C & S Homecare Ltd

# C & S Homecare Limited

**Inspection report**

113b Nottingham Road, Alfreton, Derbyshire DE55 7GR
Tel: 01773 836111
Website: www.cshomecare.co.uk

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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** |

## Overall summary

This was an announced inspection which took place on 6 and 7 January 2016. We gave the provider 48 hours' notice to ensure that the registered manager was available for our inspection.

We previously carried out an inspection on 14 July 2014 in response to concerns about the service. On that inspection, we found the service had breached three regulations relating to the delivery of care: Care and welfare of people who use services, assessing and monitoring the quality of service provision, and requirements relating to workers. On this inspection we found that the provider had made some improvements in relation to these breaches.

C&S Homecare Limited is a domiciliary care service registered to provide personal care to people in their own homes. At the time of our inspection, C&S Homecare Limited was providing a service to 46 people, 34 of whom received personal care. C&S Homecare Limited provide personal care to people with a range of health conditions, including physical disabilities, dementia, Parkinson's disease and diabetes.

The provider employed 27 staff and 26 staff were involved in providing personal care. There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

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 provider did not have a robust system in place to ensure that the quality of people's care was audited, and steps taken to improve the service.

Risk assessments were not always in place to enable staff to identify risks associated with people's care and take steps to minimise them.

There were enough staff available to meet people's needs, but people did not always receive care at the times they expected. Staff were given an induction, but were not always given the training they needed to meet the needs of people they provided care for. Staff supervisions and appraisals did not always take place as planned.

People were protected from the risk of abuse. Staff understood how to recognise suspected abuse and felt confident to report concerns. The provider had policies and procedures in place to support staff to report abuse or allegations of abuse.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005. However, not all staff had undertaken training in the principles of the MCA.

People were supported by staff to access healthcare professionals to maintain their health and wellbeing.

People felt supported by staff who cared for them, and who treated them with dignity and respect.

People knew how to make a complaint, and the provider demonstrated that they investigated, responded and took action to improve the service.

People who used the service, and their relatives, were given the opportunity to share their views on the quality of the service. The provider analysed this feedback to improve the quality of the service. However, the provider's quality assurance systems did not always identify areas of poor care.

On this inspection we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

# 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 consistently safe.

We could not be assured that people were supported to receive medicines as prescribed. Risk assessments were not always in place to enable staff to identify risks and minimise them. People felt safe, and staff knew how to take steps to protect people from the risk of abuse.

**Requires improvement**

**Is the service effective?**
The service was not consistently effective.

The provider did not always ensure that staff undertook training they deemed necessary to provide good care. Not all staff had received training in the Mental Capacity Act. However, people using the service had capacity to consent to their care, and staff understood the importance of obtaining consent.

**Requires improvement**

**Is the service caring?**
The service was caring.

People felt supported by staff who were kind, caring and who listened to their views and wishes. People were involved in making decisions about their own care. Staff treated people with dignity and respect.

**Good**

**Is the service responsive?**
The service was responsive.

People received care that was tailored to their needs and preferences. Staff knew when people's needs changed, and recorded this in care plans. People knew how to make complaints and felt that they would be listened to when they raised issues.

**Good**

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

The provider's audit systems did not consistently identify areas of poor care. Staff training, supervision and appraisals did not always take place as planned. People and staff felt able to make suggestions or raise concerns about the service to the registered manager.

**Requires improvement**

# C & S Homecare Limited

**Detailed findings**

## Background to this inspection

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

This was an announced inspection which took place on 6 and 7 January 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection team consisted of one inspector 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 our inspection we reviewed the information we held about the service including notifications the provider sent us. We spoke with the local authority commissioning team and Healthwatch Derbyshire. Healthwatch are an independent organisation that represents people using health and social care services. No concerns were raised by them about the care and support people received. We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

During the inspection we spoke with nine people who used the service and one relative. We spoke with the registered manager, who is also the owner and a director of C&S Homecare Ltd. We also spoke with three care staff and one social care professional. We accessed a range of records relating to how the service was managed. These included four people's records, three staff recruitment and training files, the training matrix for all staff, and the provider's quality auditing system.

Requires improvement

# Is the service safe?

## Our findings

We could not be assured that people received their medicines as prescribed. We reviewed the medicines administration records (MAR) for three people. These were not always completed correctly. For one person, there were gaps in staff signing for the application of a prescribed cream application. There were also gaps where tablets had not been signed for. For another person, we saw that their medicines had been not signed for on numerous occasions.

People told us they were responsible for their own medication, but that, where necessary, staff would remind them, or check that medication had been taken and sign the MAR sheet. Staff were knowledgeable about how to support people to take medicines as prescribed and in accordance with their care plans.

People did not always have risk assessments in place to enable staff to support them safely. One person did not have any information about the risks associated with their catheter care. The care plan directed staff to follow the risk assessment, but one was not in place. The same person was assessed at being at high risk of pressure sores, but there was no specific risk assessment or care plan to support staff to minimise the risk of these developing. The person and staff were provided with generic guidance on supporting people to maintain healthy skin, but this was not tailored to the person's individual needs. However, staff we spoke with demonstrated that they understood how to provide care and the risks associated with the person's catheter care and skin care. The registered manager acknowledged that there was no risk assessment for catheter care or skin care and assured us that a risk assessment would be carried out. This demonstrated the provider could not consistently protect people from the risk of avoidable harm.

Staff were knowledgeable about the risks involved in people's care, and could describe how the minimise risks to people. One staff member described how they would safely support a person to transfer from their bed to a chair using a hoist. Their description reflected the guidance and best practice that was in the person's care plan and risk assessment.

People were protected from the risk of abuse. People told us that they felt staff supported them to remain safe and free from the risk of abuse. One person said, "I think they're well trained – I've never felt unsafe, or that they didn't know what to do." Another person said, "I feel safe with them 110%. I never feel rushed by them – never, even if they are busy, they'll take their time with me."

Staff were trained and knew how to recognise abuse or suspected abuse. They understood the provider's policies and guidance on keeping safe from the risk of abuse and felt confident to raise concerns. They understood how to report concerns to the registered manager, and felt able to raise concerns with the Local Authority or CQC if this was necessary. One staff member said, "I've got to be vigilant to the risk of abuse for people. I would report, even if I wasn't 100% sure."

Staff felt confident to respond to emergency situations, and the provider had an on-call system so that staff always had someone to contact. The records we looked at supported this, and we saw where staff had contacted emergency services for people when this was necessary. The provider had a system in place for staff to report accidents, incidents and near-misses. We saw this was reviewed regularly and action taken where necessary.

People did not always had staff to support them at times when they needed. People said the provider communicated with them if staff were late, but had mixed views about receiving care at the times agreed with the provider. One person said, "They're always here within ten minutes either way of the time I asked for – I can't complain about that, can I?" Two people told us that staff did not have enough travelling time between visits. They felt this meant some staff were often late. A relative said, "They are very punctual – occasionally if they're delayed they'll ring and let us know. I can rely on these carers totally." Staff felt there were enough of them to be able to provide support to people, although they did not always feel they had sufficient time to travel between care visits. This meant there was a risk that people would not receive care at the time they needed it.

The registered manager told us, and records showed, that the provider would not offer a service to people unless they had sufficient staff to meet their needs. We saw that there was a protocol in place for staff to follow if they were running late for people's care, and this ensured that people knew what to expect if staff were late.

Requires improvement

# Is the service safe?

Recruitment procedures included checking references and carrying out disclosure and barring checks to ensure that prospective employees were suitable to work with people receiving care in their own homes. This meant that people and their relatives could be reassured that staff were of good character to support people with their personal care.

Requires improvement

# Is the service effective?

## Our findings

Staff told us that their induction and training was a mixture of online courses and shadowing experienced colleagues. They also had practical training in how to support people to move safely. Staff did not always feel that online training was effective. One staff member said, "Watching a video is ok, but you need practical training. I would have felt more confident with hands-on training." Another staff member said, "I prefer practical training to computer training." Staff told us that they could ask for refresher training and additional training. For example, one staff member said they had asked for extra training in caring for people at the end of life, and another had asked for training in supporting people with diabetes.

The provider did not always ensure that staff undertook ongoing training. Training records showed that staff had access to yearly refresher training in a range of subjects, including health and safety, infection control, first aid and risk assessment. However, records showed that staff were not always doing the annual refresher training. For example, one staff member's training record had no evidence that they had undertaken any training in infection control, risk assessment or person centred care. Not all staff had done safeguarding refresher training in the last twelve months. The provider could not demonstrate that staff were receiving their annual training which ensured that staff skills and knowledge were kept updated.

All staff had a probationary period before being employed permanently and undertook an induction period of training the provider felt essential. The Care Certificate is a set of standards that social care and health workers apply in their daily working life. It sets the new minimum standards that should be covered as part of induction training of new care workers. The Care Certificate was introduced in April 2015. All of the staff who started work after April 2015 had completed the Care Certificate as part of their induction training. Nine staff had a level 2 National Vocation Qualification in health and social care, and five of those staff were working towards a higher level qualification.

Staff confirmed that they had supervision, but did not always think that they got enough feedback to help them improve. One staff member said, "I don't get any feedback about my care skills – I would like this and feel I need this." The registered manager, and the supervision policy, confirmed that staff had supervision every three months and an annual appraisal. However, the records we saw showed that supervision did not always take place as frequently. For example, one staff member who started in July 2015 had no record of supervision until December 2015. Staff supervision records did not record whether any feedback had been given about performance. The registered manager confirmed that feedback was usually given verbally at the time it was needed, rather than being recorded in the supervision records. This meant that we could not be sure that staff were getting the feedback and support they needed to improve their care skills.

People were happy with the care provided by staff from C & S Homecare. One person described their care as, "Excellent, they're reliable and know exactly what to do." Another person said, "New ones are always trained well before they visit us." A relative said, "[Person] has a regular small team, likes most of them, and they fully understand his condition, and how [they] like things done."

The provider worked to match people with staff who had the skills and experience to provide them with good care. For example, staff who were new to the role would not be assigned to work with people with complex needs unless they had a period of shadowing more experienced colleagues first. The provider also carried out spot-checks on staff providing care. These checks looked at a range of care tasks, and whether staff supported people with dignity and respect.

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

All of the people receiving personal care were able to consent to this. People told us that staff sought their consent before carrying out personal care tasks. The care records we looked at had forms to indicate that people consented to the care package they were receiving. However, the records associated with documenting

Requires improvement

# Is the service effective?

people's consent were not always dated. We spoke with the registered manager about this, and asked them to ensure that records associated with consent were clearly completed and dated.

Staff understood that they could only provide care with people's consent. They also understood the principles of the MCA, and knew what to do if they were concerned about people's capacity to consent to care.

Good

# Is the service caring?

## Our findings

People felt supported by staff who were kind, considerate of their needs and feelings, and caring. One person said, "My two main carers are absolutely fantastic – they can't do enough for you, they've been really great to me." Another person said, "They're very good. They are always there for us if we need anything." A third person said, "I'm pretty happy with them – I'd recommend them. They treat me very nicely." A relative told us that staff listened to the person and provided support in a caring manner. For example, "They don't come in and take over, they listen to him, and are very respectful and kind to him. I've never heard them be rude to him."

Staff we spoke with felt that they cared for people and wanted to be able to make a difference to their quality of life. One staff member said, "I love developing relationships and trust with people. They need to be able to trust you to provide good safe care, and this takes time."

People were involved in making decisions about their care. Some people had chosen their preferred staff. One person commented, "[Registered manager] is good at matching carers with people – she knows who I'll click with, and who I won't." People's care plans contained information about their wishes and preferences as well as their assessed needs. One person's care plans had specific information about their morning and evening routines, and their preferences for how care should be given. For example, the way in which they liked staff to wash them.

One said they appreciated the continuity of care that they received by having a small team of regular carers. They said, "I've told them I don't want lots of people in and out – it makes you feel so vulnerable, so I appreciate them listening to me." Staff preferred to work with people to provide consistent and regular care, and said that the registered manager tried to ensure that people received care from the staff they wanted. The registered manager confirmed that this was the case. People were supported by familiar staff who listened to them and tried to ensure that care was provided in the way people wanted.

People felt that staff supported them to remain as independent as possible. One relative said, "They give [person] as much independence as possible. [Person] values that." One staff member said, "It's good when clients tell us what they want – they're in control and it enables them to remain independent."

People's care plans recorded details about their personal preferences for their support. This included information about what people were able to do for themselves, and what staff needed to support them with. For example, one person's records had detailed information about how to support them to get dressed, along with information on their clothing preferences.

Staff were knowledgeable about advocacy services and how they could support people to express their views about care. One staff member described how they would support people to access local advocacy services and demonstrated that they knew how to do this.

Staff treated people with dignity and respect, and understood how important this was for people. One staff member said that it was important to pay attention to small actions, "Such as putting a towel over a person when using the hoist to help them use the toilet, and giving people privacy." Another staff member said, "Dignity and respect is a big thing for me."

Staff respected people's right to confidentiality, but were also clear about balancing this with passing on information about risk or concerns appropriately. One staff member said, "We don't discuss one client with another, or say who you're going to see next. But if there is information about risk, I may need to disclose this."

Good

# Is the service responsive?

## Our findings

People received care that was tailored to their needs and preferences. One person said that their health was variable, so staff knew to offer more support on some days, and encourage independence on better days. Another person said that staff knew how they liked care to be offered, even when they felt unable to communicate this well. They said, "My carers know me so well they take one look at me and know how I am. One came yesterday, and said to me, "You're not very good, are you?" I don't like telling them, but they know how I like things done even when I feel too bad to tell them." A third person said staff will amend their personal care dependent on how they are feeling. They said, "At the moment my legs are too bad to get into the shower, so they give me a good all-over wash instead. They never let me down, and most are pretty good."

Several people said when their preferred staff were not available, their care remained consistent. People felt reassured they had support from the same staff and would be informed if their regular staff were not able to visit them. Staff told us they worked with the same people so they became familiar with their needs and preferences. Staff told us that there was a protocol to call the office if they were late or unable to visit people. We saw that the provider responded to those calls by contacting people to inform them and, where necessary, make alternative arrangements so their care needs were met. This meant people knew what to expect from the provider if their service needed to change.

Staff responded to people's changing needs by ensuring that their care plans were up to date and reflected their preferences and needs. Staff said that although the care plans had enough information, they also needed to get to know people and find out how they liked care to be provided. One staff member said, "I do talk with other staff about a client's preferences if I'm seeing someone I haven't seen before."

The provider demonstrated that they involved people in planning and reviewing their care, and we saw that people's wishes and preferences were documented for staff to be aware of.

People knew how to raise concerns and make complaints. They told us that they felt the staff and registered manager listened to them, and that any complaints or issues would be taken seriously and dealt with to their satisfaction. One person said, "I've known the managers for a long time. If there are any problems, which are rare, I ring them – communication is good." Another person said, 'I'd ring the office if I had any issues. I'm sure they'd sort it out.' A third person described a complaint they had raised which was dealt with to their satisfaction. They told us that staff had missed one care call, and said, "It was a one-off, I had just come back from holiday, and the message didn't get through to [staff] that I was back. They were very apologetic, and it's never happened since."

Staff told us that people were given a copy of the provider's complaints procedure. Staff understood how to support people to raise concerns or make a complaint. One staff member said, "I will talk to them about how this works and also suggest advocacy to support them." Staff said that people often raised small concerns about their care in conversation, and staff were clear that they needed to try to support people to resolve these. Staff said, "We need to listen to people when they say they're unhappy with something. [Registered manager] will try to change staff."

Records showed that people regularly contacted the office to raise concerns or issues with their care, and the provider sought to resolve these. For example, one person contacted the office to request consistent staff that they preferred. We saw that this person's preferences were met. Another person said they did not wish to be supported by a particular staff member, and the provider arranged for this to happen.

The provider regularly sought people's views about their care. One person said their care plans were reviewed regularly, and they viewed this as an opportunity to raise any concerns. Another person said that they regularly received questionnaires, saying, "They ask us to rate things from 1 to 5. I put on my last one that I missed my regular carer, who'd not been coming to me for a while. Ever since then I've had her back, so they do listen."

Requires improvement

# Is the service well-led?

## Our findings

The provider had systems in place to audit the quality of care people were receiving, but this did not always identify issues that would place people at risk of harm.

The provider did not audit the medicine administration records regularly, and relied on staff reporting any issues or concerns. MAR sheets have codes to allow staff to provide an explanation for medicines not being given as prescribed. These codes were not being used appropriately. There were gaps in the MAR records that meant the provider could not demonstrate that people had been supported to have medicines as prescribed. Evidence showed that staff were not reporting issues with medicines as the registered manager expected them to, and this was not being identified as an issue in audits. Information about risks associated with not taking medicines as prescribed and how staff should respond were not always dated. This meant there was a risk the information about what action staff should take was not up to date. There was also a risk poor practice around medicines could not be identified or remedied quickly. The monthly audits did not identify that some people did not have appropriate risk assessments in place. The provider was not able to demonstrate that staff training and supervision was consistently in place. Seven staff members were overdue for their planned supervision, and six staff had not had their annual appraisal in a timely manner. For example, one staff member had been due their annual appraisal in July 2015. Not all staff were trained in the Mental Capacity Act, and evidence showed that one staff member had not received any training in some key caring skills. The monthly audits did not highlight the need for training for staff, which meant we could not be sure all staff skills were up to date. We spoke with the registered manager about this, and they acknowledged the concerns we raised. They assured us that they would take steps to improve their auditing system.

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

People felt that the provider ran the service well, and they knew who the registered manager was. One person said that they felt because the registered manager had previously worked in care provision this made for better management, stating, “They understand the job – it makes a difference.” Another person said, “The owners are very good – they don’t make their staff do anything they wouldn’t do. They will provide care themselves if necessary. I think they’re good employers – I’ve never heard staff [have issues] them.” A third person told us, “I don’t think staff are praised enough by management. I think they should have a ‘Carer of the Month’ award, or something similar to encourage them.”

People and staff felt the registered manager and provider was very approachable. Staff felt supported by the registered manager and provider and felt able to raise concerns or make suggestions about the service. One staff member said, “If something’s not right, I’ll tell [registered manager] and she’ll listen to me. She’s very responsive.” Staff we spoke with enjoyed their work and were motivated to provide good care. One staff member said, “I’m very proud of what I do – it’s a privilege to look after people.”

The provider had effective ways of seeking feedback from people, relatives and staff about the service and acting on this. This was done through reviews of care, monthly audits of any feedback people had given, regular questionnaires to people, relatives and staff, and staff meetings.

The registered manager understood their responsibilities, including their duty to notify CQC of events as required by law.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance<br><br>How the regulation was not being met: The provider did not have systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (2) (a). |