Lowbirch Limited

Laurel Bank Support at Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 25 January and 1 February 2017 and was announced on both days. The service was last inspected June 2015 at which time they were found to be in breach of Regulations 12 safe care and treatment, Regulation 17 Good governance and Regulation 18 staffing. We found the registered provider had not made the required improvements and there were continued breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found there were additional breaches in regulations 9 person centred care, 11 Need for consent, 13 Safeguarding service users from abuse and improper treatment and regulation 19 fit and proper persons employed. This showed there had been a decline in the quality and safety of the service since our last inspection.

Laurel Bank Support at Home is a domiciliary care service offering care to people in their own homes. The service covers areas in both Tameside and Stockport and was offering support to approximately 104 service users at the time of the inspection.

There was no registered manager at the time of the inspection. There was a manager in post on the first day of the inspection; however they had left the service by the second day. 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.

Staff had undertaken mandatory training; however they were unable to demonstrate their knowledge and understanding of subjects including safeguarding vulnerable people from harm.

Risk assessments were not always in place and where they were they did not reflect the specific risk or the measures needed to minimise the risk.

Staff recruitment processes were not always in line with the organisations policy.

Medicines were not managed safely and there were poor standards of care for specific conditions including diabetes.

Staff were not well trained and supported to carry out their roles effectively.

The service was not working within the Mental Capacity Act 2005, and was not gaining consent from people for the care they received.

Whilst staff were kind and committed, they lacked understanding in relation to treating people with dignity and respect. Staff also confirmed they sometimes overstepped the boundaries of a professional carer.

Care plans were not person-centred and did not reflect the needs of people who used the service. There was

little evidence that care plans were reviewed.

There was no leadership in the service, which had been without a registered manager for a period of 480 days. There was no oversight or monitoring of the quality and safety of the service by the senior manager or registered provider.

The service was found to be in breach of seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff had undertaken safeguarding training, however they were unable to demonstrate their knowledge or understanding of their role and responsibilities in keeping people safe.

Risk assessments did not identify specific risks or show staff what measures were needed to minimise risks.

Medicines were not managed safely and people did not receive medicines as they were prescribed.

Is the service effective?

Inadequate

The service was not effective.

Staff were not adequately trained or supported to carry out their roles effectively.

The service was not working within the Mental Capacity Act 2005, and people's rights were not protected.

Records did not accurately show what or how much food and hydration people were receiving.

Is the service caring?

Inadequate

The service was not caring.

Staff were able to demonstrate they were kind, caring and committed to supporting people, however they also confirmed they sometimes overstepped the boundaries of a professional carer.

Staff were not all able to describe to us how they protected the privacy and dignity of the people they cared for.

There were no care plans which referred to people's preferences and wishes for the end of their lives.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not person-centred and did not contain all the information which would be needed to meet people's needs.

There was little evidence that care plans were reviewed to ensure they were current and reflected the needs of the person about whom they related.

Complaints were recorded and whilst there was some evidence of actions having been taken, there were no supporting documents to show that an investigation had taken place, nor were there copies of responses to the complainant.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership in the service. The registered provider had not carried out regular checks of the service to ensure the service was of good quality and safe.

There were no robust processes in place to monitor the quality and safety of the service. The one process we saw was ineffectual as it was not correctly carried out.

Records were of poor standard and did not reflect the support which had been given. Policies were out of date and key information was not always included. The service was not operating in line with the organisational policies which were in place.

Laurel Bank Support at Home

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 checked 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 25 January, 1 and 17 February 2017 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 the office would be open and manned.

Prior to the inspection we spoke with the local authority commissioners and reviewed the Provider Information Return (PIR) which had been submitted by the service in September 2016. The information provided by the commissioning authority in the form of a contract monitoring visit report showed they had identified concerns about the running of the service and the quality and safety of the provision and had asked that action be taken.

The inspection was carried out by one adult social care inspector on the 25 January and 1 February and the Inspection Manager on the 17 February 2017. During the inspection we spoke with the registered provider, manager, the general manager, two care coordinators and four members of care staff. We spoke with six people who used the service via telephone to gather their views of the service. We reviewed the care records for five people who currently received support, the recruitment files for three staff, policies and procedures, complaints and compliment records, audits that had been carried out on daily records and medication administration records (MARs), quality assurance questionnaires and staff rotas.

Inadequate

Is the service safe?

Our findings

People who used the service told us, "I do feel safe when my usual carer comes", "I usually get the same carer, they do sometimes come very late, and they don't let me know."

At our last inspection in June 2015 we found the service was not managing medicines safely. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made the required improvements and we found continued breaches of the regulation.

We reviewed the risk assessments which were in place in people's care files. We found that risk assessments were not always in place where they needed to be. For example we found one person with complex needs, who was being assisted with their medicines by care staff, did not have a complete medication assessment in place. There was no information about the medicines which were currently prescribed, no medical history and no record of whether the person had any allergies. We found another example where a person was assisted to have a bath. There was no information in their care records to show why they needed this assistance, and there were no risk assessments to ensure staff were clear on how they needed to be supported and to ensure this was carried out safely. For example we found an example of a person with poorly controlled diabetes, there was no risk assessment or instruction to staff to show what they should do to keep the person safe when their blood glucose levels were too high or low.

This was a continued breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We reviewed the medication administration records (MARs) which had been completed and returned to the office. We found the standard of recording on the MARs was very poor. We found the MARs were not filled out correctly as specified in the organisational policy and procedure, as there was incomplete information about the dosage and timing of medicines. There was no signature to show which staff had filled out the MAR at the beginning of each month when a new record was put in place. We found there were missing signatures throughout the records which had not been identified or addressed with the staff concerned. We found no evidence competency checks had been carried out to ensure care staff were competent to administer medicines to people safely.

This was a breach of Regulation 12 safe care and treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff we spoke with told us and records confirmed they had undertaken safeguarding training, this training was completed online. Staff were not able to explain to us what their role and responsibility was in keeping people safe. We saw there was a matter which was being investigated and followed up by the local authority safeguarding team that related to a person who had commenced receiving support from the service, however critical information about their care needs had been missed and the person had not received vital medicines for a period of several weeks as a result of this. We noted from the daily care records and medicine administration records we reviewed there were missed signatures, which would indicate

medicines may not have been given and in one case there was no record of one of this person's scheduled care calls having taken place. This meant the service was not recognising and reporting safeguarding concerns or taking action to keep people safe.

We asked to see records of accidents and incidents that had occurred in the service. However these were not supplied during or after the inspection. We noted that whilst there were references to significant incidents in daily care records, these had not been recorded and acted upon by the service and provider. For example we found an instance where a person had been found to be 'unresponsive' and emergency services had been called, the notes also referred to there being 'blood everywhere'. No further information was documented to confirm what action had been taken in response to ensure the safety of the person involved.

People we spoke with told us care staff were sometimes 'very late' and whilst they understood this was because of unforeseen circumstances, they told us the office did not let them know what was happening, and people found this stressful. One person told us, "There was a time when my regular carer was off, they missed the call, I rang the office and they said they would try to get someone to come; I told them not to bother as it was so late by then." We noted there had been some missed calls reported in the summer of 2016 and another in December 2016. We found records indicating other missed calls which had not been picked up or reported to the local authority.

This was a breach of Regulation 13 safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they had regular carers who attended their homes to support them. People felt at ease with these care staff and told us they knew them well.

We reviewed the recruitment files for three staff who had worked at the service for varying periods of time. We found that whilst the service had undertaken appropriate pre-employment checks including references and disclosure and barring service (DBS) checks prior to people commencing their roles, they had not continued to check the good character of staff by renewing their DBS checks every three years in line with their organisational policy. We found this to be the case in two of the three staff personnel files we reviewed.

We reviewed how staff performance and capability was monitored and acted upon where there were concerns. We found there had been issues identified with members of staff, however there had been no follow up or disciplinary action taken where they had continued to be in breach of the organisations policies and procedures, for example by failing to complete daily care records correctly.

This was a breach of Regulation 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the number of care staff who were employed by the service and how many hours of care they needed to cover. We found there were sufficient staff to cover the planned care hours, however some staff were working very long hours, which would mean that if they were absent for any reason there would be a significant number of calls which would need to be covered by other care staff.

Inadequate

Is the service effective?

Our findings

People we spoke with told us "I think the staff know what they are doing; they come three times a week and help me to shower and with my bandages."
At our last inspection in June 2015 we found the service was not giving staff adequate support as they were not receiving regular supervision or appraisals. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made the required improvements and we found continued breaches of the regulation.

Staff we spoke with told us they had an induction prior to starting work. Staff told us and records confirmed that the majority of the training they received was 'online training'. There were practical sessions carried out by senior members of staff in the organisation's residential services in administration of medicines and practical moving and handling. We found from speaking to staff some of them had poor understanding of mandatory training for example safeguarding and person centred care, this meant they were not able to apply the training to their everyday practices.

Staff told us they were 'sometimes called in for supervision', but this was not regular or structured. Records confirmed this was the case. The service was not offering its staff supervision or appraisal in line with the organisations policy which stated supervision should be carried out a minimum of four times per year. Most staff were only receiving one supervision per year. We saw little evidence that senior staff were carrying out 'spot checks' to observe care practice and to identify any areas of concern or development. The manager told us on the first day of the inspection that they had carried out only one appraisal in the time they had been with the service which was a period of 10 months.

Staff we spoke with told us communication was an issue. For example staff described speaking to a members of the office team out of hours, staff told us there had been occasions where this had meant a message needed to be passed on to ensure action was taken, however staff told us the messages were then not passed on which led to things being missed.

This meant that staff were not suitably trained or supported to carry out their roles effectively; this was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that where care staff were responsible for the provision of meals and drinks as part of the package of care, the records did not detail what food and drink had been given and consumed, which meant it was impossible to know if people were receiving adequate nutrition and hydration until there was physical evidence such as weight loss.

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 found there had been no assessments carried out of Mental Capacity of people where there was reason to believe they may lack capacity, for example if they had a diagnosis of dementia. We found there was evidence that people were making decisions which may have a detrimental effect on their health and well-being which they may not have capacity to make and which may not have been in their best interests. We did not see any evidence that this had been recognised or any action taken to hold a best interest meeting with everyone who was involved in the person's care.

We looked at whether the service had sought and gained the consent of people using the service for the care they received. We found there was a service user agreement which was signed in most cases; however this was specifically a contract which referred to the financial arrangements and the cancellation rights of both parties. There was no consent to care document and care plans were not signed to show the person had agreed to their contents.

This was a breach of Regulation 11 need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from daily care records that emergency services had at times been called by care staff; however we did not see reference to accessing other health professionals for instance contacting people's general practitioners if people were feeling unwell.

Inadequate

Is the service caring?

Our findings

People told us they got on well with their care staff, and they were generally happy with their care.

Staff we spoke with demonstrated their passion for supporting people, and described care which was kind and sympathetic. People told us they were happy with their care staff and the level of support they received. However some of the staff we spoke with told us they were aware they 'probably overdo it' and felt the people they supported were like family and it is 'not just a job'. We were concerned that some staff did not understand the boundaries which needed to be in place to remain professional and were describing people they supported as friends or members of their families. We discussed this with the general manager who said they would address this with staff.

We found no information in people's care plans which showed any thought had been given to people's culture or spiritual needs, there was also no reference to other areas of people's lives which made them an individual and people's diversities had not been considered.

We saw no evidence that people who used the service were given the opportunity to be involved in the way in which they received care and support, for example people had not been consulted about the content of their care plans.

The service did not send out any newsletters or updates to the people who used the service of developments or future plans.

We reviewed whether people who may not be able to make decisions without support had access to an advocate. An advocate helps a person who needs support to make decisions and to communicate those decisions if they are unable to do so independently. An advocate can be a family member, friend or an independent person who is appointed. We did not see any reference to people having advocates even where there was evidence they lived alone and had reduced capacity due to their dementia.

Staff we spoke with were clear of their responsibilities to maintain people's confidentiality and were aware of the importance of keeping service users information secure. Staff were in some cases less clear about how they should maintain and promote the privacy and dignity of people whilst supporting them with personal care. People we spoke with however told us they were usually treated with dignity and respect by their regular care staff.

We found care plans did not contain information which would remind staff of the importance of encouraging people to do things for themselves or how they should maintain people's independence, and staff did not reference the importance of maintaining people's independence when we spoke with them about how they supported people.

We did not find any information contained in any of the care plans we reviewed in relation to people's wishes for the end of their lives. We discussed this with the general manager who told us staff found this a

difficult subject. We explained that it is important to gain this information from people whilst they are able to give their preferences to ensure people's wishes are met.

Inadequate

Is the service responsive?

Our findings

We reviewed the care plans for five people who were using the service. We found that care plans were not person centred and did not contain up to date consistent information. We found key information which had been supplied by the commissioning authority had not been identified and was missing from care plans. For example, in one case a key function of the care and support was the monitoring of the person's blood glucose levels as they were diabetic. This had been missed and the person had not received treatment of their diabetes as a result.

We found there was conflicting information in care plans, as different sections of the plans contained differing information. For example, in one person's profile their diagnosis of dementia had not been included; however this was contained in other sections of the file.

We found there was very little information about people's lives in their care plans, and in some cases the history contained a single sentence for instance "no family locally, friend supports". We found care plans were task led and did not contain information about the preferences, likes and dislikes of people. For example, where care staff supported people with meals there was no information about the foods they liked and disliked. There was no reference in care plans to people as individuals or detail as to what made each person unique, this meant care staff had little information available to them from which to build conversation which was relevant to people.

We found there was little evidence that care plans had been reviewed to ensure they were current and accurately reflected the needs of people using the service. People we spoke with told us they were not asked to be involved in the planning or review of their care, and most people told us they did not know what was in their care plans. We saw no evidence that people, their relatives or advocates had been invited to be involved in the creation or review of care plans.

We saw there was an instance where it had been identified during a safeguarding investigation that care plans needed to be updated and improved, this was dated November 2016. On the first day of our inspection there was no evidence this work had been carried out, we discussed this with the general manager and by the third day of inspection were provided with an updated copy of the person's care plan

We reviewed the way in which complaints were recorded, investigated and responded to. We found there had been five complaints recorded in 2016. These complaints related to late calls, care staff not staying for the full duration of calls, dissatisfaction with care standards and medicines being left out for a person to take after the care staff had left. We saw that whilst there was some record of remedial actions being taken, there was no evidence of investigations having taken place, or that formal responses to the complainants had been provided in line with the organisations' policy. This meant it was unclear how complaints were being responded to.

This was a breach of Regulation 16 Receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Inadequate

Is the service well-led?

Our findings

in place to ensure they were monitoring the quality and safety of the service. We found this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made the required improvements and we found continued breaches of the regulation.

The service did not have a registered manager at the time of the inspection. There was a manager who had been in post since March 2016 and was responsible for the day to day running of the service on day one; however they had left the service before we returned on the second day. There was a general manager and the registered provider in the senior management team for the service.

The service had been without a registered manager for a significant period of time, this had led to inconsistent management and a decline in the quality and safety of the service. People we spoke with told us they did not know who the manager was, and did not know their name.

Staff told us they felt there was a good sense of morale and teamwork, however when asked to explain how they worked as a team staff told us they spent most of their time working in isolation and reported there were few opportunities to come together, for example staff meetings. One member of staff told us "I only see office and other staff when I come in for occasional staff meetings, we don't get any newsletters of anything."

We found there was a lack of leadership in the service, and issues which had been previously identified by the general manager, the commissioning authority and the Care Quality Commission had not been addressed such issues included the way in which rotas were being managed and the use of the electronic call monitoring system by care staff. In addition to a lack of improvement we found there had been a deterioration of the quality of care and safety in the service. We discussed the concerns we had with the general manager who told us neither they, nor the registered provider carried out any formal auditing of the service. Whilst they felt they had asked the manager to provide them with information about the quality and performance of the service, when this had not been supplied no action had been taken to address this shortfall. This meant the registered provider and general manager had not had oversight of the service for a considerable period of time.

We found the culture was not open and transparent and challenge had not been given where it had been needed from the general manager and registered provider, which had allowed the service to decline and put people at risk of harm.

We found there had been notifiable incidents that had occurred which had not been identified or reported to us or the local authority safeguarding team, this meant the service was not meeting the requirements of their registration

This was a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009.

We found the only process which had been introduced to monitor the quality and safety of the service was in relation to auditing the daily care records and medicine administration records (MARs) which had been returned from people's homes. We found this process was not effective as the audits were not being carried out appropriately. We found multiple instances where the form stated the records were complete and there were no issues, yet we found missing signatures from MARs and daily records which were of very poor standard and not compliant with basic standards of regulation. For example, entries which did not include time of arrival and leaving, records were not written in black ink and there were records which did not reflect the support given during care visits. There were no other audits or processes in place to monitor the service.

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