Elite Staffing UK Ltd

Elite Staffing UK

Inspection report

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Tel: 01924455001

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

Summary of findings

Overall summary

The inspection took place on 30 March 2016 and was announced a day prior to the inspection. This was to ensure there would be someone in the office on the day of the inspection. Follow up telephone calls were made to people and staff on 5 April 2016. The service had previously been inspected in December 2013 and was found to be compliant with the Health and Social Care Act 2008 Regulations at that time.

The service provides domiciliary care services to people in their own homes. The people who receive these services have a wide range of needs and most are older people. The service provides minimum call times of 30 minutes. At the time of the inspection there were 16 people receiving support from the service.

The service did not have a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had recently left the service and was in the process of deregistering as the registered manager. A new manager had been appointed but was not yet registered and the nominated individual was overseeing the day to day running of the service.

People told us they felt safe and staff had received safeguarding training in order to keep people safe. Staff understood their responsibilities in relation to safeguarding people from abuse or harm and appropriate action was taken when necessary to protect people.

Risks to people were not always assessed and therefore measures to reduce risks were not always given consideration. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recording of the administration of people's medicines was not safe. Records did not provide a clear and accurate record of the medicines people were prescribed and the medicines which staff had administered. This demonstrated a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff to meet people's needs and there were robust recruitment practices in place, which meant staff had been recruited safely.

Staff told us they felt supported and staff had received induction and training. However some staff had not fully understood their training. Although staff felt supported, regular formal supervision did not take place.

People and relatives we spoke with told us staff were caring. People's privacy and dignity were respected and people received support in terms of their religious and cultural needs. Staff developed positive relationships with the people they supported.

Care and support plans were detailed and personalised, taking into account people's choices and preferences. People told us they had been involved in their care planning and felt they could make their own choices.

People and staff felt the service had improved since the beginning of the year. Staff felt supported and people felt able to contact the office in the knowledge they would be listened to. The manager had begun to audit some areas of practice. However, auditing systems were not yet robust and areas which had been identified as requiring improvement through the inspection process had not been identified through auditing. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe and staff understood signs of potential abuse and could explain what action they would take if they had any concerns.

Risk assessments were not always completed.

Staffing levels were appropriate to meet the needs of people who used the service and staff were recruited safely.

The recording of the administration of people's medicines was not safe. Records did not provide a clear and accurate record of the medicines people were prescribed and the medicines which staff had administered.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received relevant training, although a knowledge test showed some staff had not fully understood the training.

Staff told us they felt supported.

Staff had received training in relation to the Mental Capacity Act 2005 and people made their own decisions. Consent to care was sought.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were caring and they treated people with dignity and respect.

Confidentiality was respected.

People's cultural and religious needs were respected.

Is the service responsive?

Good

The service was responsive.

People told us they were able to make choices in relation to their care and support.

Care plans were detailed and personalised, enabling people to receive support that was appropriate for their individual needs and preferences.

Complaints were well managed, resulting in satisfactory outcomes.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff and people told us they felt the service had recently improved.

Policies and procedures were in place and up to date.

The manager had begun to carry out audits, although these were not yet robust.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned 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.

The inspection took place on 30 March 2016, with follow up telephone calls being made to staff and people who used the service, and their relatives where appropriate, on 5 April 2016. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office. The inspection was carried out by an adult social care inspector. Prior to our inspection, we looked at the information we held about the service and considered any information we had received from third parties or other agencies.

As part of our inspection we visited the registered office and looked at three care plans and associated records such as daily notes and medication administration records, three staff recruitment files, the training matrix, records relating to quality assurance and audits, policies and procedures and records of accidents and incidents. We spoke with two people who used the service and three relatives of people who used the service. We also spoke with three members of care staff, the manager and the nominated individual, who was involved in the day to day running of the service.

The registered provider had been asked, during December 2015, to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR had not been returned by the registered provider to CQC so could not be used to inform the inspection.

Requires Improvement

Is the service safe?

Our findings

A relative told us, "It's a lot better now. There are two staff at each call and they're always there on time now. I ring to check sometimes. It's improved. Yes, it's safe." This relative also told us there had previously been an issue that staff had not been wearing uniform or carrying identification badges. However, they said this issue had been resolved and staff now always wore uniform and carried identification.

Another relative told us, "They came to look at our equipment to make sure it was safe. They assessed it to make sure staff could use it." This relative also said, "They're always on time. They used to be late, but now it's better with just Elite."

A person who received care and support from the service told us, "They come on time."

Staff had been trained and understood appropriate policies and procedures in relation to safeguarding people. All of the carers we asked told us they had received safeguarding training and they were able to demonstrate an understanding of different types of abuse. Staff were aware of signs that may indicate someone living in their own home, or in the community, may be at risk. Staff and the manager were able to explain what they would do if they had any concerns that people were at risk of abuse. Appropriate referrals had been made where any concerns were raised. This showed people who used the service were protected from the risk of abuse, because staff were aware of their responsibilities in keeping people safe.

We saw where concerns had been raised in relation to a potential safeguarding occurrence, a log had been kept by staff, detailing issues and actions taken. This was then appropriately referred to the police and the local safeguarding authority as appropriate. This demonstrated staff took appropriate action to safeguard people from abuse or harm.

The nominated individual was clear that staff would encourage people to maintain their independence, whilst minimising risks where possible. We were advised that, when a person began to use the services of Elite Staffing UK, the manager or care coordinator would visit the person in their own home and assess the risks to the person, to staff and consider environmental risks.

One person's care plan contained risk assessments which related specifically to the person. For example, an assessment of risk and actions staff should take in relation to the person's pet. This person also had a completed moving and handling risk assessment in their care plan, detailing the equipment the person used. However, one of the care files we sampled did not have appropriate risk assessments completed. For example, forms were available in the file which related to risks inside the home, outside of the home, bathing and stairs for example. However, these risk assessments had not been completed. There was a template for a moving and handling risk assessment but this had also not been completed. A risk assessment in this person's file stated, 'will let anyone in who says they are official. Very vulnerable.' However, there were no details to show how this risk could be, or was being, reduced. This meant people could be at risk of harm because risks to some people had not been assessed.

We discussed this with the manager and nominated individual, who advised they were in the process of updating risk assessments and care plans and assured us this would be addressed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks to the health and safety of service users were not assessed and therefore the registered provider could not do all that was reasonably practicable to mitigate risks.

We saw staff took action to keep people safe. For example, a member of care staff had been unable to obtain access to a person's house when they failed to answer the door or respond to the carer. The carer identified this was unusual and was therefore concerned. Unable to contact family, the staff member contacted the out of hours service who advised the police should be called. The police attended and access was obtained. The person was unharmed. However, this prompted discussion with the person and contact was made with the person's social worker, and a key safe was then fitted, to enable staff to gain access to the person's property in the future. This showed the carer was aware of their responsibilities to take action to keep people safe.

The care plans we sampled contained important information relating to any relevant medical condition. This helped staff to understand people's individual health needs and provide appropriate support.

Accidents and incidents were reported and analysed. We saw actions were taken, for example a referral was made to a social worker and general practitioner when carers recognised a person was sustaining bruises due to an inappropriate walking aid. This resulted in new equipment being provided and the issue was resolved.

We found safe recruitment practices had been followed. We sampled three staff files and found reference checks had been completed from two referees. Identity checks had been undertaken and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We saw there was a staff disciplinary policy and this had been followed when necessary. This showed staff were clear of expectations and action was taken if the conduct of staff fell below that which was expected.

The staff we spoke with felt staffing levels were adequate to meet people's needs and they felt the care and support was well organised.

Some people were supported to take their medicines. We looked at some medication administration records (MARs) and at the medication policy which stated, 'Timing and adherence to prescription instructions must be followed. This must be clearly indicated on the MAR and in the care plan.' The MARs we checked from October 2015 to February 2016 did not record the time the medicine was administered. Furthermore, the name of the medicine was handwritten on the MAR but without information such as dosage and frequency being included. This put people at risk of receiving incorrect doses of medicines at incorrect frequencies.

From checking the records, one of the medicines had previously included a warning label stating, 'Do not take with any grapefruit product.' However, as the medicines were being handwritten on the MAR, the most up to date records did not have this information recorded. This could mean staff were not aware of potential hazards relating to medicines.

Some of the MARs we looked at had not been signed by the person administering the medicine. For example, on two dates in February 2016, the MAR had not been signed by the member of staff, yet they had

written in the daily log, 'Given medication.'

We discussed our findings with the nominated individual following the inspection and highlighted the safety risks this presented. The nominated individual was receptive to this and agreed to address this issue and consider staff training in relation to the administration of medicines immediately following the inspection. The examples above demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff did not follow policies and procedures and this meant medicines were not safely and properly managed.

Staff told us they had access to personal protective equipment such as gloves and aprons. We asked the people we spoke with whether staff demonstrated good hygiene and whether they wore protective equipment and people confirmed this was the case. A relative we asked told us staff wore protective equipment when providing care to their family member. This demonstrated good practice and helped to prevent and control the spread of infection.

Requires Improvement

Is the service effective?

Our findings

A relative told us, "Staff are alright. They know what they're doing now." This relative felt the service had improved and become more effective in recent months.

Another relative said, "We always know who's coming. It's the same carer."

The nominated individual told us staff induction consisted of a weeks' training, including moving and handling practical and theory, medication training, first aid awareness, safeguarding and shadowing more experienced members of staff. The staff we spoke with confirmed they felt they had received appropriate induction to prepare them for their role and they had the opportunity to shadow more experienced staff. This showed staff had received essential training and information, prior to commencing their role.

The staff files we sampled showed staff had received training in areas such as dementia care, person centred care, equality and diversity, fire safety, first aid, food hygiene, medication administration, mental capacity, infection control and moving and handling. Training was completed by watching DVDs and knowledge was then tested afterwards. Although staff had completed the knowledge test, these had not been sent to the training provider in order for certificates to be issued. We saw records of two staff members who had completed training in some areas, such as medication administration, fire training and health and safety but, when they completed the knowledge check, they had not gained the required pass mark in order to be issued with a certificate. We highlighted this concern to the nominated individual who advised these staff would receive refresher training and retake their knowledge check. This meant that, although staff had received training, the registered provider could not be sure they had understood their training sufficiently to provide effective care and support.

A staff member we spoke with told us they felt they had received the training they required to perform their duties effectively. The staff member said, "I feel I have enough training. I would ask [name of nominated individual] if I felt I needed more support. I feel it would be provided." Another staff member told us they had asked for additional training in a particular area and this was provided.

The nominated individual told us, in relation to staff supervision, there was an open door policy and staff were able to raise any concerns at any time. However, formal one-to-one supervision had not taken place since the beginning of the year. The staff we spoke with confirmed they felt able to approach the nominated individual or the manager and they felt supported. However, this meant there was a risk that competence was not maintained because appropriate ongoing or periodic supervision was lacking.

We saw staff had received an appraisal within the last year. Items discussed at appraisal included the employees understanding of their key responsibilities and duties, which parts of the job they did well and whether any further training was required. Action plans resulted from appraisals. This showed staff performance had been appraised and training had been reviewed.

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.

We checked whether the service was working within the principles of the MCA. We saw most staff had completed MCA training. The staff we spoke with were clear that people could make their own choices and decisions. The daily communication logs indicated staff were aware people should make their own decisions. We saw some examples where staff had recorded when a person had declined support. Mental health assessment forms had been completed which indicated people had capacity to make their own decisions.

We found care and support plans had been devised with people and people had signed to show they consented and understood the care and support that was being provided. This ensured people were consenting to their care.

The nominated individual and manager told us they undertook regular quality assurance checks. They checked whether staff were on time and wearing their uniform and wearing their identification badges for example. The staff we spoke with also confirmed this was taking place. One member of staff told us they understood this needed to be done in order to make improvements to the service. We saw evidence of checks from February 2016, which checked time and attendance records, care plans, task lists as well as staff uniform and identification badge check.

Some people received support to eat and drink. The staff we spoke with told us people could choose what they wanted to eat and drink and the people we spoke with confirmed this. We saw staff completed food and fluid intake charts and returned these weekly to the office, with any issues highlighted. This showed people were receiving support with their nutrition and hydration needs.

People were assisted to access health care. For example, we saw staff had contacted a person's general practitioner and emergency services when they had chest pains. This showed people received additional support when required to meet their care and treatment needs.

Good

Is the service caring?

Our findings

A person who received care and support told us, "I'm happy with them. They're kind." This person also said, "They're very helpful."

One relative we spoke with told us staff were respectful of their family member and maintained the person's dignity. The relative told us, "[Name] seems comfortable. They know how [name] likes it."

Another relative said, "They don't rush [name]. They're caring. They know [name]'s likes and dislikes and know everything [name] needs." This relative told us that the positive relationship the carer had developed with their family member meant they opened up to the carer and would let them know if they were not feeling well for example, when they might not let their own relative know.

A member of staff we spoke with told us they enjoyed working with the people to whom they provided care and support. They said, "I get to know them. I like chatting while caring."

One relative told us English was not the first language of their family member who was being provided with care. However, the carers that provided support were able to speak the person's first language and this helped to build a positive relationship. This relative told us they and their family member had been involved in developing the care plan.

People had been supported to follow their chosen faith. A member of staff had assisted a person to attend a place of worship that was important to them. This showed people received support in terms of their cultural and religious needs.

Some of the people we spoke with told us carers helped them to access their local community. This helped to ensure people did not become socially isolated and were able to access people and places that were important to them.

We saw from the daily notes of one person that a carer had identified the person was unwell. The carer helped the person to prepare a hospital bag and accompanied the person to the hospital and had waited with the person until they were seen by a doctor at the hospital. This showed staff were caring and willing to be flexible to meet the needs of people.

A member of staff we spoke with told us they had built a bond with a particular person and they were pleased they were able to continue to provide support to the person.

We asked a member of staff how they ensured people's privacy and dignity was maintained. The staff member advised they would always ask for the person's permission before providing care and support, particularly in relation to personal care, and would respect the person's decision. The staff member was able to identify the importance of trying, as far as possible, to make the person feel comfortable by ensuring privacy, such as closing curtains and doors when appropriate. The people we spoke with felt their privacy

and dignity were respected.

Confidentiality was respected and we saw that new staff were issued with a confidentiality agreement which they agreed to and signed. This helped to ensure staff were clear of the need to keep personal data and information confidential.

Good

Is the service responsive?

Our findings

One person told us, "I tell them what to make. I can ask for things different. We get on well."

A relative told us, "They involve me and [name] in the care. They'll ask [name] where they want to go. [Name] chooses." Another relative said, "They make dinner and tea. [Name]'s able to choose what to eat."

We spoke to a person who had been assessed and for whom a care plan had been developed but they had not yet begun receiving the care and support. This person told us, "They asked what I wanted. They were here for a long time and left me some information. I'm sure I'll be safe in their hands."

We looked at three people's care plans and found they contained detailed information pertaining to the person and the support the individual required. Information was provided to carers, advising them what to do and how the person would like it doing. For example, one care plan stated, 'I am 81 years old. I live alone in my own house. I like to remain independent. For my breakfast I would like my carer to make me porridge or boiled eggs. Sometimes I will have a bun. I will let you know what I want each day. Please then clean my kitchen and prepare my lunch.' Another person's care plan stated, 'I self medicate so won't need help with this. I need to stay away from fatty foods due to my condition.'

Support plans provided a summary of people's needs in relation to mobility, mental state, medication, diet and fluid, personal hygiene and communication needs for example. These provided staff with clear information regarding the support the person required.

Care plans contained a section which showed the person had been involved in developing their plan. A section entitled, 'Service User's view of support needs' contained information such as the person's social history, social networks, former/current lifestyle, recreational activities, religion/culture and preferred activities. This helped staff to provide care and support that was personalised to individuals.

Care staff kept a record of daily communication and logs for people they supported and these were regularly returned to the office. A system had been introduced whereby any accidents or incidents or important information that needed to be highlighted was flagged with a particular colour. This helped staff to identify any issues that may need addressing. Information contained within daily logs was comprehensive and included information such as what the person had eaten, care and support that was provided and medicines administered.

The nominated individual told us care plans were reviewed every three months. We found two of the three care plans we viewed had been reviewed since January 2016. One of these reviews resulted in an additional member of staff being deployed to provide support to a particular person, due to their increased need. We spoke to a family member of this person who told us they felt this had had a positive impact on the care and support their relative received. This showed that, for some people, their care and support had been reviewed and changes were made where necessary. However, the third care plan we viewed had not been reviewed since January 2015. We raised this with the nominated individual and the manager, who advised

they were in the process of reviewing all care plans with people and we could see this was taking place.

People were given information regarding how to make a complaint. This was included in service user handbooks. We asked the people we spoke with whether they would know how to complain if they were unhappy with the service and they told us they would feel able to complain. A relative we spoke with told us they had made a complaint and this was dealt with appropriately and they were satisfied with the outcome.

Requires Improvement

Is the service well-led?

Our findings

There had been some changes to the organisation since the beginning of the year. The previous registered manager was no longer managing the service. There was a new manager, who had been in post since January 2016, but the manager was not yet registered with the Care Quality Commission. They advised they would be applying to become registered. The nominated individual for the service had become more involved in the day to day management of the service since the departure of the previous registered manager. All of the staff and people we spoke with told us the service had improved over the last few months.

A member of staff we spoke with told us they felt much more supported following the recent changes to the organisation and they felt able to approach the nominated individual and the manager of the service. This staff member felt that relationships between carers and management had improved.

A relative we spoke with said, "The office staff are helpful. I don't have any problems and if I did I'd just ring them up." Another said, "They're good. They're helpful in the office."

A staff member told us, "It feels settled at Elite now. I like it." This staff member told us the manager was supportive and they felt they could speak to office staff if they had any problems. However, the staff member also told us there had been some issues with staff pay and staff not being paid on time. We discussed this with the nominated individual who advised this had been a problem due to the recent changes in the business but this was in the process of being resolved.

Another member of staff said, "Staff in the office are very good. Any problems and they help. Even the manager asks how everything is."

We saw a certificate was displayed which had been issued by a registered charity, confirming the charity would continue to work with Elite Staffing UK to provide volunteering, work experience and employment/apprenticeships opportunities to learning recruited by the charity and Elite Staffing UK. This showed Elite Staffing UK was working in partnership with other organisations to provide opportunities for people to learn and develop.

The manager of the service explained their ethos was to ensure people were given as much choice as possible and care plans were developed with this in mind. A person we spoke with had recently had a home visit from the manager, in order to develop their care plan. They confirmed they wanted to keep their independence and felt they could make their own choices.

The manager explained that, once an initial visit had taken place and a care plan had been developed, the carer would be introduced to the person prior to the service commencing. The manager explained this helped to ensure staff and people who used the service were compatible and also provided reassurance to people so they felt safe.

The manager had begun to audit care plans. Some care plans had been recently reviewed and audited and this was ongoing, although not yet completed. There was no timescale for this to be completed and we therefore recommended the nominated individual and manager develop an action plan to ensure this work continues.

The nominated individual told us staff meetings were held weekly with the manager and office staff. However, meetings with carers were not held on a regular basis. We were told there was an open door policy and carers could speak with office staff and the manager whenever they wanted. Staff confirmed this was the case. However, staff meetings are an important forum for learning and information sharing.

People were given handbooks which contained important information relating to their service, such as the support provided, number of hours support which would be provided and the costs charged. People had signed the handbook.

We asked the nominated individual how people's views were sought. We were told this was done informally. No questionnaires had been sent to people and no formal meetings were held to obtain feedback about the service. It is important to seek the views of people using services in order to continue to make improvements and we highlighted this to the nominated individual and manager.

We looked at the policies and procedures in place at the service. We saw policies were in place and had been recently updated in relation to moving and handling, infection control, accident and incident reporting, health and safety, medication management and safeguarding for example. This showed the registered provider had appropriate policies in place.

The manager explained they had been looking to procure a new improved system for monitoring calls and organising the service. The systems being considered included an electronic system that would alert the office staff automatically if there were any late or missed calls, so office staff could investigate. This showed the manager was looking at ways to improve the service.

Although it was clear the new manager was making progress and looking to improve the service, we found management oversight was lacking. The new manager had begun to audit care plans, and we could see some plans had been updated and recently reviewed. However, the manager and nominated individual had not identified that some plans were lacking in risk assessments. Some staff training was in need of refreshing because staff had not met the pass-mark test following learning. Although staff felt the manager and nominated individual were supportive, there was a lack of evidence of formal supervision. Furthermore, although communication logs and MAR sheets were returned to the office, robust auditing would have identified there were some errors in the administration of medication. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have systems and processes in place to assess, monitor and improve the quality and safety of the services.

There is a requirement for the registered provider to display ratings of their most recent inspection. We saw the registered provider had due regard for the duty of candour and the most recent inspection report was clearly displayed.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not properly and safely managed and staff did not follow policies and procedures in relation to managing medicines. Regulation 12(2)(g). Risks to the health and safety of service users were not assessed and therefore the registered provider could not do all that was reasonably practicable to mitigate risks. Regulation 12(2)(a), 12(2)(b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have robust systems and processes in place to assess, monitor and improve the quality and safety of the services 17(2)(a), 17(2)(b).