and who was providing the care did not know who had recommended the application of the cream or if a referral had been made. Conversely, another person we visited in their home told us that the service had been very good when their health had recently deteriorated. We saw that the service had contacted their GP, district nurse and the occupation health service for an assessment in order to obtain appropriate equipment.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that the care workers that supported them had the knowledge and skills to provide the care they required. Care workers told us that the induction training they received was good and provided them with the knowledge they needed. We saw that care workers completed initial induction training which covered areas such as health and safety, safeguarding, mental capacity and moving and handling. After they had completed their induction they shadowed an experienced member of staff before providing care on their own.

Care workers were provided with training relevant to meet the specific needs of people they cared for. We saw in one person's care plan that care workers providing specialist support had been given individual training on managing that person's condition. Each care worker working with that person had been assessed as competent by the provider.

However, care workers did not receive regular refresher training or supervision to ensure their knowledge and practice was provided effectively. The manager told us that this training was being carried out and we saw during our inspection that care workers were being trained. However, the manager told us that care workers with out of date training were providing care to people because if these care workers were not used the service would not be able to provide the care required. Care workers told us they did not receive regular supervision while providing care or unannounced spot checks of the care they were providing. Records confirmed this.

We observed a care worker providing care to a person in their home. We saw that they sought the person's consent before providing any care and support. This was done in an informal manner without fuss. We noted that the service did not carry out an assessment of a person's capacity before providing care. We asked the manager about this and they told us that as the service provided domiciliary care it was not thought that this was necessary. However, they went on to say all care workers had received training in the Mental Capacity Act 2005 and if concerns arose the appropriate referrals would be made. We did not see any examples of when this had happened. Care workers told us they had received training in mental capacity both during induction and regular refresher training and felt they would recognise if a person's capacity deteriorated.

The quality of support people received to maintain a balanced diet varied across the service. One person we visited in their home was living with dementia. We saw that a relative of the person had left a note in the premises saying that their relative did not always remember to eat. There was no care plan in the person's home. There was no recording of what the person had had to eat and drink each day, neither was there any plan to support this person with their nutritional intake. The care worker we were with was unable to tell us how this person was supported to maintain a balanced diet. We were not assured that this person was receiving an adequate diet. However, we visited another person in their home who was also living with dementia. We saw that the care worker gave the person a choice of health options for lunch and when the person had chosen, provided them with a well presented healthy meal. When the care worker left the person they ensured they had a drink within reach. The care worker recorded the food given and that a drink had been left.

Requires improvement

Is the service caring?

Our findings

People told us that care workers who provided their care were compassionate and understanding of their needs. One person said, "I have got to know my carer, they are very good." A relative told us, "The ladies that come are charming."

The care workers we accompanied on visits to people's homes knew the people they were supporting. One care worker gave us a brief overview of a person's family history before we visited them to ensure we did not mention something that may upset the person. When care was being provided we observed that appropriate conversation took place, friendly but not crossing professional boundaries.

People and their relatives told us they had not been actively involved in making decisions about their care and support. Care records did not record that people had been consulted and involved in decisions about their care

People confirmed their privacy and dignity were respected at all times. Care workers understood the importance of respecting and promoting people's privacy and dignity. They gave examples of how they did this, such as making sure doors and curtains were closed when they provided personal care and covering people with towels when assisting them to wash.

People told us that communication from the service was poor but that it had improved in the weeks prior to our inspection. For example one person told us that they had not previously know who would be visiting them to provide their care but that the service was now sending out a list of care workers who would be providing their care the week the week before it was due. People also told us that communication from the office was poor and that the when they telephoned the office and left a message they often did not get called back.

We observed care workers providing care and support in a respectful manner. We saw that when care workers left a person after providing care they took action to ensure that the person's needs were met. For example they left them with a drink and anything they may need to hand, for example television remote control or a telephone.

Inadequate

Is the service responsive?

Our findings

People did not always get the care they needed because the service did not always carry out the visit to the person's home to carry out the care. One relative gave us an example of when their relative went without personal care because care workers had not arrived. The service has recorded 76 missed visits in between 1 December 2014 and 23 February 2014.

Three people we visited did not have care plans in place and there were no plans of the care to be provided. No assessment of the person's needs had been carried out. The only records in place were the daily recording of the care which had been provided. Two of the people without a care plan were unable to speak with us. The one person who was able to speak to us told us that the service had not carried out an assessment of their needs or provided them with any information or explanations about the care they would receive.

We saw in one person's care plan that they required support to manage a health condition. There was no information in the care plan about the condition or what support was being provided for the condition. Daily records for this person also recorded that they had developed a pressure ulcer. There was no record in the care plan of support in place to manage the pressure ulcer or a referral to the appropriate healthcare professional.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans we viewed were written on the provider's corporate pro-forma. They were not always completed in sufficient detail to show how people would like to receive their care and allow the person to have as much choice and control as possible. For example one care plan we looked at recorded that a person needed assistance with dressing. There was no record of what they needed assistance with and what they could do for themselves. Some care plans did not contain any background information about the person which would show how they may like to receive their care and support.

People's preferences were not always recorded and acted upon. For example one person told us they did not like one gender of care worker supporting them on the days they had a shower. Despite this and their request being recorded in their care records this gender of care worker was sent resulting in the person declining to have a shower. We spoke with the manager about this and saw it was recorded on the service computer system before we completed our inspection.

People told us that they were not involved in reviews of their care. We saw that care plans had not been regularly reviewed with the person receiving care. For example one care plan which had been written in January 2013 and another written in October 2013 had not been reviewed. These care plans had been signed to indicate that people agreed with the information it contained when it was written but there was no record of if the person's needs had changed in that time.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with did not feel confident to contact the office to make a complaint or raise a concern. One relative told us, "The office has a lot to learn to make sure clients wishes are put into place." We discussed with the manager what they were doing to ensure that people felt confident to raise concerns and complaints. We saw that procedures and training had been put in place to address this. However, this had only been implemented a short time before our inspection and we were unable to judge if this had improved the service.

Requires improvement

Is the service well-led?

Our findings

Quality assurance procedures had not been carried out effectively. For example where the service administered medicines the records of this should be returned to the office for auditing to check people had received their medicines as prescribed. On our visits to people we found these records dating back as far as June 2014 were still in people's homes and had therefore not been audited. Some care plans contained a record indicating that they had been audited. However, we saw that errors and omissions had not been identified and where they had been no action had been recorded to address the fault.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service does not have a registered manager in place. The last registered manager left in May 2014. Since then there had been three managers including the current manager. The current manager started managing the service in January 2015 and at the time of our inspection had not registered with the CQC.

The provider told us how they are addressing failings in the service which they became aware of in May 2014. They had put a new manager in place who was being supported by an operations manager. Following the new manager's appointment and, in consultation with Cambridgeshire County Council, the service was transferring approximately one third of its clients in one area to another provider. This was because the service recognised that it was unable to provide a good quality of care to people in this area.

Care workers told us they did not feel supported by the service. They gave examples of their rota being changed with little notice and ringing the office and not getting called back. They told us that regular meetings for care workers providing care were not being held. Care workers told us they did not feel they were not involved in running the service. One care worker told us they did not visit the office if they could avoid it. However, another told us that they felt the management of the service was improving since the new manager had started and they were getting their rota the week before they were due to provide the care.

The service maintained records on both paper and computer based systems. Paper records we viewed were disorganised. One care plan we looked at which was for one individual contained two other people's information. Up to date information could not be found easily in the files because it was mixed with old information. Not all information in the paper files matched with what was recorded on the computer, for example, the times of care visits for one person were different on paper records to those held on the computer.

Prior to our inspection we received information from Cambridgeshire County Council that the service was not effectively monitoring the number of calls that were being missed. We discussed this with the manager and they told us that this had been the case. They then showed us their system for monitoring missed calls, which were each being investigated as a complaint. We saw that the system was robust and had resulted in a reduction in the number of missed calls.

The manager showed an understanding of the risks to the service and demonstrated how they were working to address these. This included regular meetings with office staff to address and problems or concerns. Office staff had received additional training in the service system for documenting complaints and allocating calls to care workers. We saw that the manager was putting systems in place to ensure staff knew what was expected of them. This included telephoning care workers who were providing care at weekends to ensure they knew what their calls were. They told us this had resulted in less missed calls at weekends and figures we saw confirmed this. They had also appointed an out of hours contact rota so that care workers knew who they could contact if they needed support when the office was closed.

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 13 CQC (Registration) Regulations 2009 Financial position **The provider had not ensured people were fully protected from the risks associated with medicines.**

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider had not ensured there was sufficient staff to ensure that people who use the service were safe.**

Regulated activity	Regulation
Personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People were not involved in their care planning and review.**

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider was not ensuring the welfare and safety of the service user by carrying out an assessment of the needs of the service user and planning and delivering care to meet the service users individual needs.

The enforcement action we took:
We have issued a warning notice.