# Triangle Community Services Limited

# London East

## Inspection report

48-50 Well Street
London
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Website: www.triangle.care

Date of inspection visit:
15 November 2016
17 November 2016
21 November 2016

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

# Summary of findings

## Overall summary

We inspected London East on 15, 17 and 21 November 2016, the inspection was announced. We gave the provider 48 hours' notice to ensure the key people we needed to speak with were available. This was the first inspection of the service since it had registered with a new provider Triangle Community Services Limited.

London East provides personal care and support for people living in their own homes. In addition to providing personal care, they also provide respite care which helps family carers take a break from their caring responsibilities. At the time of the inspection there were 43 people using 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 was unavailable during the dates of the inspection, we were told they were attending meetings. During the inspection the service was overseen by the team leader and the branch manager.

The provider carried out risk assessments in people's homes. We found that risk assessments had not always been reviewed when and updated when people's needs changed. Care plans lacked detail and guidance for staff to follow when supporting people with their care needs.

Staff understood what abuse was and knew how to report concerns. Safeguarding concerns had been acted on and investigated but the Care Quality Commission (CQC) had not been notified of these.

The provider followed their recruitment procedures to make sure that people employed to work in the service were suitable to do so.
Staff had received training and where further training was required there was a plan in place for staff to complete this. Staff had attended supervision but had not received regular annual appraisals.

There was a suitable number of staff to meet the needs of the people who used the service. However, care calls to people's homes were not adequately monitored to ensure they received their visits on time and to

ensure staff took sufficient rest breaks.

Staff did not always follow the legal requirements in relation to the Mental Capacity Act (MCA) 2005. People told us they were involved in decisions about their care.

People's medicines were not always managed in accordance with safe procedures and improvements were needed.  Staff had received the required medicines training.

People were supported with their nutritional and dietary requirements but this was not always recorded in their care plans.

Changes in people's healthcare needs were identified by care workers and they were referred to healthcare professionals when required.

Systems to assess, monitor and improve the service were in place. However, these were not always thorough in identifying and addressing shortfalls found in the service. Where incidents had occurred actions were put in place to improve the delivery of the service.

Staff understood the importance of treating people with dignity and respect. People and their relatives told us they were supported by caring staff who listened to them. Staff had a good understanding of people's diverse needs.

Staff spoke positively about the management of the service. People were able to contact the service and speak to staff if they had any questions about their care.

People knew how to make a complaint and were confident any concerns they raised would be acted on. Surveys had been sent to people to obtain their feedback about the services they received.

We have made a recommendation about keeping people's records safe and secure. We found five breaches of regulations relating to the safe care and treatment, staffing, consent, good governance and notification of other incidents. You can see what action we asked the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Although staff had completed the required mandatory medicines training, people's medicines were not always managed in accordance with safe procedures.

Risks to people's care and support needs had not been appropriately assessed.

Staff visits to people's homes were not always adequately organised or monitored to ensure that people's needs were met as stated in their care plans.

Staff had received safeguarding training and knew how to recognise and report abuse.

Robust recruitment and selection procedures were followed to check new staff were suitable to work with people who used the service.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not receive annual appraisals to ensure they understood what was expected of them. They had been supported with training and supervision to enable them to provide effective care for people.

Staff did not always follow the legal requirements in relation to the Mental Capacity Act 2005.

People received support to have the food and drink that they enjoyed. However their food preferences were not always recorded in their care plans.

Staff supported people to access healthcare professionals to ensure their healthcare needs were met.

## Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect. Positive relationships had been developed between people and staff.

Staff spoke highly of the people they cared for and how much they enjoyed their roles.

People and their relatives told us staff were caring and listened to them.

## Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans lacked detailed information about people's preferences and wishes in relation to how they wanted to receive their care and support.

People's cultural needs were met.

There was a complaints procedure for people to raise their concerns. People knew who to contact in the service if they needed to raise any concerns or complaints.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems to assess, monitor and improve the service were in place. However, these were not always thorough in identifying and addressing shortfalls.

The provider did not keep the Care Quality Commission informed of some safeguarding incidents which they have a legal obligation to do so.

People and the staff spoke positively about the service and were confident that any concerns would be resolved.

Surveys had been sent to people to obtain their views about the care and support provided to them. Incidents and action resulting from these had been used to improve the delivery of service.

# London East

**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 inspection took place on 15, 17 and 21 November 2016. The inspection was announced and was carried out by one inspector. We gave the provider 48 hours' notice to ensure the key people we needed to speak with were available.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the PIR, and notifications sent to CQC by the provider. The notifications provided us with information about changes to the service and any significant concerns reported by the provider.

We made telephone calls to six people who used the service and two relatives. Additionally we spoke with six care workers, the human resources manager, three client hour's coordinators, two lead care and support workers, the team leader and the branch manager. We looked at the records in relation to six people's care including their medicines records. We also viewed eight staff recruitment and training records, minutes of meetings with staff, quality assurance audits, complaints, staff rotas and some of the records relating to the management of the service.

Requires Improvement

# Our findings

All the people we spoke with told us they felt safe receiving care from the staff that supported them. One person told us, "I feel very safe and if I didn't I would call the agency right away", another told us, "I have no concerns about my safety."

Despite this positive feedback we found that risks associated with people's health care needs were not always managed adequately to ensure people received safe care.

There was a procedure to identify and manage risks associated with people's care, however risk assessments did not always accurately identify the risk and were not always updated when people's needs changed. For example, we saw records that showed the provider had contacted the local authority regarding a person's mobility needs and equipment had been requested but the care plan and risk assessment had not been updated to reflect this. Furthermore, the risk assessment documented the person had a history of self-harm and neglect but there was no further mention of what the specific needs were and how they should be met to ensure their safety. Another person's risk assessment did not provide any further information when their health needs had been assessed. The comments section in the risk assessment was incomplete. Therefore care records did not accurately reflect people's individual needs and how these were to be met to ensure that care and support was provided in a way that protected people from avoidable harm. We spoke to the branch manager regarding this and they agreed the care records required updating.

People were not always effectively supported to ensure that their medicines were managed safely. The service had policies and procedures in place in relation to the safe handling of medicines; however we found the guidance provided was not always being followed. For example, we looked at a sample of four people's medicine administration records (MARs) over a period of two months. We found staff were not always completing the MAR's correctly as we saw a number of gaps where staff had failed to sign the MAR to show if people had taken their medicines. We also found that the arrangements in place for the administration of medicines and topical medicines such as the application of creams and ointments was not recorded on two people's MARs. In addition to this, three people's care records did not include the details of any allergies or reactions people may experience or how they should take their medicines, for example, with food. This information had not been completed. The care workers we spoke with told us they had received medicines training, but two care workers could not tell us what people's medicines were used for. Therefore we could not be assured that staff were safely supporting people to take their medicines.

The above concerns were discussed with the branch manager who confirmed staff had received appropriate

training and returned the MARs to the office once completed. However, they acknowledged that shortfalls had not been identified through the quality assurance audits completed by staff.

The above issues relate to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

Staff carried out regular risk assessments within people's home environment to identify and take proportionate measures to control any risks. For example, they checked to see if people's equipment was working and how care workers could access people's homes. Where people had mobility needs staff used a key safe to gain access to their home. This was recorded in people's care plans. Staff that had a good understanding of the emergency procedures they should follow in the event they were unable to gain access to people's homes and we saw that these were followed and the appropriate agencies contacted if staff were concerned about a person's safety.

We looked at the roster system and saw there was a sufficient number of staff to meet people's needs. However, rotas that we looked at showed that care workers did not have enough travel time between visits and this had an impact on them arriving late for calls. On four separate occasions care workers had been allocated care visits with no travel times between calls. We found a number of care calls allocated on the system included overlapping of call times and staff working excessive hours. For example, in the minutes of the team meeting it was noted that one care worker was allocated in excess of 90 hours per week and other care workers had reported they were not given enough work. We also found inaccuracies in care workers rotas. One care worker had done a waking night shift, took a four hour break then returned to do a late evening shift for nine hours. A second care worker did a waking night shift and had taken a three and a half hour break then returned to do an early seven hour shift. We spoke to the care workers regarding this who told us they were given their rotas a week before their scheduled visits and at times they were late but called people to let them know. Therefore people did not always receive safe care as they care was not always provided at the times that they required it.

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

We pointed out these shortfalls to the branch manager who acknowledged that more thorough scrutiny and auditing was needed in respect of the allocation of times of care visits to people's homes and rest breaks for care workers.

Recruitment records showed that the provider carried out robust checks about employees' suitability before they started work. These checks included evidence of the candidate's experience, good character, right to work and criminal record checks. This showed that there was a system in place to make sure that staff were only employed once the provider was satisfied they were suitable to work with people who used the service.

Disciplinary processes were followed where there were concerns about staff conduct, for example, arriving late for calls or not reporting concerns to the office. We saw that thorough investigations had been carried in all these instances. The branch manager told us that there was an on call system which ensured that people who used the service and staff had access to support 24 hours a day, seven days a week if they required it. There was a daily handover of any concerns that had been reported to the office staff so that these could be followed up to ensure people had received safe care. Care workers carried their identification badges which included their name and photograph so people could identify the care worker who would be helping them in their homes.

People's safety had been promoted because staff understood how to identify and report abuse.  Staff were aware of their responsibilities in relation to keeping people safe. They were able to tell us the different types of abuse that people might be at risk of and the signs that might indicate potential abuse. Staff had reported safeguarding concerns to the local authority and discussions had taken place to ensure that steps were taken to keep people safe. However we did not receive formal CQC notifications about two safeguarding allegations that had occurred in June 2016 as required.

The training and evaluation records we looked at confirmed staff understood and had received training on whistleblowing. Policies and procedures were in place to provide them with additional guidance if necessary.

Requires Improvement

# Our findings

Staff were not always supported with their on-going professional development. In all of the eight staff files that we looked at we saw that staff had been employed by the service for a number of years, however we found they had had not received annual appraisals. This was not in line with the providers' policies and procedures. Annual appraisals are intended to measure staff performance against their specific roles and support them with any further development that they require. The branch manager acknowledged this and told us they would implement staff appraisals with immediate effect.

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

Staff told us they had received regular supervision and the records we looked at confirmed this; however when we looked at the supervision matrix to cross reference the dates against the records held in staff files we found the dates on the matrix were incorrect. The branch manager agreed to update this.

Staff confirmed they had received training which enabled them to perform their role effectively. Records showed they had completed training that included a comprehensive induction, medicines, moving and handling, equality and diversity, safeguarding, first aid and infection control. Where people required support with stoma care and Percutaneous Endoscopic Gastrostomy (PEG) feeding, records demonstrated that some care workers had been trained by healthcare professionals to assist with this. We noted that staff cared for people with dementia but care workers had not received training in dementia awareness. The branch manager showed us the training matrix and told us there was a plan in place to have all staff complete training in this area and other additional training such as learning disability awareness, mental health and end of life care. Staff had completed or were in the process of completing a recognised national vocational qualification.

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 found that the provider's practice was not in keeping with the legal principles and requirements of the

MCA. We saw that if a person was unable to sign documents, the provider had asked a relative to sign as a 'best interest's representative' when there was no evidence that the relative had a Lasting Power of Attorney (LPA). For example, a staff member had recorded that one person living with dementia was unable to sign consent to assist with their medicines and this was signed by their relative. However, there were no assessments in place to show the person's mental capacity had been assessed or a best interest decision made. Care plans gave guidance for staff to document if people had LPAs and were able to manage their finances however we found in three files this information was not completed. This was not in line with the provider's policies and procedures which gave guidelines that read 'representatives must have an Enduring Power of Attorney (EPA), LPA or court appointed deputy to make decisions, if not 'make a best interests decision on their behalf but should consider if an IMCA needs to be appointed.'

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

The registered manager acknowledged this shortfall and showed us the assessment template that staff were required to use during the initial assessment with people but this had not been implemented. Where people had capacity to make their own decisions we saw consent forms had been signed, for example, to allow people's contact details to be passed to the Care Quality Commission, for staff to support them with their medicines and the for the care they were provided within their homes.

We found that people were supported to have sufficient food and drink. People we spoke with and records we looked at showed that staff supported people with planning and preparing their meals. Discussions had taken place with health and social care professionals regarding a person with diabetes related dietary needs. We asked people about their food preferences and the support they received with their meals and they commented, "They help me with food for my lunch, is usually cooked and they just warm it up. I eat food that is soft like pasta" and "I show the carer what type of food I like, rice and curry, they also shop for me." However the care plans we looked at for three people were not personalised to include people's food preferences and their likes and dislikes.

Care workers we spoke with were clear about the signs and symptoms people may present with to indicate that they were physically unwell and knew what action to take. Staff recorded the type of support and care they gave to people by providing details about what they did and if they needed to be referred to a doctor, chiropodist, district nurses or other healthcare professionals. For example, one person required a larger sliding sheet and this was ordered, another person had pressure sores and required regular moving and positioning. The chart was regularly completed by staff and advised the care workers to inform the district nurse if there were any concerns about the person's skin integrity. Care plans noted which healthcare professionals were involved with people's personal care needs and how they needed to be supported with their continence care.

Good

# Our findings

People and their relatives told us they were supported by caring staff. People told us, "I'm always sad if my regular care worker has to take time off" and "They are lovely, always helpful." A relative commented, "They are quite caring they spend a lot of time here, my [family member] never seems worried or frightened, the care workers always talk to me about her/his needs."

Staff we spoke with told us how they developed positive relationships with the people they cared for. One care worker said, "It's great when I get a lovely smile, it makes my day. Another care worker commented, "I love to help people who can't help themselves, I like to make people happy and make sure they are safe. I always ask them what they want and give them options." We noted that one person suffered from a mental health condition and it was recommended in their care plans to fill their day with activities to support their emotional wellbeing.

People told us were actively involved in their own care, offered choices and that they felt listened to. In a person's care plan it was documented, 'I appreciate good manners respect my wishes and listen to me.' One person had a visual impairment and commented, "I can't see what I'm wearing but they help me to choose my clothes, they do listen, they are very nice." Another person told us, "The care worker comes once a week, I realise sometimes [care worker] is getting older, we get on well. We chat to each other while they are doing the work. I ask a lot of questions and the [care worker] always answers me, I want to be able to communicate I can't get out much, so it's nice to be able to talk to them."

Staff had a good understanding of the importance of treating people with dignity and respect. Staff described to us how they ensured people were respected by explaining to them what was happening, being discreet, and closing curtains and doors when supporting them with personal care. The branch manager explained that where one person required 24 hour care they had the same care workers booked on the rota for consistency. They told us, "In the 24 hour rota I made sure there were not too many different care workers going in and out their home it's important to protect their privacy."

The provider worked with people who were receiving end of life care. A relative we spoke with told us they had regular discussions with the branch manager about their family member who was receiving palliative care and said, "[Name of person] has a district nurse visit every day and have spoken to the manager about their [health care needs] it is written in the plan about [family member's] challenging behaviour. Some carers have more patience, all have different approaches, but I am always here to make sure they are doing things right."

Requires Improvement

# Our findings

People and their relatives told us that if staff were late they called to let them know but said sometimes they were not provided with consistent care workers. One person said, "I'm really happy with the carer they always turn up and never let me down, when we first started they were turning up the wrong times, they are fairly regular now which is good, it's now settled" and "They are late at times but only when there is traffic they phone to let me know." Relatives told us, "I suppose they could improve the consistency of carers who come in," and "Most of them come on time but they kept changing, one carer did not turn up and didn't tell me I spoke to the manager and it was a one off, the regular carers call me when they are late."

The registered manager told us they did not use the electronic call monitoring system and called people to check if care workers had arrived on time. The provider had systems in place to help ensure that continuity of care was provided as they had a group of care workers who they matched with the people they would be supporting to help ensure they were able to meet people's individual needs and preferences.

The care plans we looked lacked detail and guidance for staff to follow when supporting people. We saw there were assessments in place provided by the commissioning authorities and these contained essential information about each person. The branch manager said a copy could then be transferred to the care plans after a review of the person's needs was undertaken, however this was not always completed. For example, we saw an updated assessment completed by the referring authority but this was not reflected on the providers care plan or risk assessment for the person. One person used a mobility aid to help them transfer. There was a moving and handling risk assessment which did not document the number of care workers needed to do this. The care plan in place did not guide staff to help the person transfer safely. Care plans had records of a person's medical history, but did not always contain personal information about the person and did not always describe people's likes, dislikes and interests. This meant some people's needs had not been fully assessed and identified to ensure that care workers met these.

These issues represented a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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The daily records we looked at and the people we spoke with demonstrated that people were receiving the support that they had been assessed for. Where two care workers were required, both had signed the records to confirm they had visited the person's home. However the daily records kept in people's homes were written on single pieces of loose paper that could be removed, lost or misplaced. We recommend the service consider guidance on keeping records safe and secure based on current and best practice, in line

with the Data Protection Act.

The provider raised awareness with staff about people's diverse needs before they commenced employment. For example, new employees were given interview questionnaires that asked care workers questions about people's cultural needs and what may be different for them when supporting people from diverse backgrounds. Two people had requested specific gender care and they told us this was acted on. Information such as the service user guide was provided to people to help people understand the care available to them when they began to use the service.

People we spoke with told us that they knew how to complain and that this was included in the care manual which was given to them when they used the service. They told us, if they were unhappy they would tell the staff or contact the office. One person said, "I have never had to make a formal complaint but I have contacted the office with minor issues and they have always been quick to respond." A relative told us, "My [family member] seems very happy I have never heard her/him complain." A second relative told us about when they had made a complaint and this was acted on quickly. We saw the complaints that were held on file and these had been responded to and resolved. There was one complaint that had not been dealt with within the appropriate timescale. The branch manager explained they had not heard back from the complainant in order to progress this further.

Requires Improvement

# Our findings

Reviews of people's care were undertaken in people's homes to check the assessed care was being carried out. They included medicines, paying bills, personal care, records of daily logs and housekeeping; however these were not always effective and did not identify the concerns we found. For example, we saw that a risk assessment was completed for a person's medicines, and documented the person managed this themselves. The review had identified the person had stopped taking their medicines for one week and the person had told them they would start to take their medicines again. However there were no notes to inform us if this was reported to a healthcare professional or the branch manager.

The weekly minutes of staff meetings held showed that where concerns had been raised the provider did not always demonstrate what actions were taken in relation to these, such as more frequent spot checks on care workers. Regular audits of people's medicines, care records, capacity assessments and call times were not carried out thoroughly by the provider to identify and address shortfalls including risks associated with people's wellbeing. Staff had not received annual appraisals to support them with their ongoing development. This meant that systems were not effectively monitored to improve the quality and safety of the services provided to people.

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

The registered provider is required by law to notify the Care Quality Commission (CQC) of important events which occur within the service. We saw records during our inspection about two safeguarding incidents which were not reported to us that occurred in June 2016 .They included safeguarding allegations of financial abuse, neglect and verbal abuse. Although the provider had taken the correct steps in responding to and acting on these concerns, no notifications had been received by the CQC in relation to these. After the inspection, these were emailed to us by the branch manager.

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

People using the service their relatives explained they were able to contact the office staff if they needed to discuss the care and support they received. One person told us, "I've had to contact the office. I've got the number in my phone. They're always there just if we've got appointments or something" and another person said, "I can contact [team leader] anytime, who always gets back they are very good." The branch manager told us satisfaction surveys were sent to people to obtain their feedback about the service but these had

been recently sent out and it was too soon to receive people's overall views of the provider.

We saw examples of incidents that had occurred in the service that were used as further learning to improve the quality of care the service provided. For example, conducting unannounced spot checks and reinforcing policies and procedures with staff when an incident had occurred. The provider used a quarterly project progress report to determine the monitoring of business growth, incidents and accidents, complaints and compliments.

Staff described the branch manager and staff who worked in the office as "helpful" and "a good team", and a care worker reported, "They have been a really great help the manager and the office staff, they always sort things out." Another care worker commented, "They do check up on you to make sure you are ok, they have even checked on my safety when I 'm travelling."

The provider held a membership with the United Kingdom Homecare Association (UKHCA). The UKHCA provide support, guidance and advice for organisations that provide care, including nursing care, to people in their own homes.

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>How the regulation was not being met:<br><br>The provider did not notify the Commission of incidents of abuse or allegations of abuse in relation to service users were they are required to do so. How the regulation was not being met:<br><br>Regulation 18 (1)(2)(b)(e) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>How the regulation was not being met:<br><br>Consent was not always sought where people lacked the capacity to make an informed decision, or give consent in accordance with Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1) (2) (3) (4) (5) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met: |

Care and treatment was not always provided in a safe way for service users as the registered person did not always assess the risks to the health and wellbeing of service users and did not always do all that was reasonably practicable to mitigate any risks and did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>How the regulation was not being met:<br><br>Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a)(b)(c) |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>How the regulation was not being met:<br><br>Staff did not receive regular appraisals of their performance to enable them to carry out the duties they are employed to perform and the provider did not deploy sufficient numbers of staff to meet people's needs. Regulation 18(1)(2)(a) |