Kingfisher Care (Midlands) Ltd

Kingfisher Care (Midlands) Ltd

Inspection report

8 Robinson Way
Burbage
Hinckley
Leicestershire
LE10 2EU
Tel: 01455 616493
Website: www.example.com

Date of inspection visit: 3 and 11 November 2015
Date of publication: 11/01/2016

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?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

We made an announced inspection of the service on 3 November 2015 and returned announced on 11 November 2015.

Kingfisher Care (Midlands) Limited is a small home care agency providing personal care to people who live in their own homes. At the time of our inspection 14 people were using the service. During our inspection we learnt that the service was transferring its office from 8 Robinson Way, Burbage to Unit 35, Sparkenhoe Business Centre, Southfields Road, Hinckley LE10 1UB. We advised the provider that they were required to formally notify the Care Quality Commission of the change to their location.

The service had a registered manager until they resigned in October 2015. A registered manager is a person who

Summary of findings

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. An interim manager was appointed to manage the service pending the appointment of a registered manager.

People using the service were safe because staff understood their responsibilities for safeguarding people from abuse and avoidable harm. However, the provider had identified that people's care plans and risk assessments associated with people's care routines were not always accurate or up to date. The provider had commenced a comprehensive review of all care plans.

The provider had effective recruitment procedures which they improvised during the period the service was left with few care workers. This enabled the provider to have enough care workers to cover scheduled home care visits. New staff with existing Disclosure Barring Service checks were allowed to support people after appropriate risk assessments were carried out.

The provider was able to deploy enough staff to make all scheduled home care visits, though not all visits were made at times people expected during October 2015. There had been an occasion in October 2015 when an untrained care worker was involved in administration of medicine, but no harm was caused to the person using the service.

People using the service were mainly supported by staff who understood their needs. However, during October 2015 when there was a high turnover of staff people felt they were supported by inexperienced staff. Staff had varied awareness of the Mental Capacity Act 2005. People's care plans contained no information about whether they were presumed to have capacity to make decisions about their care or whether decisions about their care were made for them in their best interests. The provider was addressing this omission.

People using the service received support with meals. Care workers helped people prepare meals or they heated pre-pared meals for people. Care workers supported people to access health services if a need was identified during a care worker's visit.

People told us that staff were caring. People developed caring relationships with care workers they had become accustomed to, but since several had left in October 2015 this process had restarted. The provider had procedures for involving people in decisions about their care and support. During our conversations with people, none said anything to suggest staff had not treated them with respect. However, two people's privacy was not respected when staff made an unscheduled and unexpected visit that upset them.

People using the service contributed to the assessments of their needs when they first began to use the service and when their care plan was reviewed. The provider had begun a comprehensive review of all people's care plans after identifying inaccuracies in a person's care plan about how they needed to be supported.

People were able to raise concerns about the service. They were listened to and the provider acted upon what people said. The provider used an annual survey to obtain people's feedback about the service.

The provider kept people using the service informed of operational difficulties that affected how the service was delivered. People using the service and staff had opportunities to be involved in the development of the service. The provider had reviewed their arrangements for monitoring the quality of the service after previous arrangements had lapsed. These arrangements were in their early stages but they were recognising signs of improvement.

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?

Requires improvement

The service was not consistently safe.

Staff understood and practised their responsibilities for keeping people safe and recognising and acting upon signs of abuse.

Risk assessments associated with people's care were not always accurate.

There had been a lapse in staff adhering to the provider's management of medicines procedures.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were usually supported by staff with the relevant skills, experience and knowledge, but this lapsed during October 2015 after several experienced staff left the service..

People's care plans contained no information about whether they were presumed to have mental capacity to make decisions about their care.

People were supported with their nutritional and health needs.

Is the service caring?

Requires improvement

The service was not consistently caring.

People told us staff were caring and that they were treated with respect, though there had been a single lapse that occurred through a mistake.

People were involved in decisions about their care but their preferences about times of home care visits were not always met.

Is the service responsive?

Good

The service was responsive.

People received care and support that met their need and preferences apart from a short period in October 2015.

People knew how to raise concerns with the provider and when they did hey were listened to and acted upon.

Is the service well-led?

Requires improvement

The service was not consistently well led.

The provider had introduced improved procedures for involving people using the service and staff in the development of the service.

At the time of our inspection there was no registered manager. The provider had appointed a manager to run the service.

Summary of findings

New procedures were introduced during the period of our inspection for monitoring and assessing the quality of service.

Kingfisher Care (Midlands) Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 November 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be in the office. We returned to the service announced on 11 November 2015 to look at more records.

The inspection team consisted of an inspector and an expert-by-experience. An expert-by-experience (ExE) is a person who has personal experience of using or caring for someone who uses this type of care service. Our ExE had experience of adult social care and domiciliary care services.

Before our inspection we reviewed information we had received about the service. This included feedback from a relative of a person using the service. We also received information from the provider about operational difficulties they were experiencing as a result of almost half of the workforce, including the registered manger, leaving the service. This information resulted in us bringing forward a planned inspection of the service.

We spoke with eight of the 14 people using the service at the time of our inspection and relatives of five people. We looked at three people's care plans. We looked at how home visits were planned and records associated with those visits. We spoke with three care workers, the acting manager and the registered provider. We looked at a staff recruitment file and evidence of staff training. We spoke with the provider about their quality assurance procedures.

Requires improvement

Is the service safe?

Our findings

When we spoke with people using the service nobody expressed any concerns about their safety when they were supported by care workers. A relative told us that they and the person using the service felt safe when care worker's visited to provide care. They told us, "We're safe, we have a good laugh with them. They are sociable people."

Care workers we spoke with were familiar with safeguarding procedures. They knew what signs to look out for to identify whether a person was at risk of abuse and knew how to report concerns to their manager. They knew they could contact the local authority adult safeguarding team and Care Quality Commission to report concerns. The provider's safeguarding policy included contact details for both.

People's care plans included assessments of risks associated with their care and support, including the use of equipment such as stand-aids. Stand aids are equipment that are used to support people to get in and out of bed or chairs. In October 2015, a health professional identified that a person's care plan risk assessments were `inadequate and contradictory'. This meant the risk assessment did not reflect a person's needs or accurately describe how they should be safely supported with their mobility. As a result of this, the provider implemented a review of every person's care plan to ensure that they were being safely supported. The review included checking the accuracy of risk assessments in people's care plans. The review of care plans had begun at the time of our inspection and was expected to be completed by 31 December 2015. This meant that at the time of our inspection, people's care plans and risk assessments did not confirm what people told us about being supported safely. However, the provider was addressing this through the review of people's care plans.

At the time of our inspection 14 people used the service. Ten staff covered 200 hours of home visits each week. The provider's ability to meet those calls was severely tested during October 2015 when five staff and the registered manager left the service. The provider forewarned us of the situation. The risk was that people would not receive home visits from care workers. New staff were recruited, all of whom had recent experience of being home care workers. An interim manager was also appointed. The provider worked with another home care agency to ensure that people using the service continued to receive home care visits. People using the service told us they continued to receive calls during October 2015.

The provider's recruitment procedures were improvised during October 2015 when there was an urgent need for new care workers to replace those that had left. Staff recruited at that time were known professionally to the acting manager who worked with those people immediately prior to joining Kingfisher Care. New staff were appointed without formal interviews. They received an induction into the service and the needs of people using the service. This included shadowing experienced care workers. New staff had existing current Disclosure and Barring Service (DBS) checks. DBS checks help to keep those who are known to pose a risk to people who use CQC registered services out of the workforce. New DBS checks were applied for after people started work. Risk assessments were carried out concerning care worker's suitability to work for the service pending the completion of new DBS checks.

The provider's procedures for supporting people with their medicines make it clear that only staff trained in medicines management carry out that role. A `near miss' incident occurred on 14 October 2015 when a person untrained in medicines management began to support a person with their medicines before stepping aside to allow a trained care worker to complete the task. Since then only care workers with certificated training in medicines management have supported people with their medicines.

Requires improvement

Is the service effective?

Our findings

We had mixed feedback from people using the service and relatives about the skills and experience of care workers who supported them. A person told us, "[Care workers] do the job they are supposed to do although it has been an up and down relationship." People told us they had experienced care from several care workers and that those they saw less often were not as knowledgeable about their needs as care workers they saw more.

The provider's ability to ensure that people were supported by care workers with the necessary skills and experience was compromised when a significant part (nearly half) of the workforce left the service during September 2015. Several experienced care workers left and they were replaced by new staff whose induction was fast tracked so that they could make home visits soon after joining the service. However, this meant that not all the required pre-employment checks were carried out.

During October 2015 people using the service experienced home care visits from several care workers rather than care workers they had got used to seeing. However, a person told us, "The situation is getting better again." Records we looked at on the second day of our inspection confirmed that to be the case. We found that in the period 19 October to 8 November 2015 the majority of calls, 370 out of 426 (87%) were made at times people expected. The provider expected this to improve after new staff completed their induction.

People were starting to receive home care visits from the same carer workers who were increasing their knowledge of people's needs and the way the wanted to be supported. A relative of a person using the service told us, "It's improved since mid-October. They have new staff." Our review of records for the period 19 October to 8 November 2015 also showed that to be the case.

Care workers we spoke with mirrored people's comments about the instability caused by nearly half of the care workers leaving. An experienced care worker told us that new care workers or staff who had previously done little of no care were shown what to do by experienced care workers who stayed with Kingfisher. A new care worker we spoke with confirmed that to be the case and added that they had been introduced to, "most of the people I'll be supporting."

The new staff that joined Kingfisher Care were experienced care workers. They had received mandatory training relevant to homecare care workers in the employment they had immediately before joining Kingfisher care. That training included moving and handling, safeguarding, medications management. Those care workers had provided Kingfisher with training certificates to show they had that training. The acting manager was a qualified trainer who showed new staff how to use stand-aids. The provider had plans to deliver training that supported care workers to increase their knowledge and awareness of people's specific individual needs.

New staff were supported through induction into the service and familiarisation with people suing the service. The provider had reintroduced staff meetings and one-to-one supervision meetings for staff where they could discuss their performance and make suggestions about the organisation of the service. For example, staff contributed ideas about improved scheduling of home care visits that the provider had acted upon.

The Mental Capacity Act (MCA) 2005 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. We checked whether the service was working within the principles of the MCA.

The acting manager was aware of their responsibilities under the MCA. They understood that under the MCA, people were presumed to have capacity to make decisions about their care, including consent to care. They had identified that people's care plans had no information about whether people were presumed to have mental capacity or had given consent to receiving care and support. This omission was planned to be corrected through a comprehensive review of every person's care plan.

Care workers we spoke with had limited awareness of the MCA. They knew they had to obtain a person's consent before providing care and support. More senior care workers had a better understanding of the MCA. The provider was developing a plan to provide MCA awareness

Requires improvement

Is the service effective?

training for staff. They made arrangements to order a copy of the Mental Capacity Act Code of Practice and to access information on the internet about the MCA that could be used in training.

Some of the people using the service were supported with their meals. This was mainly limited to support with hot drinks and warming meals in a microwave, although some staff helped people prepare meals. Home care visits were timed to coincide with people's preferred meal times, but during October not all visits were at times people expected because of the situation caused by the turnover of staff.

People were supported to access health services. For example, the provider liaised with occupational therapists to support people to be provided with equipment that helped them with their mobility. However, a relative felt that their parents had not been supported to access other services they felt were relevant. They told us, "My parents are both very vulnerable, [my relative] is very frail and been waiting weeks for a social worker. There seems to be no effective communication around people's needs, although the care [from Kingfisher Care] is OK. The carers who do come are quite attentive." We discussed this with the provider and they told us had made referrals to social services when they were concerned about people's well-being.

Requires improvement

Is the service caring?

Our findings

When we spoke with people about whether they felt care workers were kind and compassionate, they mainly responded in positive terms. Comments included, "Mostly the carers are nice but I have complained and stopped one from coming here", "My carer is super" and "My carer is good."

People using the service had built up a relationship with care workers working for Kingfisher Care, but this had ended when nearly half the care workers had left the service in October 2015. During the first part of October 2015, people using the service had experienced some instability as a result of being visited by new care workers. Punctuality of calls also suffered. A relative told us, "It was chaotic in October. Most of [the care workers] were fine, it was just that carers coming at different times was stressful." The provider had telephoned or visited people using the service to explain what the problems facing the service. They had told people that there would be short period when calls would be outside the times they expected and that they would be seeing new care workers.

Care plans we looked at contained evidence that people using the service were involved in making decisions about their care. Care plans contained information about how people wanted to be supported and information about their needs and preferences. People had stated at what times they wanted their care visits to take place. The provider had not, until the time of our inspection, monitored whether or not people had experienced home care visits at times they wanted. A survey of people using the service carried out in September 2014 showed that most people were pleased with the punctuality of calls, but this changed in October 2015. A relative told us that late calls had caused his parent stress because they relied on care workers coming at the same times in the mornings. The provider acknowledged that people's preferences about times of calls had not been met in the early part of October 2015, but that the situation had begun to improve from mid-October. A relative of a person using the service told us, "They [Kingfisher Care] are getting it together again. I can't say enough about the carers." Records we looked at confirmed that to be the case. The provider had also introduced systems for monitoring the times of visits. A care worker told us, "It's getting better. I make my calls at the same times. It's got to be like that otherwise people's routines are ruined." Another care worker told us, "Nine out of 10 calls are when people expect them. It's always been good. It's been up and down recently but it's getting better."

The provider had set about overcoming the challenges presented to them by a loss of a significant number of staff. They did this in a way that demonstrated that people using the service mattered to them. The service was maintained through a difficult period. A person told us, "The Kingfisher staff that stayed pulled out all of the stops." The provider acknowledged that people could be better informed by the service about which care workers to expect and that people should always be informed if a care worker was running late. The provider had introduced new procedures for scheduling home care visits and monitoring when care worker's arrived at people's homes. Those procedures, once bedded in, would make this possible to keep people better informed.

People's care records were kept in their homes. Duplicate records were kept securely in the provider's office and were accessible only to authorised staff. Staff contracts included a clause that required staff not to disclose or use information about people using the service if they left the service.

Most people using the service and their relatives did not say anything to suggest they were not treated with dignity or respect or that their privacy was not respected. There had been a lapse of respecting people's privacy when a non-scheduled visit was made to a person's home by mistake and another person told us that a particular care worker did not always tidy their house or close curtains to their liking. People were more concerned with when they received homecare visits and that those visits were by regular care workers who understood their needs. People told us it was important to them that they received visits from `regular' care workers. A person we spoke with summed this up when they told us, "I've lost count how many different carers I have had this year." This was not something the provider monitored. However, it was possible to monitor the situation from care worker's time sheets. We looked at time sheets for October 2015. Most people were supported by up to three different care workers and the most care workers a person had visit them was seven. The new system the provider had begun using

Requires improvement

Is the service caring?

to schedule home care visits made it possible to keep to a minimum the number of care workers a person had visit them. Care workers told us that they were beginning to visit the same people on a regular basis.

Good

Is the service responsive?

Our findings

People using the service or their representatives were involved in the assessments of their needs and in the planning of their care and support. People's care plans included information about how they wanted to be supported and when they wanted care workers to visit them. People's comments about this ranged from being satisfied that their personal needs and preferences were met to not being met. A relative told us, "Punctuality has been good." Others were not as positive. A person told us, "Carers are supposed to come between 9 and 9.30am but sometimes it is nearly 11am [before they come]." Another told us, "My time for carers is 8.30 to 9am but sometimes they come 10.30 to 11am." Irregularity of home visit times featured during the first part of October 2015 but began to improve from 17 October 2015 when an interim manager was appointed.

People told us that their needs were met, but that on occasions it was because they had to explain to care workers what they needed to do. A person told us, "I have to tell them [care workers] what to do." Another person said, "Some carers seem to know what to do but with others we have to keep telling them [what to do]." This situation had come about because of a sudden turnover of staff and for a short period in October 2015 people were supported by new care workers who were not as knowledgeable about their needs. During the period the provider had placed a greater emphasis on home care visits being made rather than being missed. People's preferences about times of visits were not, for a short time, prioritised. A relative told us, "They [Kingfisher Care] have been in a difficult position but it's not their fault."

The provider had introduced a new system for scheduling home visits. This took into account people's preferences for times of home care visits. It also made it easier to arrange for regular care workers to visit people, which was something people told us was important to them. This new system was in its early stages on the first day of our inspection but we saw on our second day a week later that the system was improving and people's preferences were being increasingly met.

The provider had procedures for reviewing people's care plans but these had lapsed. The acting manager had begun a comprehensive review of every person's care plan. People using the service were involved in those reviews. The review process was expected to be completed by 31 December 2015. However, this did mean that at the time of our inspection we were unable to evidence the benefit and impact of the review of care plans.

People using the service were able to raise concerns and complaints. People had access to information about the provider's complaints procedure in `client information' leaflets. People told us they were able to contact the manager and the provider. Some people had done so and their concerns were investigated and responded to and where appropriate included an apology. People's views were sought through an annual survey. The last survey resulted in positive feedback but it pre-dated the period when the provider experienced difficulties. A survey was planned to take place in December 2015.

People were provided with a `client guide' that included information about the service. This included contact details for the office. A person using the service told us, "Communicating with the office can be difficult." The office was not permanently manned as all staff were engaged in care activities. Calls to the office were redirected to the acting manager, but this meant they could not always respond or take action if they were involved in a home care visit at the time. The provider told us they were going to recruit an office based person to take telephone calls and make appropriate responses immediately.

Requires improvement

Is the service well-led?

Our findings

The service did not have a registered manager at the time of our inspection. A registered manager had resigned in September 2015. An interim manager had been appointed who intended to apply to CQC to register as a registered manager of the service.

People we spoke with told us they had not been asked for their feedback or comments about the service. A person told us, "I've never had any communication from the office in over eight months."

However, people using the service were involved in developing the service insofar as their views and opinions about the service were sought and acted upon. Their views were sought through an annual survey. At the time of the last survey in September 2014 seven of the 10 people using the service at that time participated in the survey. The results of the survey were positive. No areas of improvement were suggested by the people responding to the survey. Another survey was scheduled to take place in December 2015.

At the time of our inspection the provider was introducing other means for obtaining people's feedback. These included a programme of reviewing people's care plans and monthly telephone calls and visits to people using the service. This programme had not started at the time of our inspection, but was scheduled to begin in December 2015.

All care workers were issued with a handbook that set out standards the provider expected of them. These included standards in relation to punctuality of home visits, completion of all the required care routines, treating people using the service with respect and developing their knowledge and skills. The provider's programme of monthly telephone calls and visits to people using the service was intended to review the performance of care workers.

The provider had a range of policies and procedures that underpinned the service. Staff had access to these polices in the provider's office and were aware of them through induction and guidance in the care worker's handbook.

We had mixed feedback from people about the running of the service. A person told us, "There is no stability and they have trouble keeping carer's. There have been a few changes recently. I didn't know who to contact about concerns but did get a named contact last week." That comment reflected the situation the provider faced after the registered manager and significant number of staff left. Another person told us, "The boss is really trying. He has been out to see us to explain the situation." This indicated to us that although the service had not performed as well as people would have liked, the provider had managed what was a challenging situation and had ensured the service had continued to operate. This involved working with another provider to ensure that all scheduled home care visits were made, even though some were outside the times people wanted.

The provider and acting manager had made themselves known to people using the service and their relatives. They involved themselves in providing care and support. Mistakes were made but these were acknowledged and learnt from and areas requiring improvement were identified and acted upon. This was especially the case in relation to people's care plans which were identified as requiring comprehensive review. The provider had kept people informed of operational difficulties that affected the quality of service provided during a period when several staff left the service. This showed the provider to open and transparent with people using the service.

The acting manager was, at the time of our inspection, intending to apply to be registered manager. If followed through and successful that would mean the service was without a registered manager for approximately two months.

The provider and acting manager understood the Care Quality Commission (CQC) registration requirements. These included notifying CQC of incidents affecting people using the service.

The new management team and staff had a shared understanding of the challenges facing the service. For example, care workers we spoke with told us of the importance of visiting people at times they expected and that people were supported by regular care workers. They and the management team felt they had emerged from what they thought was a very challenging period and that improvements were becoming evident. A care worker told us, "It was difficult at the beginning, but now there are more care workers people are visited by the same care workers." Our review of records showed that to be the case.

Requires improvement

Is the service well-led?

At this inspection, apart from a survey of people using the service carried out in September 2014 we saw little evidence of quality assurance activity. Information about the performance of the service was available but it had not been used to assess what was done well or what required improvement. For example, there was no analysis of how effective the service was in terms of meeting people's preferences about the times of home care visits. There was no recorded assessment of punctuality of home visits or whether care workers had completed all care routines. However, at the time of our inspection the provider began introducing procedures for monitoring the quality of the service. These included procedures for receiving and acting upon people's feedback. The new procedures made it easier to monitor punctuality and duration of home visits, whether all care routines were completed and whether people were supported by regular care workers. All of those things were important to the people using the service. The procedures that had been introduced were in their early stages and not, at the time of our inspection, generating information about the service's performance. We were able to see on the second day of our inspection that improvements in organising and monitoring home care visits were evident, but the monitoring procedures were still in their early stages and we could not, therefore, see consolidated improvement.

This section is primarily information for the provider

Enforcement actions

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