Care4U (Leicestershire) Limited

Care 4 U - 466 Melton Road

Inspection report

466 Melton Road
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Care 4 U - 466 Melton Road is a domiciliary care agency providing personal care for people in their own homes. The service provides personal care for older people and younger adults. At the time of the inspection, the branch manager stated 80 people were provided with personal care from the service. This was a comprehensive inspection.

The inspection took place on 14 and 18 September. The inspection was announced because we wanted to make sure that the registered manager was available at the time of the inspection.

At our last comprehensive inspection in May 2016 we rated the service as 'Good'. On this inspection improvements were needed to ensure that people were comprehensively safe, that the service was effective, responsive and that quality assurance systems were effective in driving improvements in the service. Because of these issues, the overall rating for this inspection has reduced to 'Requires Improvement.'

A registered manager was in post. This is a condition of the registration of the service. 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 and associated Regulations about how the service is run.

We identified concerns about a number of issues. A requirement notice has been issued due to a breach of regulation in relation to the service not meeting the requirement for good governance.

Staff was not deployed in a way that would always provide people with the safe personal care they needed. Risk assessments were not always comprehensively in place to protect people from risks to their health and welfare.

Not all staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have effective choices about how they lived their lives.

Staff had largely received training to ensure they had skills and knowledge to meet people's needs, though training on a number of other relevant issues had not yet been provided and an effective check on whether staff were competent following training was not always in place.

Care plans did not always contain detailed information individual to the people using the service, to ensure that their needs were always met.

People and relatives were not always confident that concerns had been followed up. They were not always satisfied with how the service was run.

Some staff members said they had not been fully supported in their work by management.

Management had not carried out comprehensive audits to check that the service was meeting people's needs and to ensure people were provided with a quality service.

People and relatives told us that most staff were friendly, kind, positive and caring and said they had been involved in making decisions about how and what personal care was needed to meet any identified needs.

Care plans were available to people and staff, which helped to deliver a service to meet people's care needs.

Staff recruitment checks were in place to protect people from receiving personal care from unsuitable staff.

Most people and their relatives told us that they thought staff provided safe personal care.

Staff had been trained in safeguarding (protecting people from abuse) and understood their responsibilities in this area.

People and relatives told us that medicines had been supplied so that people could take their medicine safely.

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 consistently safe.

Risk assessments to protect people's health and welfare did not always contain sufficient information to protect people from risks to their health and welfare. There were not always enough staff to safely meet people's needs. Lessons had not been comprehensively learnt from some incidents to prevent situations arising again.

Staff recruitment checks were in place to protect people from receiving personal care from unsuitable staff. People and relatives thought that staff provided safe care when they were with people. People had been assisted to take their medicines.

Is the service effective?

Requires Improvement

The service was not comprehensively effective.

Staff had received training to meet people's care needs, though further training, and further checks on training, were needed for staff to understand all the care needs people had. A person's health needs had not been fully met by staff. Not all staff were aware of issues relating to mental capacity legislation and assessments.

People had received an assessment of their needs. Staff had received support to carry out their role of providing effective care to meet people's needs. People's consent to care and treatment was sought by staff and their nutritional needs had been promoted.

Is the service caring?

Requires Improvement

The service was not comprehensively caring.

Systems were not always in place to deliver a caring service. People had calls that were too early or too late and staff did not have the time to stay for the agreed length of time. People's concerns were not always being responded to.

People and relatives told us that staff were kind, friendly and

caring and respected people's rights. People's choices had been met. Staff respected privacy and independence. People or their relatives had been involved in setting up care plans to reflect people's needs.

Is the service responsive?

Requires Improvement

The service was not comprehensively responsive.

People and their relatives were not always satisfied that the service responded to needs to supply a timely service. Care plans had not comprehensively included personal information to assist in providing an individual service.

People and relatives were not always confident that concerns had been followed up, though formal complaints had been investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not comprehensively well led.

Systems had not been comprehensively audited to identify whether a quality service had been provided. Some people and relatives told us that management did not always listen to them and put things right. Some staff told us that the management team did not provide good support to them.

Care 4 U - 466 Melton Road

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 and to look at the overall quality of the service and provide a rating for the service under the Care Act 2014

Care 4 U - 466 Melton Road provides personal care for people living in their own homes. This inspection took place on 18 and 19 September 2018. The provider was given 48 hours' notice because the location provides a personal care service and we needed to be sure that someone would be in. The inspection team consisted of one inspector.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about.

We reviewed the provider's statement of purpose. A statement of purpose is a document which includes the services aims and objectives.

We contacted commissioners for health and social care, responsible for funding some of the people who used the service and asked them for their views about the agency.

During the inspection we spoke with seven people who used the service, five relatives, the provider, the branch manager and three care staff members employed by the service.

We looked in detail at the care and support provided to four people who used the service, including their care records, audits on the running of the service, staff training, three staff recruitment records and policies of the service.

Requires Improvement

Is the service safe?

Our findings

Safeguarding systems had not kept people comprehensively safe.

Care plans contained risk assessments to reduce or eliminate the risk of issues affecting people's safety. However, not all risk assessments contained sufficient detail to promote people's safety. For example, the risk assessment for a person with continence needs stated staff needed to assist with this care but did not detail how often this care was needed.

A risk assessment of another person to prevent breakdown of their skin included that creams needed to be applied if needed to protect from pressure sores developing. However, it did not detail the signs of skin breakdown to assist staff to apply creams. Records did not always detail that the person was supplied with creams. The person needed repositioning but charts were often left blank, which indicated a risk that the person had not been repositioned. The registered manager said these issues would be followed up. Information was supplied after the inspection visit that staff had been retrained in repositioning people.

Staffing was not sufficient to ensure that people were safe. A number of people and relatives said that staff had sometimes been over an hour early or late for calls. A relative told us that staff during the week were on time but they had been regularly early by an hour at the weekend. This meant their family member was not properly awake when care staff saw them and was at risk of falling. Records showed some calls were up to 90 minutes late and that for people needing two staff to provide personal care, sometimes only one staff member turned up. In these situations, their family members assisted the staff member. A staff member confirmed this happened. This did not provide people with a service that safely met their needs.

Lessons had not always been learnt from incidents. A complaint had been substantiated about a person having late calls. The lessons learned from this indicated the person was now receiving timely calls. However, the individual lesson learnt from this situation had not been transferred to other people who also had untimely calls.

Most people and relatives told us that staff provided safe personal care. One person said, "I feel very safe with staff." Another person said, "Yes, I have never felt unsafe when staff have been with me."

Some care plans and risk assessments were comprehensively in place. For example, a risk assessment to prevent pressure sores had relevant information in place to remind staff to place cushions from the person's right side to the left side to relieve pressure on both sides of the person's body. This helped to keep the person safe from skin breakdown.

The staff told us they were aware of how to check to ensure people's safety. For example, they checked rooms for tripping hazards and left people's walking frames near them so they could easily get to them. There was a system to risk assess facilities in people's homes and this covered relevant issues such as fire precautions and the management of dangerous substances.

A local authority said that they had been recently been working with the provider to improve recording of medicines administered, ensuring accidents and incidents were reported and dealt with in a timely way and ensuring robust care planning to ensure people received care that met their needs.

People and relatives told us that there had been no issues regarding medicines. One person said, "I get my tablets when I need them." There were medicine sheets in place for staff to record when they prompted or supplied people with their medicines. Records indicated that prescribed medicines had been supplied. Some gaps had been identified in audits of medicine administration and staff reminded to complete records. These procedures assisted staff to safely provide medicines to people.

Staff recruitment practices were in place for new staff. Records showed that there had been checks with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and ensure that staff employed are of good character. Staff records showed that before new members of staff were allowed to start, checks had been made with previous persons' known to the respective staff member. This meant systems were in place to prevent the employment of unsuitable staff.

Staff members had been trained in protecting people from abuse and understood their responsibilities to report concerns to management and other relevant outside agencies if necessary, if they had not been acted on by the management of the service.

The provider's safeguarding policies (designed to protect people from abuse) were available to staff. These informed staff what to do if they had concerns that people had suffered abuse. The safeguarding policy included different types of abuse and contact details for relevant agencies for staff to report abuse or suspicion of abuse to.

The whistleblowing policy in the employee handbook included information for staff to report to management and a provider support contact. There was information directing staff to report to a relevant agency but not to the safeguarding authority or the police. After the inspection visit, this procedure was amended to include this information. This meant staff had ready access to clear information of how to whistle blow to ensure their safety.

People and relatives told us that most staff were conscious of infection control issues. They said that staff had worn personal protective equipment when supplying personal care to people and that they had washed their hands between tasks. However, one relative said that staff member did not wear gloves and another staff member did not change gloves between tasks. The branch manager said this would be followed up. Staff had been reminded in staff meetings about wearing proper infection control equipment. Staff members were aware of how to ensure people were safe from infection risks such as wearing suitable equipment and carrying out hand washing between tasks.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection.

We checked whether the service was working within the principles of the MCA. One staff member did not have an awareness of this legislation, though they stated they always supplied choices to people even though they lacked capacity. This meant there was a risk that staff lacked knowledge on how to provide effective care within the legal framework. The branch manager indicated this would be followed up with staff.

People and their relatives told us that care staff had responded to health concerns. A relative told us that if staff had any concerns about the health of their relative, they would report this to them. Records showed that if the person was ill, staff members referred them to the GP or called an ambulance. This indicated that care staff were aware of obtaining healthcare and ongoing support for people. However, there was an incident in records where a person's blood sugar levels were high. However, there were no evidence that this had been followed up or reported to the office. The registered manager said this would be followed up.

Most staff told us that they thought they had received enough training so that they were able to effectively meet people's needs and they had to complete refresher training. One staff member said they had not received practical training in how to move and assist people. After the inspection visit, the branch manager followed up this issue and stated that further training had been provided. The service had a training room with moving and assisting equipment. Records were in place to show that other staff had been supplied with practical training from trainers with an accredited certificate.

Staff said that management reminded them to complete training. One staff member said, "We get a lot of training and I have learnt a lot since being here."

New staff were expected to complete induction training on a wide range of relevant topics. This covered issues such as infection control, moving and handling and keeping people safe from abuse. There was evidence that staff received training based on the care certificate. This is nationally recognised comprehensive induction training for staff.

Most people and relatives thought that staff had been trained to provide effective care. A person said, "They know what they're doing." A relative told us some staff did not know how to prepare microwave food but this had been sorted out.

Staff had received training in a number of people's specific long-term health conditions such as dementia and there was guidance available to staff on other issues such as blood disorders. However, training had not been supplied on some health conditions such as stroke care, catheter care and sensory impairment. The branch manager stated this training would be supplied. A relative said that staff did not know how to carry out catheter care and this was left to the relative to do. This was followed up by the branch manager who stated staff had received this training in the past and would receive refresher training so they were able to carry out this task.

Training had been completed by trainers in person, video or online. Questionnaires were in place to check that staff understood training. However, these were not always completed by staff or checked by management staff. The registered manager said these issues would be followed up.

Staff records indicated supervision had taken place. This included discussing relevant topics such as promoting health and safety, preventing infection and staff conduct towards people. This provided staff with support to discuss any issues they were unsure of. One staff member said that they had not received supervision. The branch manager said this would be followed up.

The branch manager said that new staff were shadowed by experienced staff for three days. This was recorded in staff files. Additional shadowing would be supplied if new staff were still not confident after this time. A staff member confirmed that when new staff began work, they had been shadowed by an experienced staff member. This helped to ensure that they knew how to provide effective care to people.

People had an assessment of their needs which included relevant details of the support they needed, such as information relating to their communication needs. This provided the basis for ensuring that people's needs were effectively met.

People and their relatives said staff provided assistance with food and fluids. One person said, "Staff prepare food and give me drinks. It's okay." Care plans included information about meeting people's needs such as leaving people with drinks so they didn't get dehydrated. There was also detail about what people liked to eat and drink. This indicated that the service took account of people's food and drink preferences and needs.

The service worked and communicated with other agencies and staff to enable effective care and support, such as the local authority adult care department to obtain new agreements about care calls.

We saw information in care plans to direct staff to communicate with people and gain their consent about the care they provided. Staff members told us that they asked people their permission before they supplied care. A relative confirmed that staff explained what they were doing and asked for their family member's consent when providing them with personal care.

Requires Improvement

Is the service caring?

Our findings

Systems were not always in place to deliver a caring service. People had calls that were too early or too late and staff did not have the time to stay for the agreed length of time. People's concerns were not always being responded to. One person complained about having a male staff member rather than their choice of having a female staff member. The provider said this was because the support plan from the local authority did not state the person's preference. Once it had been assessed, only female staff were then provided.

People and their relatives said that staff were caring, kind and friendly in their approach. A person told us, "They are all very friendly and nice people. I have had no problems at all." Another person told us," My main carer is brilliant. She is a godsend." A relative said, "The staff are very good. They are friendly and chat which my [family member] likes very much."

Information from the service stated that the provider would put people first and maximise choice, control, independence, empowerment and inclusion and would respect people, their choice and value diversity and difference. These principles and values were also included in the staff handbook. This helped to orientate staff in their approach towards people receiving a service.

Information for people who use the service stated people would be involved in reviews and assessments of their care. People and relatives said that care plans had been developed and agreed with them.

The staff handbook included a statement about antidiscrimination based on relevant issues such as sex, race and religion but did not mention sexual orientation. After the inspection visit, the branch manager submitted amended information which included this detail.

The service took into account people's wishes with regard to religion and culture. A relative said, "Staff are good. They can speak my mum's language." A staff member told us that they had learnt phrases from the language of a person they provided personal care to. Another relative said that some staff had not followed their cultural wish not to wear shoes in the kitchen. However, once this had been reported to the office, it had been resolved.

People and relatives told us that dignity and privacy had been maintained. Staff gave choices such as about the food people wanted to eat and the clothes they wanted to wear. Staff told us they respected people's choices in all issues, for example, what name they wanted to be known by, what food and drink they wanted and what clothes that they wanted to wear.

People said staff tried to encourage independence so people could do as much as possible for themselves. Staff were also aware of encouraging people's independence such as people being able to wash themselves. Care plans promoted people's independence by stating people were able to complete certain things for themselves.

Requires Improvement

Is the service responsive?

Our findings

People told us that the service did not always respond to people's needs. A person told us, "Staff are nice but they come too early sometimes. I'm not ready for them." A relative told us, "70% of the time they come at the right time. The other times can be usually about 30 minutes early or late which is not convenient for my [family member] who gets anxious about this."

Another relative said, "We get calls which are up to 40 minutes late or 45 minutes early and staff don't always stay the full agreed time. Times of calls can be changed without our agreement, which is frustrating. We don't always get told if staff are running late."

Records showed that people had not always received a timely service. Some calls had been early or late for over an hour. Information in reviews and complaints showed concerns about untimely calls. Staff told us there was not always enough travelling time or any travelling time between calls and this made them late. Records we saw confirmed this to be the case.

People and relatives told us that they did not always receive rotas in advance of when care staff would arrive. Some used to have the rotas sent to them on the Friday before but this had changed to the following Monday. This meant they did not know which staff were coming to provide care and at what time. Staff also said they were not supplied with weekly rotas. This did not respond to people's needs and was not in accordance with the statement of purpose of the service, "To provide a… service that is reliable and responsive to service users changing needs and preferences." After the inspection, the branch manager provided evidence of that action had been taken so that people and relatives would receive the rotas on time.

There was information in care plans about the person's needs. However, the information about people's personal history, likes and dislikes and preferences were not included. This meant staff did not always have the full opportunity to be aware of the people's preferences and lifestyles, to work with them to achieve a service that responded to their individual needs. The registered manager indicated this would be followed up. Care plans were available in people's homes. This meant that staff had up-to-date information about people's care needs. If needs changed, staff would be informed by text by the office.

People and relatives were not always confident that concerns had been followed up. This is also referred to in the 'Well led' section of the report. Some people and relatives were not satisfied with the service they received. They told us that office management staff did not always deal with their concerns. A relative said, "I have been in touch with the office about call times and they just seem to blame the care staff and the care staff blame the office staff. This is not a very good situation."

Another relative said, "I have been in touch with them and they don't get back to me." Another relative told us, "I got in touch with the manager and she had a poor attitude and said that nothing could be done. I asked her to speak to another member of staff but she didn't pass this on." The branch manager later confirmed that she had followed these issues up.

Some people and relatives were satisfied with the service. A person told us, "I am happy with the care as it is now. We have used them for a long time and we have a regular carer so things are ok at the moment. He will tell us if he is going to be late and he always turns up." A relative said, "We have no concerns about the service at all. They always turn up and are usually on time." Another relative told us, "We are happy with them. There are regular staff who [family member] knows."

We saw that formal complaints had been investigated and followed up and the complainant had been provided with information about the results of their complaint. Apologies had been issued where relevant.

The provider's complaints procedure in the service user guide gave some information on how people could complain about the service. However, this did not contain contact details for the complaints authority or details about the local government ombudsman as agencies who would handle complaints. The procedure set out that that the complainant should contact the service for their complaint to be investigated. The procedure also implied that complainants could contact CQC if they were not satisfied, to have their complaint investigated. CQC does not have the legal power to investigate complaints. The branch manager sent us an amended procedure to include this information.

The registered manager was aware of the new accessible information requirement. The accessible information standard is a law which aims to ensure that people with a disability or sensory loss are provided with information they can understand. It requires services to identify, record, and meet the information and communication support needs of people with a disability or sensory loss. People's communication needs had been recorded and assessed.

End-of-life care and information was in place. There was a detailed care plan in place dealing with end-of-life care. This included the person's wishes, the administration of painkilling medicine, handling the person gently and making them as comfortable as possible.

Requires Improvement

Is the service well-led?

Our findings

Some people and relatives were not satisfied that office management staff always dealt with their concerns.

People received satisfaction questionnaires asking them about the quality of care. These indicated some satisfaction with the care they were provided with by staff. An analysis of the surveys had been carried out. However, evidence was not in place that all issues had been dealt with. The survey analysis had not included an action plan to take forward some issues which had not been highly rated. These included that over a third of respondents said they would not recommend the service and the same percentage would not know how to make a complaint. Nearly half of respondents only rated the service as adequate.

Comments included, "Carers seem to be rushed." "Communication between office and carers doesn't seem very good when problems arise." "Care workers not listening to what clients want." "Carers not turning up." "Some staff in the office have no idea… It is frustrating having to repeatedly call back to get an answer. There was no action plan in place to deal with these concerns.

Staff told us that the management team did not always support them. A staff member said, "The office don't listen to what you say and don't get back to you." Another staff member said that office staff did not respond properly to concerns raised by staff. They said that the office staff did not ring them back when they left a message or passed on information.

Staff had spot checks to measure whether they provided a good service to people. There was evidence of a staff member having a spot check in August 2018. The staff member had recorded what care they had provided before they had provided it. A member of the office management staff had recorded this as being acceptable practice even though they raised it as a concern with the staff member. The registered manager agreed this should have been recorded as a cause for concern and action taken.

There was a system in place to ensure quality was monitored and assessed within the service. This included relevant issues such medicine audits, audits of care records and staff recruitment. However, the audits of care records had not always identified that calls had been untimely and whether people had been provided with care that met their needs. Audits of some medicine records did not record gaps on medicine records. Audits of records did not always pick up that there was only one staff attending a call that two staff were assessed as needed to attend. A service user file review checked whether the reviews had taken place but not whether all issues identified had been acted on. Another service user file review did not pick up the issue of a person having a health concern. There were no audits for staff training. This absence of detailed auditing had not comprehensively protected the welfare of people.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Good Governance.

Staff members we spoke with told us that most of the management team expected staff to be friendly and approachable and treat people with dignity and respect. However, two staff said they would not

recommend the service to relatives and friends because the interests of people had not always been put first.

A number of people and relatives were satisfied with the service and that office staff and the branch manager had tried to assist them when there were problems. A person told us, "I have a good service. It is well managed." Another person said, "I would definitely recommend this service." A relative told us, "It's good. We have had no problems."

In the compliments file, this contained positive comments such as, "Thank you for the good team of care workers going to mum" and "District nurses say we provide a top-class standard of care."

The service published a customer newsletter. The September 2018 edition had useful information about health and safety for people who use the service and advice to keep warm in winter and encouraged people to tell the service if anything wasn't right with the service. This showed some transparency and an intention to improve the service.

Information was available which clarified governance duties and responsibility for management and staff. This ensured that all staff were clear as to what their responsibilities were.

Staff meetings had been held where issues were discussed including instructing staff to stay for the full length of the call, the need to complete medicine charts and adhering to call times. Memos from the branch manager included reminding staff to sign medicine sheets and undertaking refresher training. This showed management had attempted to deal with some of people's concerns. Management supplied a newsletter to staff which included care issues such as reminding staff about timekeeping and reporting health concerns to GPs. They were thanked for their hard work, which helped to maintain staff morale.

The home had a registered manager, which is a condition of registration. At the time of the inspection, there were three registered managers. It is a legal responsibility that registered services display their inspection ratings. This had been displayed on the provider's website.

The registered manager and members of the management team were aware of when notifications had to be sent to CQC. These notifications told us about any important events that had happened in the service. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood this legal obligation.

The service worked with the local authority. At the last compliance visit from the local authority in September 2018 there were issues that the service was working on including always reporting accidents to the local authority and to have complete care plans.

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 17 HSCA RA Regulations 2014 Good governance Systems had not been comprehensively audited to identify whether a quality service had been provided. The concerns of people and relatives had not always been listened to and followed up by management. Staff were not always provided with good support by the management of the service.