Celtic Care Services Limited

Celtic Care Services Ltd (Swindon)

Inspection report

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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

We inspected Celtic Care Services Ltd (Swindon) on 23 August 2016. Celtic Care Services are a domiciliary care agency based in Chiseldon near Swindon. The agency provides support and personal care to people living in their own homes. At the time of this inspection 57 people were supported by the service.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The systems to monitor and improve the quality of the service provided were not always effective. There was lack of evidence that the registered manager ensured people's feedback was acted upon.

People did not always receive effective care due to communication barriers they experienced with the staff. People and relatives told us they found it hard to communicate with the staff and told us there were situations when the staff were not unable to understand when a person was for example in pain.

There were risk assessments in place for people who used the service, but we found not all risks had been fully assessed and recorded. Some risk assessments were not personalised and did not reflect people's needs. The provider's systems for management of documentation around medicine management were not robust. Staff did not have enough guidance on how to support people with administration of prescribed creams.

There were systems and policies in place to protect people from the risk of harm. Staff were aware of their responsibility to report any signs of abuse. People and their relatives told us staff treated people with dignity and respect. People told us staff were caring in their approach. Staff worked with other healthcare professionals to support people to maintain their health and wellbeing.

There were enough staff deployed to meet the care needs of people. The recruitment process ensured that staff were checked and were suitable to work with vulnerable people. Staff received training appropriate to their roles and they were aware of people's individual needs. Staff felt supported and received one to one meetings with their line manager.

Staff were mostly knowledgeable about and followed the requirements of the Mental Capacity Act 2005 (MCA). This protected the rights of people who may not be able to make certain decisions themselves. People told us their consent to care was sought by staff and they were involved in making decisions about their care.

People's needs were assessed prior to commencement of the service. People's care records contained details of people's personal preferences, wishes and how they wanted to be supported. The provider had a

system in place for responding to people's concerns and complaints. People told us they knew how to make a complaint.

We found two breaches 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 this 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.

Risks to people's well-being were not always recorded or personalised in relation to people's individual needs.

The provider's medicines management systems were not always safe.

Staff were aware of their responsibilities how to keep people safe and how to recognise and act upon signs of abuse.

There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always experience effective care due to communication issues with staff.

Staff were aware and followed principles of the Mental Capacity Act (MCA).

People were assisted to access health services and meet their nutritional needs.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

People's dignity and privacy was respected.

People told us their independence was promoted.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in care planning process.

People told us they received support in a way they wanted.

People knew how to complain and were confident any concerns would be appropriately responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager did not have comprehensive systems to identify concerns at the service and drive improvement.

There was no evidence people's feedback was acted upon.

Staff knew how to raise concerns.

Celtic Care Services Ltd (Swindon)

Detailed findings

Background to this inspection

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

This inspection took place on 23 August 2016 and was announced. We told the provider two days before our visit that we would be coming. We did this because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be in. The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). The provider had completed and submitted their PIR. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. We also contacted the local authority commissioners of services and to obtain their views on the service.

We contacted eight people and three relatives to obtain their feedback about the service. We also spoke with seven care workers, the care co-ordinator and the registered manager. We looked at six people's care records, five staff records including training and recruitment information and a range of records about how the service was managed.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. Comments included: "I feel very safe with them, I can't fault them, very safe" and "I feel safe with them because they follow the rules". One person's relative told us "My [person] feels safe".

Staff we spoke with were aware of safeguarding people and their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to the office. One staff member told us, "I'd report to the office and document what I saw". Another staff member said, "If I suspect abuse I'd text my manager and give social services a call".

People's individual risks in relation to their mobility or individual conditions related to skin integrity were assessed and recorded. We however found these were not always personalised or reflected people's needs. For example, one person was cared for in bed. They were assessed as at high risk of developing a pressure ulcer. Their assessment contained a number of actions on how to manage this risk including 'ensure customer mobilises regularly during the visit'. Two more people had been assessed as at low risk of developing a pressure ulcer however, the management plan recorded was identical to the one recorded for the person who was assessed as at high risk. This meant the measures introduced to manage the risks identified did not reflect the individual level of risks for each person therefore could be ineffective.

We also found some risk assessments were not completed. For example, one person's care plan reflected they used fluid thickener in their drinks but there was no risk assessment for this. When we raised this with the staff they told us the person's family provided all drinks. However records showed staff supported the person with taking their medicine which included providing a drink. When we asked the staff about this they told us, "[Person] doesn't like thickened fluids (water) for when [person] takes medication". There was no risk assessment in place and no evidence this risk has been assessed and discussed with the person. This meant there was a potential risk the person could choke and there was no guidance for the staff how to act in such a situation.

People told us they received their medicines when required. One person told us, "They are pretty good with giving me my medication". Another person told us, "They help me with medication from a dossette box". Staff received training in medication management and told us their competencies were monitored. One staff member told us, "I've had medication training, the records are not a problem and my competency has been checked". Another staff member told us, "No worries helping with medicine, they check me regularly".

We however found the records did not always reflect people's needs around medicines management. For example, one person's care plan read "Please prompt my medication four times a day". This person's assessment received from social services stated the person was to be 'assisted' with medication as they were 'at risk of mismanaging their medication'. The person had a medication risk management profile in place which said the person was 'unable to manage medication' and it was recorded 'carers to administer medication'. We checked the provider's medicines policy and the policy did not specify the difference between prompting and administering of medicines. There was no clear guidance for staff in relation to the

difference between assisting a person with their medicines and prompting a person to take their medicines. This meant the person could be at risk of not receiving their prescribed medicines.

We also identified the records around people's prescribed creams were not always fully completed and did not provide the guidance for staff. For example, one person's care plan read they needed a cream to be applied to their skin. When we checked this person's Medicines Administration Records (MAR) we noted the staff recorded another cream had been applied to different parts of the person's body than specified in the care plan. The provider used their own templates of 'Creams Application Records'. These gave no directions about how often or where to the person's body creams should be applied. This meant there was a potential risk of people not receiving their creams as prescribed.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient staff to meet people's needs. For example, where two staff were required to support people this was maintained. The registered manager told us staffing levels were set by the 'Dependency needs of our clients'. The service used an electronic system to monitor support visits and the system raised an alert if staff were identified as being late. This enabled the service to inform the person, contact staff and make alternative arrangements as required maintaining people's safety.

People told us they felt there were enough staff to meet their needs. Comments included; "I have enough staff I feel lucky to have them", "We are lucky to have the same staff" and "They come on time if anything they come early". Staff told us they felt there was enough staff however it was a busy time. Their comments included; "There is enough staff but the past couple of weeks have been tight. I think it is because of holidays. I'm really busy at the moment" and "I think there's enough (staff), we're a bit busy with holidays but we are ok".

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

The service recorded incidents and accidents and took appropriate action to prevent future re-occurrences . Blank accident forms were available in people's files. Records showed nine incidents were recorded this year and appropriate action had been taken when required. For example, one person had slipped but did not fall whilst receiving personal care. Staff reported the incident and the person was referred to an occupational therapist.

Requires Improvement

Is the service effective?

Our findings

People we spoke with raised no concerns about staff knowledge in relation to their training however they raised concerns around staff competencies in relation to communication difficulties. People referred to the language barrier they experienced when communicating with the staff.

Comments included; "It can be hard with the language barrier. I had pain in my body once and they did not understand me", "The staff cannot speak English and they don't understand what I am saying. They don't understand the equipment and I have to explain it to them", "It is difficult to understand them and they do not understand me. That is hard. It would be better if they could speak English before they come. Communication is hard, definitely" and "Some speak better English than others, so it can be a bit of a problem". This meant people did not always receive effective care and support.

People also felt they were not always able to have meaningful interactions with staff due to the language barrier. One person said, "It is hard to have a chat with the ones who are from abroad but we do try". Another person told us, "It's not their fault they just don't understand so it can be difficult". One person's relative also told us, "They (staff) are all very lovely but with some of them their command of English varies, it does concern me, if there was a problem and doctor (was needed) or something".

Staff also told us they found the language barrier difficult. One member of staff told us, "This is a big problem as some foreign staff do not have command of the English language. I've been out with staff where they cannot understand the client. I would say over 50% of our foreign staff have this problem". Other comments from staff included; "I had clients complaining, some (staff) don't listen and don't understand" and "Lots of my colleagues do have problems with English. Quite often I hear two poor English speaking care workers are put together and this is not good". One person told us they experienced staff talking in their own language. They said, "If they talk their language to each other they explain that they are not talking about me but talking about work".

We asked the registered manager about concerns raised by people and staff about the language barrier. They said "We conduct interviews where we check their English. We only recruit staff who can speak and write English". We had some communication difficulties whilst speaking with staff. One member of staff we spoke with, when asked what training they completed, was not able to recollect much. They pointed out at the stack of training DVDs and told us, "Done all these". They were however not able to recollect the names or the content of the training and had difficulties in understanding some questions.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received an induction and completed training when they started working at the service. The induction training was linked to 'Care Certificates', a recognised set of standards considered as a good practice. This training included fire, safeguarding, moving and handling and infection control. Staff also shadowed experienced staff members before working alone. Staff training records were up to date and

evidenced the staff training plan was ongoing. Any staff training required was highlighted with a planned date for completion. Staff complimented the training, one member of staff said, "I've done the care certificate. The training was good but like anything, it is not until you are actually doing the work that you really learn. I did shadowing and that helped". Another staff member added, "Induction was very good, it gave me confidence".

Staff told us and records confirmed staff were supported and received supervision in line with the provider's policy. Supervision is a one to one meeting with a line manager. Staff were able to raise issues and make suggestions at supervision meetings. For example, one member of staff had requested further training in dementia and this had been provided. Another staff member had requested to enrol for a nationally recognised qualification in care and they had received a level two award. Additionally supervision 'follow up' logs were maintained. These records identified any actions required as a result of supervision meetings and detailed when the action was completed. For example, one staff member requested a new uniform. We saw a new uniform had been provided. Staff practices were also monitored through spot checks.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People told us they were involved in making decisions about their support. Comments included, "They ask me what I want to wear they are pretty good like that", "They let me choose what I wear" and "They give me the choice of what I want to wear".

Five staff we spoke with demonstrated an understanding of the MCA and how they applied its principles in their work. Staff comments included; "This is people making their own decisions. I give them options, I'm not biased and I go with their preferences", "I support people to make their own decisions. I show them, make sure they understand and provide choices" and "If they have capacity I give them lots of options. If I suspect they don't I'd call the office". Two staff we spoke with were unable to explain the principles of the act but told us they knew how to involve people.

People were supported to meet their nutritional needs if required. Most of the people we spoke with were either independent with their meals or they had their families supporting them. One member of staff told us, "I prepare food for people and I only assist one person to eat. They are mentally very capable and they tell me what they want and how they want it".

People were supported to access health services when needed. People told us staff would assist them with arranging appointments. One person said, "I hardly ever need help with GP but they would help me if I needed". On the day of our inspection staff needed to ring the ambulance for a person who was unwell. One of the external professionals complimented the service for involving the external professionals when required. They commented "Good communication with applying for other health services".

Good

Is the service caring?

Our findings

People and their relatives complimented the caring attitude of the staff. One person told us, "They are very caring, if I have a problem with my leg, they help me". Another person told us, "They are caring towards me, they are polite and listen to me, I don't get anyone who is abrupt to me. I'm lucky I suppose". A person's relative told us, "They are all nice to [person] and know their needs. They do try their best". Another person's relative told us, "[Person] is easily pleased, likes some (staff) more than the others".

Staff were enthusiastic about their work and told us they found supporting people rewarding. Comments included, "I do have caring relationships. Clients are all different and if I hear something has happened to one of them I'll call the office to make sure they are alright", "I love this job. It is the people. I see the same people all of the time which is nice", "I definitely have good relationships. I've known most of my clients over two years. We always have a laugh. This is really rewarding work and I love my clients" and "You get fond of them (people)".

People's dignity and privacy was respected. One person told us, "I wash myself but they do treat me with respect". Another person said, "Most of the time they are caring and listen. We still can have a chat and a laugh. They are very good about dignity and respect no one has been rude to me". A person's relative told us, "From what I have seen they are caring and do listen to him and treat him with respect and dignity". Staff we spoke with gave us examples of how they promoted people's dignity. Comments included: "I draw curtains and shut doors. If family are around I make sure I keep things private", "I cover people up as much as I can and keep care private. I also involve them as much as possible" and "I knock on doors and give them privacy where ever I can".

People's independence was promoted and people's opinion was sought. One person told us, "They encourage me to get out of bed". Another person told us, "They encourage me to exercise and walk". A person's relative told us, "They are very good in getting [person] up and out for a walk". People's care plans highlighted the need to keep people independent. One person's care plan read, "Care staff need to give me more time to make my needs known".

Staff confirmed they were aware of importance of involving people. Comments from staff included, "I ask them (people), if they can't hear I show them" and "I just ask for permission every time. Simple". People's care plans highlighted the importance of involving people. One person's care plan read, "I would like staff to give me a shower or a wash, please ask first".

People were cared for by the staff that knew how to maintain people's confidentiality. A member of staff told us, "We don't speak about work or me". Another member of staff told us, "We don't discuss people's issues with others". People's care files and records were kept in their homes. Duplicate records were kept securely in the provider's office.

Good

Is the service responsive?

Our findings

The provider had systems in place to ensure they engaged with people to assess their needs before they were supported by the service. People's personal details were recorded and included their health needs, preferred names and preferred times of visits. People's care documentation contained information about the level of support required on each visit and guidance to the staff how to best meet their needs. Where applicable people's files contained assessments received from social services.

People's records gave details about their wishes and preferences. For example, one person's care plan read, "I'd like carers to leave bathroom tidy", "I need time to reply to any questions, I have good memory" and "I'd like my carer to allow me to choose something to wear from my wardrobe".

People's feedback confirmed people were involved in setting up and reviewing their care plans. One person told us, "Originally I was involved making the care plan". Other comments included, "I was involved in making my care plan" and "We have had a review a couple of months ago, they are done every six months".

People told us the service responded well to their changing needs. One person told us, "They do give me the care that I need and want". Other people told us, "They know what I need and do just that" and "I would say up to a point they deliver the service I need and want".

Staff we spoke with told us how they ensured people received a service which was individual to their needs and recognised every person's needs were different. Comments from staff included; "Each individual has different needs so I tailor the care to them", "Not everyone is the same. I get to know them so they feel as if they are the only person you care for. That's personal" and "Every client has their own needs, they are individuals".

Details of how to raise issues and complain were provided for all people and their families when the person joined the service. Details included contact information for the Care Quality Commission (CQC). The service had recorded three complaints in 2016. All the complaints had been dealt with compassionately and in line with the providers' policy. People told us they knew how to complain. One person said, "If I was not happy I would tell [name of the staff]. I have not made complaint. I did have to call [name of the staff] to find out where the carer was but it got sorted". Another person said, "If I was not happy I would call the office". One person's relative told us, "I was concerned as [person] didn't like one carer, they dealt with it". One of the external professionals told us, "When you identify something the managers are very quick to investigate and ensure the client is in a safe and supportive environment".

People's comments and compliments were recorded. The compliments folder held numerous positive comments about the service from, people, their families and in one instance from a hospice.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well-led and the provider's quality monitoring systems were not always effective. For example, we asked the registered manager how many missed visits had occurred this year. The registered manager said, "I think about eight". The registered manager could not provide us with details of exactly how many missed visits had occurred. We also asked what systems were in place to monitor late and missed visits collectively to look for patterns and trends. The registered manager said, "We don't do that. We investigate and resolve issues on an individual basis (after a missed visit had occurred). Records are produced at the other (sister) branch but not here". This meant the registered manager had no system of identifying any trends relating to missed or late visits or proactively monitoring these to prevent them from happening for people.

The registered manager had a matrix in place that showed when people's care plans needed to be reviewed. However, these reviews were not always completed. We identified two care plans where review dates were overdue. One person's plan was due for review on the 30 June 2016 and another on the 16 August 2016. Neither care plan had been reviewed as planned. The care plan audit had not identified these review dates had expired and no information was available when these would be reviewed. There was also no evidence of care plan audits in relation to the quality of the information contained within them. The issues related to care plans identified by us during our inspection had not been identified by the registered manager.

There were also no systems in place to monitor trends and patterns around falls, accidents and incidents. This meant the registered manager had no overview of these and was not able to use this information for continuous improvement. We spoke with the registered manager about this and we asked if they had systems in place to monitor these. The registered manager said, "I won't lie to you, no, I don't have any systems to do that".

Quality assurance surveys were sent out to people and their families annually. We saw the 2016 survey results which were positive, particularly in relation to care and staff. However, no evidence of any follow up actions resulting from the survey was available. For example, one question related to information sharing between the service and people and 57% of responses stated the service 'hardly ever' or 'never informed' people of any changes. The provider's overview of the survey reflected these results were worrying. However, we could find no details on how the registered manager intended to address this concern. The registered manager said, "I believe each result was dealt with by the nominated individual on an individual basis". The registered manager could not tell us what actions, if any had been taken.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was responsible for one more sister location based several miles away. This meant they divided their time between the two branches. Chiseldon office was manned by a care co-ordinator who was mostly available during the day unless an assessment was required to be carried out.

We asked people and their relatives about their views on how the service was run and their comments about the management. One person told us, "I have heard of the manager but not met him, nor has he contacted me". The feedback received from two people reflected people referred to the care co-ordinator as the manager and not the registered manager. Their comments included; "I have only met the [co-ordinator's name] once, she has not been back to visit or called me", "I am happy with [co-ordinator's name], I have not met her but we have had a chat and a laugh on the phone". One relative told us, "I am happy with [co-ordinator's name], she has called to enquire about my [person]".

The feedback received from the staff reflected the care co-ordinator was their direct line manager and the main point of contact. Staff praised their support, comments included; "Yes I get on well with my manager. She is a good manager and she's very supportive", "My manager is good, easy to talk to and she is really supportive. She makes you feel comfortable" and "Manager is very good".

Staff meetings were regularly held, learning was shared and staff could discuss and raise issues. For example, at one staff meeting staff discussed what they considered to be 'appropriate conversations' they could have with people. They emphasised ensuring people's personal information remained 'confidential'. Staff told us learning was shared through meetings, briefings and texts. Staff comments included: "We share learning through texts and at meetings", "We do share learning".

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff comments included: "I would report any concerns to the office or I can whistle blow or ring CQC", "I can whistle blow, call CQC in addition to telling the office". One staff we spoke with was not aware of whistleblowing policy but told us they knew where to find numbers to ring if they had any concerns.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and the registered manager did not have effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The provider and the registered manager did not always assess and mitigate the risks relating to the safety of service users and did not maintain accurate records in respect to the risks identified and care and treatment provided. Regulation 17(1)(2)(a)(b)(c).

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and the registered manager did not ensure there were suitably qualified staff to meet people's needs and to keep people safe. Reg 18 (1).