Authentic Kare Company Limited

8 Wyndham Close

Inspection report

8 Wyndham Close
Oadby
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Tel: 01162927274

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

Summary of findings

Overall summary

We carried out the inspection on 17 February 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available. This was the first inspection of the service since it registered in January 2015.

The service is a domiciliary care agency that provides personal care to people in their own homes. At the time of our inspection 13 people used the service. The service is also registered to provide accommodation and personal care at 8 Wyndham Close and treatment for disease, disorder or injury (TDDI). Since registration in January 2015 the service has not provided TDDI or accommodation and personal care to people at 8 Wyndham Close. We did not inspect these aspects of the service.

The service had a registered manager. 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 registered manager had not ensured that systems or processes were in place to assess, monitor and reduce risks relating to the health, safety and welfare of people using the service. Accurate and complete records had not been maintained. This is a breach of Regulation 17 of the Health and Social Care Act (RA) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Staff understood their responsibility to keep people safe from harm and risk of abuse.

The service did not follow safe recruitment processes. We saw that there were occasions when the relevant pre-employment checks had not been carried out. The registered manager had not followed robust disciplinary processes.

Some people who used the service had their medicines administered by staff. People told us that they were happy that their medicines were being administered correctly and this was being recorded. However the medicines that people received were not clear in their care plans and medication systems were not monitored.

Risks associated with providing care for people in their own homes had not been formally assessed. Where people's conditions put them at risk of harm or their conditions deteriorated these had not been adequately assessed and measures had not been put in place to reduce the likelihood of harm.

People could not be assured that they would receive the care that they needed at the agreed times or for the agreed amount of time.

Staff had not received training prior to providing support to people to ensure that they could meet the needs of the people who used the service. Staff told us that they felt supported but they did not always receive formal supervision in line with the provider's policies. Supervision records did not consistently indicate if training or support needs were discussed.

Where people were likely to lack capacity to consent to aspects of their care and treatment, assessments had not been completed. Best interest decisions had not been made. Staff lacked knowledge and understanding of the requirements and their responsibility under the Act. Consent to care had been requested for people who had capacity to consent.

Staff were not always caring and communication between staff and people was not always clear. People felt included in decisions about their care. People's privacy and dignity was respected.

Some of the support that people needed was documented in the care plan in people's homes. Staff had access to these when they were providing care. Care needs were not always assessed fully, recorded or reviewed.

Complaints about the service had not been accurately recorded or acted upon. The registered manager sought feedback from people using the service but did not keep records to reflect this.

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 safe.

The service did not follow safe recruitment processes. Risks had not been adequately assessed and measures had not been put in place to reduce the likelihood of harm. The registered manager had not followed robust disciplinary processes. People could not be assured that they would receive the care that they needed at the agreed times or for the agreed amount of time.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not received training prior to providing support to people. Supervision records did not indicate if supervisions were happening in line with the provider's policies. The provider had not ensured that the requirements of the Mental Capacity Act were being met.

Is the service caring?

Requires Improvement

The service was not caring

Staff were not always caring and communication between staff and people was not always clear. People felt included in decisions about their care. People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care needs were not fully documented within their care plans. People were not always supported by people they knew well or of the gender of their choosing. Complaints and feedback from people had not always been addressed.

Is the service well-led?

Requires Improvement

The service was not well led.

The registered manager had not ensured that systems or processes were in place to assess, monitor and reduce risks relating to the health, safety and welfare of people using the service. Accurate and complete records were not maintained.	

8 Wyndham Close

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.

We carried out the inspection on 17 February 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available. This was the first inspection of the service since it registered in January 2015.

The inspection team consisted of an 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. We spoke with four people and five relatives of people who used the service along with an advocate of someone who used the service.

Before the inspection we reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted three health and social care professionals who had dealings with the service to gain their views of how the service was run.

We looked at the care plans of three of the people who used the service at the time of our inspection. After the inspection we spoke with three care workers employed by the service. We looked at three staff recruitment files to see how the provider recruited and appointed staff. We also looked at the records the registered manager provided kept regarding their procedures for monitoring the quality of the service and evidence of staff training.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us that they felt safe. However relatives told us that there were occasions when they did not feel that their relatives were safe. One relative said, "Initially on occasions they would send only one carer to use the hoist with my husband. I think this was when there was a problem with staffing. This was often [staff member] but we didn't think it was safe and so we said something and now we always get two carers."

Staff were aware of how to report and escalate any safeguarding concerns that they had. We saw that there was a policy in place that provided details of how to report safeguarding concerns. Staff received this when they received the staff handbook when they started working for the service.

The service did not follow safe recruitment processes. We looked at the personnel files for three staff members. We saw that there were occasions when the relevant pre-employment checks had not been carried out. On three occasions we saw that a staff member had started working for the organisation but they had not received clearance from the Disclosure and Barring Service (DBS). DBS checks help to keep those people who are known to pose a risk to people using CQC registered services out of the workforce. On another occasion suitable references had not been requested. This meant that the registered manager could not be sure that the staff employed at that time, were suitable to keep people safe. We discussed this with the registered manager who told us that this had been identified by the local authority who monitor care contracts. As a result the registered manager had arranged for DBS checks for all employees in September of last year and these were now in place.

We were made aware that there had been a concern about the conduct of a staff member. We ask the registered manager what they had done to address the concern with the member of staff. They informed us that they had sent the staff member on retraining and conducted a supervision with them. Training records indicated that the staff member had not been retrained until three months after the incident. Supervision records indicated that the staff member denied the allegations. No further discussion was recorded on the supervision record. We did see that an observation of practice was carried out by the care co-ordinator after the incident. We were also told by the registered manager that they had contacted the relative of a person using the service about the allegation but they were unable to produce a record of this contact. The relative confirmed that they had been consulted and was happy with the outcome. The registered manager had not followed robust disciplinary processes

Some people who used the service had their medicines administered by staff. People told us that they were happy that their medicines were being administered correctly and this was being recorded. We saw that staff had received the relevant training to support people to receive their medicines safely. Risk assessments had been completed to identify the risks around people's medicines and we were able to see the record of administration for one person. We found that records did not accurately indicate what medicines people should take. We were told that this was written on the dossett box In people's homes. A dossett box is a container that medicines are kept in and is designed to make it clear which medicines should be taken on each day. One person told us that there had been one incident where medicines had not

been given to their relative from their dossett box. The person contacted the care co-ordinator who arranged for their relative to receive their medicines.

We found that the medicine records were not monitored by the registered manager and there was no record of how medication errors were dealt with. This meant that people could not be sure that they would receive their medicines as instructed by their doctor. We saw that care plans did not always accurately reflect the support that people needed to take their medicines. For example someone who was identified as being at risk of developing pressure sores had been prescribed cream by their doctor to help protect their skin. There was no clear guidance in the care plan for staff to follow to ensure they applied the cream as intended.

The care co-ordinator attended people's homes prior to providing a service. This was to assess risks associated with providing care in the home environment. We saw that no record of identified risk or measures to prevent harm to people using the service or staff was recorded. This meant that people were not protected from environmental harm. We saw that within care plans the risks associated with moving and handling had been identified for some but not all people. Appropriate control measures to reduce harm had been identified and guidance was available in some case but not always. For example the type of aid that staff should use to support someone to transfer out of bed. We saw that not all risks had been identified. Where people were at risk of malnutrition, choking or pressure sores these had not been formally recognised as a risk. Risk assessments had been undertaken but the records were not always clear as to how to reduce the likelihood of harm.

People told us that the carers would frequently be late, though if very late somebody from the agency would usually phone to alert them. One person told us, "The manager may phone [relative] to tell him they will be 15 minutes late and then 25 minutes later they have still not arrived." Another person said, "The timing can be erratic either early or late but they do phone if very late and the manager is very approachable. We have never had a time when they have not turned up at all." Another person told us, that one day they had been left in bed as the carers had not arrived by 11.30am and they had to phone the agency who advised that the carer was ill but they did send a replacement. A relative told us, "They have changed the carers a few times but I generally have the same now as I said something. However the times they come are different to the times I thought we'd agreed. This has improved now I have dropped from 4 to 3 visits a day"

People also told that us that care staff did not always stay for the agreed care call time. One person said "Sometimes they leave before the allocated time is finished, for example mid-morning visit they just change my pad and half an hour is too long." An advocate told us "[Staff] will often go before the time is up even though there are still little things to do, although I'm not sure whether those are in the care plan- such as washing up the breakfast pots." A relative told us, "They don't use the full allocated time but that's ok with us- they get everything done and don't rush my wife too much." This meant that people did not always receive the care that they were contracted to receive.

Requires Improvement

Is the service effective?

Our findings

Staff did not always have the knowledge and skills to carry out their roles. One person we spoke with told us, "I don't feel that the carers had enough training. They would just stand in the bathroom and ask me what they were supposed to do." One person's advocate told us, "I would think that some [staff] could do with more training for example with manual handling- it needs more attention." However another person said, "They [staff] all seem to know what they are doing with the hoist and there is always somebody old with somebody new." Another person said "I feel that they know how to use the hoist and always make me feel comfortable." We reviewed training records and certificates held in staffs care files. We compared training records with the staffing rota and found that staff had been employed to provide care to people before they had received mandatory training such as manual handling. We found that not all staff had received the relevant training with regard to record keeping, supporting people living with dementia and the Mental Capacity Act.

We were told by the registered manager that when new staff started working for the organisation they were paired with another experienced staff member who they shadowed. Staff confirmed this. We saw that two new staff members had received aspects of the induction training and had completed shadow shifts however the training and induction records were not complete. We were unable to find induction records for a third member of staff. This meant that the registered manager could not be confident that all staff had the necessary skills to meet people's needs.

Staff told us that they felt supported by the registered manager and they met regularly with them. The registered manager told us that they aimed to carry out staff supervision and observation of care practice regularly. We saw from the three records we looked at that supervisions were not always happening. Staff told us they felt they could go to the manager whenever they felt the need. The registered manager told us that they conduct informal observations. Relatives of people using the service confirmed this. One said "The service manager occasionally comes out to check especially if it's a new carer." Staff told us they work with the care co-ordinator weekly and there performance is reviewed during this time. We saw that during supervision meetings staff were asked to review their performance and any issues regarding the support of people using the service were discussed. Supervision records did not consistently indicate if training or support needs were discussed. We asked the registered manager to review the way that supervisions were carried out and that these are recorded so that an accurate record of supervision and observations could be kept.

Staff supported people with meal preparation and to have drinks. One person told us, "[Staff] prepare me a meal and always make sure I am comfortable before they go." A relative told us their relative had a visual impairment and the carers had learnt to accommodate this or example by handing a cup of tea to them rather than leaving it on a table for them to try and find. We saw however that people's nutritional and hydration needs were not always clear within their care plans. There was a risk therefore that staff who were not familiar with people's dietary needs would not be able to meet them.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found where people were likely to lack capacity to consent to aspects of their care and treatment assessments had not been completed. We saw that a GP had been contacted to authorise medicine to be hidden in a person's food. The GP had assessed that the person lacked capacity however no best interest decision had been made. We also saw that people's relatives had been asked to consent to care and treatment on behalf of people who may lack capacity to do so themselves. Staff lacked knowledge and understanding of the requirements and their responsibility under the Act. Not all staff had received training on MCA. Consent to care had been requested for people who had capacity to consent. We asked the manager to consider their requirements as set out in the MCA and ensure the service is complying with the requirements.

An advocate of a person using the service told us that there had been occasions when the care coordinator had contacted health professionals on behalf of the person. They told us this had only done so after the GP had been informed of a concern by the advocate. A health professional confirmed that they had received contact from the care coordinator regarding concerns about people's skin. The service did not keep accurate logs or records of contact with health professionals or advice that was given. This meant that people were at risk of not receiving the health care that they needed.

Requires Improvement

Is the service caring?

Our findings

People told us that they found the carers to be caring and felt included in decisions about their care. One person said, "The things we talked about in our first meeting are being done by the carers." Another person said, "[Staff] always treat me gently and respect my dignity" A relative told us, "We feel that we have a good rapport with all the staff." Another relative said, "The carers are kind and friendly. You only have to say something once and they will then do it that way."

Other people told us that staff were not always caring. One person said "Sometimes they are a bit rough when helping me but I ask them to be more gentle and they respond." A person's advocate told us, "My friend has dementia and finds it hard to understand [what staff say] but the carers don't talk to [person] much anyway. They could also be a bit more gentle when caring for [person]" We spoke with a health professional who told us they felt staff were sometimes rushed and didn't engage with people when supporting them.

We were told that staff respected people's dignity. One relative told us, "The carers always seem friendly and caring to Mum and to me. Mums regular carer is great. She will always ensure Mum is covered up respecting her dignity. The carers and the manager also treat me with respect and will respond to any queries." Staff members told us that they understood how to maintain people's dignity. One staff member said, "I ask them if they need extra help." Another staff member told us that they were, "required to respect people's confidentiality, protect them from harm and respect their rights."

People were supported to remain as independent as possible. One person told us, "All the carers have been really helpful and kind. They also try to help me make the most of my independence- for example by helping me get ready and onto my scooter to go to the bank." Staff told us that they understood that people like to do things for themselves and that they can become frustrated when they need help. A member of staff told us "I have to know when [person using the service] is a bit agitated when he can't do things for himself so I have to reassure him."

People using the service told us that they had experienced some difficulties, particularly those people with sensory loss, with clear communication. This was related to staff accents and the speed at which staff talked. One person told us "Communicating can be a bit difficult at times especially when [staff] speak quickly." A relative said "Language and accent can be difficult particularly for somebody like Mum who has no sight and so is relying on what she can hear." This meant that people could not always understand what carers were saying to them. The registered manager told us that there was no evidence that this had a significant impact on people who used the service and people did get used to staff who have accents."

Requires Improvement

Is the service responsive?

Our findings

People had contributed to the planning of their care. One staff member told us, "[person using the service] told us they wanted to change their care plan. We told the manager who told us to ask them to strike out anything they didn't want and put what they did want on the plan. We then took it to the manager who changed the care plan and then we took it back to [person using the service] to see if they agreed." We were told that the care co-ordinator visited people prior to providing a service to them to ask what support was needed and agree the times that staff would provide care. The registered manager did not keep records of these visits or of the support assessments.

The support that people needed was documented in the care plan in people's homes. Staff had access to these when they were providing care and understood that they needed to read them to know what care people needed. One staff member told us, "The care plan is at the service user's house, you have to read the plan when you shadow." Other staff told us that they refer to the care plan when they arrive to support people. We looked at care plans and found that they were person centred and had information for staff to follow about how they should provide care to each person. Detailed in some care plans was information about what moving and handling equipment and support people needed. We saw that care plans did not reflect all the care needs that people had. This meant that staff were reliant on people themselves or relatives to ensure that they completed all the necessary care tasks.

Staff told us that they were alerted to changes in peoples support needs by looking back over the care notes since they had last supported that person or by contacting the office. One staff member said, "If we notice anything [regarding pressure sores] we tell the nurse or the manager who comes out and checks and tells us what to do." The care co-ordinator told us that when someone's support needs changed they would contact each individual staff member to update them. Staff confirmed this. We saw that care records completed by staff detailed what care had been provided and any concerns.

The care co-ordinator told us that staff were instructed to contact the office if they observed any concerns such as if someone's skin was becoming red. Or if people's care needs had changed. Staff confirmed this. We were told by an advocate however, that a person's relative had noted some sore areas on one occasion when the carers were administering personal care. It appeared that the person had had bed sores for some time prior to their relative noticing but this had not been picked up or reported by the carers who were washing the person daily. We saw records that indicated that this person was at risk of pressure sores and this was now identified in their care plan. Staff confirmed that they were required to report to the office if they noticed issues with people's skin.

Two people both female told us that they had been sent two men as carers on occasion. Both people had refused to be assisted by men. One of the people contacted the agency who quickly arranged for a female carer to go and assist. The other person was supported by their relative with their personal care on that occasion. One relative told us "They have sent two men before to assist my wife with personal care but I said No and within 5 minutes a female carer had arrived." We could not see within care plans if people had been asked if they preferred male or female carers.

People were supported to follow their interests. One person said "[Staff] encourage me to pursue my interests and I have talked to them about how important it is for me to get out each day and they help me get ready to go out."

People and their relatives told us that the numbers of different carers could be a problem. One relative said, "[Person using the service] has two fairly regular carers but recently there have been several new ones" Another relative said, "The agency is Ok. There is quite a change of staff. Different people coming all the time. This makes it difficult for my [relative] to get used to somebody and makes it hard for them as the regulars to know what is required."

The service had a complaints policy. Only one person that we spoke with was aware of the complaints procedure but people told us that they would feel comfortable addressing any complaints to the registered manager. One person told us that they had complained regarding poor time keeping but this had not improved and so they had now changed to another agency. The registered manager told us that they had received only one complaint since the service had been registered. They could not remember the detail of the complaint. We requested to see the complaint and the steps that the manager had taken to address the issues raised. The registered manager was unable to produce the complaint.

Three people told us that they had received and completed a survey of their experience of the care agency but had not received any feedback. The registered manager confirmed that they had received four responses from the ten sent out. They told us that the purpose of the survey was "To see if we have the right staff, if service users are happy and if service users' needs are being met." The registered manager was unable to provide details of the outcome of the survey and had not feedback to the people using the service.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had not ensured that systems or processes were in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people using the service. The registered manager did not carry out audits to ensure that robust records were kept. There was no system in place for care notes, accident forms or medication records to be reviewed or checked. We saw that some care notes had been collected and returned to the office but others including medication records remained in people's homes for over three months. The registered manager told us, "Ideally these should be collected every month."

There were not always appropriate systems in place to monitor activities and to learn from mistakes. Shortfalls had been identified by outside agencies rather than by the providers own auditing processes. When accidents or incidents had occurred we were told that forms were available to staff and were completed. The registered manager was only able to show us one form which had been completed by a staff member. They told us this had been the only accident. We were told that the care coordinator had reviewed the incident and ensured that people were safe and the necessary actions taken. These actions were not recorded on the form. This meant that the registered manager had no way of ensuring that appropriate actions had been taken as a result of events that occurred in the service.

We reviewed copies of the rota. The rota indicated that there were times when staff they were expected to be delivering care at two different locations at the same time. The registered manager told us that there was a built in allowance of 30 minutes either side of a planned care call to enable staff to meet all the care calls required. People told us they had been given a one hour time slot during which the carer was due to arrive. One person stated that she had complained regarding poor time keeping but this had not improved and so had changed to another agency. The registered manager did not have a formal system for monitoring the times that staff attended care calls and was reliant on people who used the service or their family members to inform them if staff arrived late or missed calls. This meant that people could not be sure that they would receive the care that they needed on time.

The registered manager told us that they meet regularly with staff and people using the service to get feedback from people and observe staff's practice. They did this by going to observe staff while supporting people in their own homes. One person told us, "[Manager] also came out last night to see us and has been out several times before. [Manager] just wants to check that we are Ok." The manager did not keep records of these meetings. The registered manager told us that they regularly reviewed care plans to see if they were meeting people's needs. We were unable to see evidence to support this. This meant that the manager was not able to demonstrate that quality assurance checks were routinely happening and action taken as a result of findings.

These matters constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was not aware of the need to notify CQC of significant events within the service.

This meant that the registered manager was not able to demonstrate that they were able to comply with their responsibilities as a registered manager. We asked the registered manager to check the requirement as set out by CQC and ensure that they follow it.

Relatives told us that they were able to contact the registered manager or care co-ordinator when they needed to. One relative said, "I do feel that the service manager listens to me and will adapt mums care as much as possible to fit in with our requests." Another relative told us, "They have also been open to me changing the number of visits I have each day. However I have had to do this partly because they give an hour time slot for each visit and when they don't always turn up at these times it ruins my daily plans." Staff told us that they were able to contact their manager when required. One staff member said "[Care co-ordinator] is always available, they would tell us if they were not going to be available."

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 17 HSCA RA Regulations 2014 Good governance The registered manager had not ensured that systems or process were in place to assess, monitor and mitigate risks relating to health, safety and welfare of people using the service. 17 (2) (b) The registered manager had not maintained accurate, complete and contemporaneous records. 17 (2) (c)