Springfield Home Care Services Limited

York Helpers

Inspection report

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Ratings

Overall rating for this service

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	
Is the service well-led?	Requires Improvement

Overall summary

The inspection of York Helpers took place on the 28 and 29 October 2014. This was an unannounced inspection to follow up previously identified breaches in regulations.

During our last inspection we found that the provider had failed to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued two warning notices for the following: Care and welfare of service users and Assessing and monitoring the quality of service provision. We found that the provider had made improvements in both areas although there was still further work to be done.

Previously we also issued three compliance actions for the following; safeguarding vulnerable adults from abuse, medication management and staffing. In line with the providers action plan these compliance actions will be followed up in greater detail at a later date.

York Helpers is owned and managed by Springfield Homecare Services Ltd. The service provides domestic help like shopping and cleaning and personal care like washing and dressing to people in their own homes. The service currently provides support to around a hundred and fifty people.

Summary of findings

The service does not have a registered manager although a new manager has been appointed since our last visit. 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.

We found that records required to ensure that people did not receive inappropriate care or treatment were poorly completed. They were not up to date, did not reflect people's current care needs and were not being reviewed and updated. You can see what action we told the provider to take at the back of the full version of the report.

We found that staffing numbers had improved since our last visit and missed calls had reduced significantly. The majority of people we spoke with said that improvements had been made although people still raised concern about the lateness of some calls and the substantial use of agency staff so we will continue to monitor the provider in this area.

Although some improvements were evident in terms of staff training and supervision this work was still in the early stages and we will continue to monitor the service to see that progress continues.

People were positive about the care and support they received from their regular carers. We received lots of positive comments about the regular care staff. People told us they were treated with dignity and respect. People did raise concern about the use of agency staff and the difficulties they experienced because of this. They told us that they wanted regular care staff who knew and understood their needs.

The quality monitoring systems in place had improved since our last visit. However additional work was required particularly in relation to audits so that the provider can monitor and review the service they provide.

Two service managers had been employed and most comments received in relation to this were positive. However the overall care manager does need to apply to be registered with the Care Quality Commission.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Records were poorly completed and did not reflect people's current care needs.

Staffing levels were still impacting on the quality of care which people received although there had been significant improvements since our last visit.

Requires Improvement

Is the service effective?
The service was not effective.

Although some improvements were evident in terms of staff training and supervision this work was still in the early stages and we will continue to monitor the service to see that progress continues.

Requires Improvement

Is the service caring?
The service was caring.

Staffing levels were still impacting on the quality of care which people received although there had been significant improvements since our last visit.

People were positive about the care and support they received from their regular carers. People told us they were treated with dignity and respect.

Requires Improvement

Is the service responsive?
Not looked at during this inspection.

Is the service well-led?
The service was not well led.

There was no registered managed in place although new managers had been employed.

The quality monitoring systems in place had improved since our last visit. However, additional work was required particularly in relation to audits so that the provider can monitor and review the service they provide.

Requires Improvement

York Helpers

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 follow up previously identified non compliance which had resulted in enforcement action being taken against the provider.

This inspection took place at the agency on the 28 and 29 October 2014 and was unannounced. We also carried out thirty telephone interviews over a two week period to people and/or their relatives and we spoke with 6 staff to seek their views.

The inspection team consisted of two inspectors. Prior to our visit we spoke with Commissioners from City of York Council and the Clinical Commissioning Group (CCG).

We spent two days at the main offices of York Helpers, speaking with the general manager, care manager and also the operations support manager. We looked at a range of records which included 6 care records, 6 medication records, 6 recruitment files, 3 sets of October staff meeting minutes, the staff training matrix and the complaints, safeguarding and incidents log.

Requires Improvement

Is the service safe?

Our findings

During our previous visits to the service in July and August 2014 we found that people were not kept safe as the provider did not have effective systems in place to recognise and report any potential abuse, which included neglect. The provider did not have a system to manage accidents and incidents and to learn from them. This meant that people were not protected from avoidable harm. We issued a compliance action. Although we looked at some aspects of this outcome under the 'Well led' domain we will be following this up in more detail during future inspections of the service in line with the providers action plan.

During this visit we looked at 6 people's care records. We found that people's care records still required additional review and development and that risks were not being appropriately identified or discussed. We found that people's records did not evidence that the risk of harm was regularly discussed with them so that risks were managed appropriately with them. This was needed so that their freedom and independence could be supported and promoted.

The problems we found breached Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

For example one individual had epilepsy. Their care record simply said "Call 999 in the event of a seizure." It did not record information about the type of seizure and staff had not received epilepsy training so that vital first aid could be provided in an emergency. We saw other examples where a risk may have been identified but no risk management put in place in response. This included an individual at risk of choking. There was no risk assessment available for this but in a summary of tasks 'Stay with 'X' while they eat.' We also saw evidence within daily notes where manual handling equipment was referred to yet when we looked at the manual handling assessment there was no mention of this equipment being in use. This meant that staff may not be providing care to people safely.

We also found other records; for example medication administration records were not completed properly and were not up to date.

During our last visit we found that people were not always kept safe as the provider had not ensured that there were sufficient staffing levels in place to meet the needs of people using the service. During this visit some people told us that staffing levels had improved. Others told us that York Helpers were still using high numbers of agency staff who did not know their needs. We discussed this with the new manager. She confirmed that there was a recruitment drive on-going. However, the agency were still struggling to recruit sufficient numbers of staff. Previously when we visited calls were regularly being missed leaving people in a vulnerable position. We spoke with thirty people about their experience. The majority of people told us that things had improved. They said that they were still receiving a number of late calls but said staff were turning up and calls were very rarely missed. However, other people told us that the late calls were impacting on them. This was particularly the case where people were reliant on staff to get them out of bed. One person said "I am in the same position from 10pm until the morning carer arrives. Sometimes this has been up to 11 hours. I am totally reliant on staff." Another person said "I am supposed to receive a call between 8 and 9am. Some mornings it is between 10 and 11am. I am unable to walk so have to lie there until someone comes." We shared this with the manager during the inspection as we were concerned that these people may be at risk.

Other people told us of the impact late calls had. One person said; "I have often had to cancel GP or hospital appointments as staff have been late. This has happened loads of times." And "I have had problems with staff not coming on time or not coming at all which is horrendous for us. The lunch call is usually ok but they come to do our tea call at 3:15 (less than 3 hours after lunch). We are not hungry then. They also come to do an evening bath at 5 instead of 6-630pm. Another person said "Missed calls have been worse these last few weeks. This impacts as I have bad arthritis and if I miss my bath then I am very stiff the next day. This has happened approximately four times now." This meant that people may not be receiving calls at the time they needed them.

Other comments from people included: "Staff have turned up late then wanted to come in and fill charts in. I wouldn't let them. They were not delivering care. However, since my review things have improved. It's difficult when we have agency as we have to explain everything to them."

Requires Improvement

Is the service safe?

We spoke with the manager about this who told us that they were in the process of risk rating their customers. She told us that this would ensure that those with the greatest need would always be a priority over someone who was less reliant. She also told us that the recruitment drive would continue so that additional staff could be recruited. We issued a compliance action for staffing during our last visit and we will follow up this area in more detail during our next visit.

In our previous visit we found that people requiring help with their medicines were not always kept safe because the provider did not have measures in place to ensure people received help and support at the agreed times when people needed to take their medication. This placed people's health and well-being at risk. Although we looked at some aspects of medicines management during this visit and identified concerns in relation to records, we will be following up this area in more detail during our next visit.

Requires Improvement

Is the service effective?

Our findings

While people's care needs were assessed before they started using the service, there was little evidence that these needs were being kept under review. For example we identified that some people's care needs had changed, but their records had not been updated to reflect that change. The lack of up to date records increased the risk of people receiving inappropriate or unsafe treatment. We also found that people were not always matched to suitable staff to ensure they were compatible. Examples of this included people with epilepsy who were supported by staff with no epilepsy training or those with memory impairment or a diagnosed dementia where staff supporting them had not received dementia awareness training. This meant that staff may not have the right skills and knowledge required to care for people appropriately. We discussed this with the manager who told us that a programme of training was being implemented for all staff. This training focused on key topics but it was hoped that in the longer term additional training which was more user specific would be provided.

We looked at the recruitment, induction, supervision and appraisal of staff. Supervision had recently commenced; however this meant that many staff had not received supervision on a regular basis. This was concerning as we had raised this with the provider in August. We spoke with staff and asked them if they received support. Comments from staff included; "I still feel that staff are not listened to. There are no staff meetings or supervision." "We used to have team meetings and get sent newsletters. This stopped but we do receive more information by post now. We are not there yet but things are improving." Most of the staff we spoke with said that the change in management was bringing about improvement but that there was still more to be done.

We looked at 6 staff recruitment files and found that they contained the required information for example a police check, two references and previous work history. Robust recruitment procedures help to protect people.

We asked people if they felt that staff communicated well with them. People who had regular staff said that they had no issues with the way their regular carers communicated. However people consistently raised concerns about the use of agency carers and the difficulties they had in communicating or making their needs known to those staff. This meant that people's care needs may not be met in the way they want them to be.

There was little evidence to demonstrate that staff knowledge and skills were being updated. We discussed this with the manager who told us that there were plans in place to look at the current training, update the training matrix and develop a longer term plan of training but this had not yet been achieved although training in safeguarding vulnerable adults and medication had commenced.

We looked for evidence to demonstrate that people were being asked to consent to any care which they received. We found that gaps were evident in care records to demonstrate that consent was being obtained. An example included people's consent to receiving medication from staff. Inconsistency means that consent may not always be sought.

Although people lived independently in their own homes, some people required support with preparation of their meals. We received mixed views about this aspect of peoples care. Some people felt that they were given choice and support in this area however others expressed concern regarding their call times and the impact this was having on their meals. An example was one person who said staff supported them with their meals and said that although their lunch call was at 12:30 their tea call was at 3:15 which was too early and meant that they were not hungry. The provider may need to look at how call times are agreed with people so that people receive the service they require.

Requires Improvement

Is the service caring?

Our findings

During our previous inspection of York Helpers we found that care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare. People expressed concern about the way they were cared for. They told us that staff were failing to turn up for their calls which meant their health and welfare was impacted upon. Due to the seriousness of these concerns we issued a warning notice. This was a follow up visit to check that the required improvements had been made. We found overall that although some improvements had been made to the quality and standard of care which people received, further work was required.

We spoke with thirty people and their relatives as part of this inspection. People told us that they received good care from their regular carers. Comments included; “In the main my relative receives the same team of staff. The staff really care they seemed really dedicated.” “The regular girls are brilliant and reliable. My relative needs people who know her and her needs. The regulars do their best to turn up on time, they are considerate and good with her. They sometimes send agency staff. I don’t want agency staff as it confuses my relative.”

Other comments included; “ I get good care and I think I am treated with dignity and respect.” “In the main they turn up on time, the staff care for me and keep me safe.” “I get a good service, it’s better now. I get a rota but not every week as sometimes they (the staff) are too busy.” “Generally Mum is well cared for. There are some good staff who are very keen. We have had a lot of agency carers. Mum does not like this and I told the agency that this causes distress to Mum.” “I have no complaints. The staff regularly turn up. The staff are like old friends.” “It’s been a bit better over recent weeks however my carer turned up late this morning and no-one rang me to warn me. My carer said that she contacted the office to ring me but it didn’t happen.”

During our last inspection we found that there was little evidence to show that in recent months the service had been consulting people about their care needs. This meant the service was not checking with people that they were still getting the care they wanted and needed. This increased the risk that people received care and support they neither wanted nor needed. Or indeed the care and support they received was no longer appropriate because their care needs had changed. People told us that they had a care plan, most of the people we spoke with said they had seen this. Those that hadn’t said they didn’t want to. One person said “I have a book which I have read (my care plan) I haven’t discussed it but I can read it when I want.” Another person said “I have a care plan, my daughter sees to that.” Although we saw some evidence of some care records being updated, others had not. This meant that people may not be experiencing their care in the way they want it to be delivered.

During our previous visit more than half the people spoken with told us they had had at least one missed visit. This was when a support worker had failed to turn up and people had been given no prior warning that they would not get the visit. Most had experienced this on more than one occasion. Some people were very angry that the service had become unreliable and they told us they had lost confidence in the agency's ability to provide good, safe care. During this visit nearly all of the people we spoke to said that carers were now turning up. They said that calls were still often delayed but that improvements had been made with reassurance from the new manager that these improvements would continue. We talked with people about the impact of these calls being late comments included; “I have previously had to cancel doctor or hospital appointments as staff were running late.” One person said “I had a review a few weeks ago. It has got better, previously staff were coming very late.”

The new manager told us that since our last visit significant time had been spent with the office staff to train and support them in the use of the care management system (used to record and book calls). They said they had focused on getting rotas drawn up and sent out to people and were making sure that any missed or late calls were recorded. The manager acknowledged that although things were not perfect substantial improvements had been made and would continue. The people we spoke with confirmed this. Comments included; "It has improved lately, it was dire", "It has improved a great deal. I get all of my calls now but sometimes I have to tell the agency carers what to do."

All of the people we spoke with during our visit said that they were treated with dignity and respect. Comments included; "The regular carers are caring and respectful", "I am treated with dignity and respect, yes." Some people raised concern about male agency staff members turning up to provide care. A large number of people supported

Requires Improvement

Is the service caring?

said that they had requested that agency staff were not sent to do their calls. They told us they found it frustrating explaining their care needs and wanted regular care staff who they knew and liked.

People were positive about the improvements which had so far been made; however they were universal in their feedback about the need for regular carers rather than agency staff. We spoke with some of the permanent care staff who told us they were on '0' hours contracts. They said they were not getting sufficient hours and in some cases told us that they were looking for alternate jobs. We have shared this with the managers so that this issue can be looked at in further detail and we will assess this further on our next visit to the service.

Although some improvements were evident in this area the agency has further work to do and we will continue to monitor the service to check that these improvements continue.

Is the service responsive?

Our findings

Not considered during this inspection.

Requires Improvement

Is the service well-led?

Our findings

During our last visit to the service we found that York Helpers did not have a robust way of monitoring how the service was operating. Senior management did not have systems in place to help them identify when things started to go wrong at the agency. They had failed to take responsibility for things that happened in the service. We issued a warning notice and this was a follow up visit to check whether improvements had been made.

During our last visit we found that the service did not have a system to learn from accidents, incidents, safeguarding concerns, missed calls and medication errors. There was no effective system to continually review these incidents. There was no evidence of analysis of these events, or action plans to show what the service was doing to minimise the risk of a similar event happening again. This meant there was no opportunity to learn from these events. During this visit we found that systems had been put in place so that incidents, accidents and safeguarding concerns were appropriately recorded with a log of any action taken. We were shown a copy of the complaints/safeguarding log. This recorded all concerns and clearly demonstrated the response made by the provider. In addition to these records, weekly reports collating any incidents, accidents, safeguarding or complaints were also forwarded to regional management so that they could review what was happening in the service.

During our last visit we found there was a lack of good leadership and management. There had not been a registered manager in post for more than 18 months. This meant the manager had not been assessed by CQC as fit and able to manage a care service. CQC took enforcement action in early 2014 about this matter. During this visit we found that two new managers have been in post for 3 weeks. One was employed as a business manager and the other as a care manager. The care manager is planning to register with the Care Quality Commission as the registered manager for the service.

During our last visit we found that robust quality assurance systems were not in place. This meant 'failings' were not identified at an early stage. There were no processes in place to develop best practice that could be used to enable the service to be continually improving. We asked to look at the quality monitoring systems currently in operation at the agency. Since our last visit the agency have supplied CQC with regular updates to demonstrate how they intend to bring about improvements at the service. We spent time with the new managers. Although there were lots of plans in place to implement a range of quality monitoring systems these were still in the early stages of development. For example a staff carer survey had been sent out and although the results had been collated, no action plan had been implemented to address the key themes and ensure that relevant improvements had been made.

Some customer meetings had taken place in individual's homes; particularly where concerns had been raised. However other people had not yet had meetings which meant that they had not had the opportunity to raise their concerns with management. We also found that although some care records had been reviewed and updated this was not consistent for everyone. This meant that records did not always reflect people's care need which may impact on the care being delivered.

The managers said that they intended to develop a newsletter to keep their clients up to date. All people had been written to, to advise of the changes in management arrangements. During our last visit people raised a number of concerns about missed calls and the impact this had on their care delivery. Since this visit the agency has now developed a complaints log which documents all concerns/complaints received and also records the action taken in response.

Weekly management reports were completed and they were sent to senior management so that these could be monitored. Managers confirmed that the quality monitoring systems were in the early stages of development and needed imbedding to see sustainability. They told us that staff had been given training in their data management system to ensure that rotas were completed and that staff were turning up to allocated calls.

We asked to look at a selection of management records which included meeting minutes, audits and supervisions records. Although some records were available for October there was a lack of general evidence to support the actions which senior management had taken over previous months other than the reporting which they had been doing to CQC and the LA. The managers told us they were clear of the risks and challenges but due to their recent time in post had not had sufficient time to address all of

Requires Improvement

Is the service well-led?

the concerns identified during our last visit. Audits on care records and medication were not available and we told the manager how important it was that these were carried out so that any shortfalls in the service could be identified.

During our last visit we found that the management team did not have systems in place to assess and monitor whether there were sufficient numbers of staff with the right competencies, knowledge and skills. This meant the service did not take timely action when these numbers started falling, which led to insufficient care workers being available for the people using the service. During this visit they told us they were recruiting experienced staff members who would then be able to provide support and guidance to new staff being employed. A recruitment drive was on-going and agency staff were being used until all the positions had been filled. Although we received positive comments regarding the permanent care staff in place, a number of concerns were expressed about the suitability of agency staff. We discussed this with the management team who told us that they trying their best to recruit more staff so that the number of agency staff in use was decreased.

The changes to the management team had led to the staff team losing confidence in the organisation. The effective processes that had been in place to support staff had lapsed. Previously staff told us they felt undervalued and demoralised. Supervision was not being provided. During this visit staff confirmed that supervision had commenced and the managers told us there was a plan to ensure that all staff received regular supervision.

We asked the agency about partnership working. Following our last visit there has been regular contact from the City of York Council and input from the Care Commissioning Group (CCG). Both agencies told us that York Helpers was working with them to bring about improvements.

Although it was evident that some improvements had been made since our last visit, the provider still had a lot of work to do. We will continue to monitor the service to check that improvements continue to be made.

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Records were poorly completed and did not protect people from the risks of unsafe or inappropriate care or treatment.**

This section is primarily information for the provider

Enforcement actions

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