Shaw Healthcare (Group) Limited

Shaw South Coast CL

Inspection report

Trinidad Village
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 3, 5, 6 and 7 September 2018. We announced the inspection on 31 August, to make arrangements for meeting people and relatives of people who use the service. This was our first inspection of the service, which was first registered in February 2018.

This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Not everyone using Shaw South Coast CL receives regulated activity. CQC only inspects the service being received by people provided with 'personal care': help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

People using the service lived in 134 flats in three buildings in Poole: Trinidad Village, Delphis Court and Belmont Court. Each building had communal lounges and an office where the care and supervisory staff who worked in that building were based. The service's registered manager was based at Trinidad Village, but also visited Delphis Court and Belmont Court. 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.

Low staff numbers had resulted in a high usage of agency staff to cover care calls. People were often not informed about who would be providing their care or at what time. Staff reported pressures on staffing levels. The provider was taking measures to address this.

There was a shortfall in the service's processes for ensuring medicines administration records (MAR) were accurate and up to date. MAR were not always complete with an explanation of any gaps in administration. You can see what action we told the provider to take at the back of the full version of the report.

Recruitment checks, such as criminal records checks and taking up references, were made prior to employment. However, full employment histories and explanations of gaps in employment were not available for all staff. We have made a recommendation regarding the implementation of a more robust recruitment system.

People were protected from abuse, infection and unmanaged risks. Information about risks was not always comprehensive or up to date, but this was attended to promptly when we drew it to the attention of the registered manager. We have made a recommendation regarding developing staff awareness and confidence in relation to safeguarding adults.

Lessons were learned when things went wrong and the service worked to bring about improvements.

People's individual needs and choices were assessed, and care was planned based on these. People received care that was responsive to their individual needs, in line with their care plans. Assessments and care plans flagged up sensory loss or communication difficulties and people had the support they needed with these. Staff followed the requirements of the Mental Capacity Act 2005 (MCA), making sure that people were involved in decisions about their care.

People were supported to eat and drink enough, where this formed part of their care package. They were satisfied with this aspect of their care. Staff liaised with health and social care professionals to ensure people had the care they needed and were supported to maintain their health. They supported people to maintain social links.

The service was taking steps to ensure staff had the skills and knowledge to support people effectively. Staff had one-to-one supervision meetings to review their practice, provide support and discuss any training and development needs. Staff had the training they needed.

People did not always receive care and support from familiar staff. People and their relatives reported that unfamiliar staff did not always know how they or their relative liked things to be done, leading to inconsistent support. We have made a recommendation regarding staff familiarising themselves with people's care plans.

People were otherwise treated with kindness and compassion, and their privacy and dignity were respected. People were supported to express their views and to be involved in decisions about their or, where appropriate, their relative's care.

Concerns and complaints were listened and responded to, and where appropriate used to improve the quality of care. Information about how to complain was included in people's information packs.

There had been challenges when the service started in February 2018, taking over people's care from an unrelated service that was rated inadequate and placed in special measures. The service continued to experience some challenges. There had been a turnover of staff and a number of staff had just joined or were about to join the service. People and relatives told us they perceived improvements in the service since it started. Quality monitoring and assurance arrangements were in place, but these had not all been as rigorous as they should have been. The service was working closely with the local authority commissioners to develop and improve the service.

The registered manager and operations manager confirmed that staff had equality and human rights training. However, when asked how they would respond to people's diverse needs and preferences no staff mentioned protected characteristics. The registered manager and operations manager told us they would organise some bite-sized training sessions for staff to raise their awareness.

The service sought to engage and involve people who used the service, their relatives and staff. People and relatives said they could generally speak with the registered manager or with the manager of care services at their complex. However, staff expressed mixed views.

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 wholly safe.

There had been a shortage of permanent staff. People were often not informed about staff changes and who would be providing their care.

The service did not always follow national guidelines in relation to medicines recording, as checks on medicines records to ensure they were correct and complete were not robust.

People were protected from abuse.

Is the service effective?

Good

The service was effective.

Care was planned and delivered on the basis of people's individual needs.

Staff liaised with health and social care professionals to ensure people had the care they needed and were supported to maintain their health.

Staff were supported through training and supervision to be able to provide the care and support people needed.

Is the service caring?

Requires Improvement

The service was not caring in all respects.

People did not always receive care and support from familiar staff, and staff did not always have a clear understanding of people's preferences. This led to inconsistent support.

People were otherwise treated with kindness and compassion, and their privacy and dignity were respected.

People were supported to express their views and to be involved in decisions about their or, where appropriate, their relative's care.

Is the service responsive?

Good

The service was responsive.

People, and where appropriate their families, were involved in decisions about their care and support.

Social contact and companionship were encouraged.

Complaints and concerns were taken seriously.

Is the service well-led?

Requires Improvement

The service was not wholly well led.

People and relatives perceived improvements in the service since it started.

Quality monitoring and assurance arrangements were in place, but these had not all been as rigorous as they should have been.

Whilst people were positive about the availability of managers, staff had mixed views about this.

Shaw South Coast CL

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.

The inspection was prompted in part by information received about safeguarding concerns, and a shortage of appropriately trained regular staff. This informed how we conducted the inspection.

This comprehensive inspection took place on 3, 5, 6 and 7 September 2018. We announced the inspection on 31 August, to make arrangements for meeting people and relatives of people who use the service. This was our first inspection of the service, which was first registered in February 2018.

Inspection site visit activity started on 3 September and ended on 7 September 2018. It included visiting the three complexes of flats served by Shaw South Coast CL and speaking with eight people and two relatives of people who use the service, and a further stakeholder. We also spoke with ten staff face to face and on the telephone. We visited the office at Trinidad Village to see the registered manager, operations manager and office staff, and to review care records and policies and procedures.

The inspection team was made up of an adult social care inspector, an assistant 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 a similar type of care service.

Prior to the inspection we gathered and reviewed information about the service, such as the service's notifications of significant incidents and information from the social services safeguarding and service improvement teams. We also obtained feedback from the safeguarding and service improvement teams. Because the inspection had been brought forward, we did not request a provider information return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we viewed seven people's care plans and records, including their medicines records

where the service supported them with medication. We also checked records relating to how the service is run, including six staff files, accident and incident records, complaints and audits and quality assurance records.

Following the inspection, we obtained feedback from a health and social care professional who have contact with the service.

Requires Improvement

Is the service safe?

Our findings

Low staff numbers had resulted in a high usage of agency staff to cover care calls. People were often not informed about who would be providing their care or at what time. Their comments included: "We don't know who's coming or when", "[referring to not receiving rotas or being told who would be coming] I'd just like to be told what's happening, what's going on", "They [workers] just come but I don't know who beforehand", and "Rotas are the thing; if they got them right it would run well… Get those rotas to us and make sure we know who's coming to us. That's what we need." Someone else said they got rotas, although "nine times out of ten they change it". The managers advised us the rotas had been withdrawn in agreement with commissioners, in order to provide outcome-based care plans that were not dependent on time- and task-focused rotas. People told us, and care records reflected that staff did not always stay the full length of a visit, although the care records did state everything necessary had been attended to. People who needed assistance with medicines had extra calls for this as agency staff were not medicines trained, nor all regular staff.

Staff said they had experienced pressures on staffing levels. Comments included: "We are struggling with low levels of staffing because a few staff have left so we are having to do their calls on top of our own calls", "There are not enough staff. If I am doing calls through the night, often residents have to wait over an hour for me to visit them", "There are not enough staff to complete planned visits. Often staff do not turn up. Staffing levels are very low", and "We have enough staff to complete planned visits apart from annual leave and sickness. Here we use agency staff; we tend to rely on them a lot of the time." Many of the calls at night were ad-hoc requests for support rather than booked requests. Consequently, people making ad-hoc requests might have to wait, as they would in other similar types of domiciliary care provision.

The provider had identified there were pressures on staffing, which had started when several staff left unexpectedly just as they took on the service. There had been absenteeism over the summer holidays and disciplinary procedures were under way in relation to this. The service was in the process of recruiting further staff and a group of new care staff were going through induction during the inspection. One member of staff told us, "I think we have enough staff to complete planned visits as now we have more permanent staff."

The registered manager and office staff told us there had been no missed visits other than those of which CQC were already aware prior to the inspection. The service identified missed visits through people or their families alerting them, through spot checks, and by checking staff rotas against care records. Whilst office staff said most people were capable of telling them if a worker had not turned up, some people might be reluctant or unable to do so.

We recommend the service proactively monitors possible missed and late visits, in order that prompt action can be taken and people receive the care they need.

Recruitment checks, such as criminal records checks and taking up references, were made prior to employment. However, full employment histories and explanations of gaps in employment were not

available for all staff. Whilst the provider's recruitment policy was clear about obtaining a full employment history, application forms asked only for details of "relevant employment". Interview records stated employment history had been explored but did not give details of employment or gaps in employment. We drew this to the attention of the registered manager and operations manager. At the end of the inspection they informed us the provider was reviewing its recruitment policy and that wording on the application form had been changed.

We recommend the prompt introduction of a more robust system for obtaining full employment details and an explanation of any gaps in employment history.

There was a shortfall in the service's processes for ensuring medicines administration records (MAR) were accurate and up to date. Medicines were administered by staff who were trained to do so and had been assessed as competent. People mostly had medicines administration records (MAR) that had been handwritten by the service, with the names, doses and instructions for each medicine prescribed and space for the staff to initial each time a medicine had been administered. Four MAR we saw had not been double signed as a check that the prescriber's instructions had been copied correctly, which is good practice although it was not required by the service's medication policy. One person's care plan referred to them having paracetamol prescribed on an as necessary ('PRN') basis, and there was a PRN protocol for paracetamol. However, there was no paracetamol listed on their MAR, despite the provider's medicines policy due for review in March 2018 stating: "All PRN medication must be transcribed and recorded onto the Service User's current MAR." Another person had PRN paracetamol listed on their MAR but no PRN protocol. A person's MAR for their skin creams did not specify the prescribed frequency or the reason for administration. Whilst the key indicator of the prescriber's instructions is the pharmacy label on the medicine container, social care providers should have robust procedures for recording a person's current medicines. Without accurate and up-to-date information on the MAR there was a risk that people could receive their medicines otherwise than as prescribed, for example at the wrong dose, time or frequency. A person's MAR had gaps where staff had not initialled against doses of two medicines that should have been given on 3 and 8 August, and no reason was recorded for the omission. The person's care notes for those days referred to medicines being given, which indicated that staff had omitted to sign for those medicines.

These shortfalls in relation to medicines are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information about risks was not always comprehensive or up to date. There was no mention of one person's epilepsy in their care plan. We drew this to attention of registered manager, who immediately ensured the care plan was updated with key information about how this person's epilepsy affected them and what staff should do if the person had a seizure. This person's name had been left off a template for care plan audits that would have identified the omission, although this had since been corrected. The service was aware that environmental risks had not always assessed and was taking steps to address this. Records we looked at contained this information. Other risks, such as moving and handling, health conditions, falls, medicines and fire risks presented by some skin creams, were assessed. Emollient creams that contain paraffin oil are flammable and can lead to a build-up of flammable residues in fabrics.

The service had a policy and procedures in place to safeguard people against abuse. These reflected current legislation and good practice. Information was clearly displayed in communal areas on how to tell statutory agencies, such as the local authority, about actual and suspected abuse and neglect. Safeguarding adults training was covered during staff induction, and almost all staff had been trained in safeguarding adults since the service commenced in February 2018. Staff told us they would report safeguarding concerns promptly to senior staff, although some had difficulty giving examples of what might be a safeguarding

concern. This may have been due to staff anxiety during telephone interviews. The registered manager and operations manager told us they would enhance staff awareness about safeguarding through 'bite size' training sessions, and through supervision and team meetings.

We recommend the service goes ahead with steps to develop staff awareness and confidence in relation to safeguarding adults.

People were protected from infection. Staff had training in infection control, including hand washing and using personal protective equipment such as disposable gloves and aprons. They had access to adequate supplies of personal protective equipment.

There was a system for learning lessons and making improvements when things went wrong. Accidents and incidents were initially recorded on paper forms, which were then logged on the provider's database. These were monitored by the registered manager, who checked that all necessary immediate action had been taken and assigned a risk level. This was recorded on the database. There was oversight and analysis by the provider's management team to ensure risks were being managed and to highlight any trends that could indicate further action required for people's safety and wellbeing.

Good

Is the service effective?

Our findings

People's individual needs and choices were assessed, and care was planned and delivered based on these. Assessments and care plans had been set up when the service commenced in February 2018. There had been further reviews if people's needs had changed. Assessments and care plans covered matters such as preferences for entering the property, social background, communication, physical and mental health, medicines, dressing and personal care, mobility, moving and handling, nutrition, skin integrity and sleep.

People were supported to eat and drink enough, where this formed part of their care package. They were satisfied with this aspect of their care and said that staff asked what they wanted to eat and prepared this. One person commented that although they were generally happy with the help they had in this regard, they thought some staff were better cooks than others. Another person said they enjoyed baking and making salads with support from staff: "I cook and have someone to help me."

Staff liaised with health and social care professionals to ensure people had the care they needed and were supported to maintain their health. For example, staff contacted a GP when there were concerns about a person's health and this had implications for their medicines. Staff had been in contact with another person's occupational therapist regarding their moving and handling needs, and equipment required.

Staff followed the requirements of the Mental Capacity Act 2005 (MCA), making sure that people were involved in decisions about their care. The 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.

The service was taking steps to ensure staff had the skills and knowledge to support people effectively. People and relatives were confident in most of their regular staff, for example saying, "They're all alright… absolutely no problems with the staff", and "The carers I have are fine". One person said one worker could be erratic, and another commented, "Sometimes the carers don't have common sense." Staff had one-to-one supervision meetings with a more senior member of staff to review their practice, provide support and discuss any training and development needs. Staff confirmed they had the training they needed, for example saying, "I have had all the training provided including mental health." New staff had two days' induction training in key topics such as moving and handling, health and safety, infection control, food hygiene, fire and safeguarding adults. All staff had had training in these topics since the service started. Induction training was going on during the inspection. Staff were only allowed to work unsupervised when they and a member of senior staff felt they were capable of doing so, after working with them and observing their work. Staff who were new to care were expected to work towards the Care Certificate, which reflects a nationally recognised set of standards for health and social care workers. A new member of staff told us, "I started the Care Certificate and have three months to complete it. I have moving and handling training this Friday."

Requires Improvement

Is the service caring?

Our findings

People did not always receive care and support from familiar staff. There had been a period of staff shortages and there was a high usage of agency staff. Three people told us how difficult they or their relative found having agency staff rather than regular staff to provide their care. One person said they had a lot of agency staff, which they found hard to cope with. A relative commented, "We keep getting agency" and so their family member's care lacked continuity. They did say this had been better over the past couple of weeks. Another person told us, "Some of the staff I hardly know 'cos they're new." A further person said they usually had regular workers, "Which I like". A commissioner's monitoring visit earlier in the summer had identified that continuity of care was improving.

People reported that unfamiliar staff did not always know how they or their relative liked things to be done, leading to inconsistent support. One person commented, "There's those that go the extra mile and those that go the quarter mile." Four people said they did not see some, usually new, staff read their or their relative's care plan before providing care, for example: "I don't think some of them read my care plan, which is very important to me… some don't always know what I want them to do" and, "Some of the carers are lovely and some have not got a clue." A person said that on occasion they felt rushed by staff, "but never by the good ones". A relative commented, "The newer ones [care workers] are not reading the care plan properly, especially the agency ones." Another relative expressed doubt that new staff read their family member's care plan, as they did not seem to have a good grasp of what the person needed. Both explained that understanding the care plan was important, as the approach of staff made a difference to whether the person would accept care. Care records contained details of people's personal histories and preferences, although a care worker commented they would find it helpful to have more detail about this. The registered manager and operations manager told us staff read and signed to say they had read people's care plans.

We recommend the service ensures staff always check people's care plans before they provide care and make it clear to people they have done so, and that the registered manager assures themselves that staff understand people's care needs.

People were treated with kindness and compassion, and their privacy and dignity were respected. People and relatives talked about staff in terms such as: "They are all nice", "They're all very helpful", "There's one of the ladies, she only has to put her face in and it makes my day", "They are friendly and helpful if you ask for anything to be done", and "They take me as I am." We saw staff and managers had a professional, friendly manner towards people. They knocked at people's doors and sought permission to enter their properties.

Gender preferences were discussed at assessment and reflected in people's care records. For example, a relative said their family member had a care worker of the same gender for their morning care.

People were supported to express their views and to be involved in decisions about their or, where appropriate, their relative's care. This occurred through assessments and care plan reviews, and managers and senior staff checking how people felt about their service.

Good

Is the service responsive?

Our findings

People received care that was responsive to their individual needs. People told us how mostly, staff did what they were supposed to do for them. One person commented, "I can't fault anything." A relative said, "Most of the time they're good… When [person's] not been well they've been absolutely brilliant", in the sense of providing the care the person needed and making extra checks on them when they were unwell. One person said they sometimes needed to remind staff to do things, such as applying their prescribed creams or leaving them with a drink. People and, where appropriate, their families had been involved in developing their care plans, which were up to date and individualised.

Staff supported people to maintain social links. Whilst this did not form part of their personal care package, people had social support time with staff. People told us about social activities staff arranged in their complexes, such as brunch clubs and bingo. They spent time with staff and each other in communal areas, chatting and playing games.

The service complied with the Accessible Information Standard. This requires that health and social care providers ensure people with a disability, impairment or sensory loss can easily understand information provided and get the right support to communicate effectively. Assessments and care plans mostly flagged up sensory loss or communication difficulties and how staff should support people with this. For example, a person who was living with short term memory loss had a care plan that prompted staff to speak slowly so they could process sentences in full. One person's assessment mentioned their hearing loss, but this was not reflected in their care plan. This was promptly corrected when we drew it to the registered manager's attention.

Concerns and complaints were listened and responded to, and where appropriate used to improve the quality of care. Information about how to complain was included in people's information packs. People told us they could complain to the registered manager or the manager in charge of care where they lived. One person commented, ""If I've gone to them with anything, they've dealt with it." Eleven concerns had been received since March 2018. These had been investigated promptly and the outcome agreed with the complainant.

Requires Improvement

Is the service well-led?

Our findings

The service commenced in February 2018, taking over people's care from an unrelated service that had been rated inadequate and placed in special measures by the CQC.

The new service provider had experienced some challenges. There had been an initial turnover of staff in February and March 2018 and a number of staff had since joined the service. People and relatives told us they perceived improvements in the service since it started: "On the whole, they're trying to up their game", "Things are definitely getting a lot better" and, "They are a lot better than they were".

Quality monitoring and assurance arrangements were in place, but these had not all been as rigorous as they should have been. These included audits about the service quality and medicines audits overseen by the registered manager and the operations manager, who visited regularly. A care plan that did not include details of a person's epilepsy, was not picked up by the audits because the person's name had erroneously been left off the audit template. Following the inspection, the provider told us this was because they sampled records to audit. However, their other processes to ensure care plans contained all necessary information, such as staff training and supervision and care plan reviews, had not prevented or identified this omission. The medicines audits had not identified shortfalls we found in relation to medicines. The registered manager and operations manager took action to address the shortfalls found in audits. They also responded promptly and constructively to issues identified at this inspection.

The registered manager and operations manager confirmed that staff had equality and human rights training and said they would challenge any discrimination they became aware of. However, when asked how they would respond to people's diverse needs and preferences no staff referred to individualised and person-centred care, rather than specifically to protected characteristics such as age, gender, race, disability and sexual orientation. This may have been due to an element of anxiety during telephone interviews. The registered manager and operations manager told us they would organise some bite-sized training sessions for staff to raise their awareness.

Whilst people were positive about the availability of managers, staff expressed mixed views. People and relatives said they could generally speak with the registered manager or with the manager of care services at their complex. A relative described the registered manager as "very nice, very pleasant. I think she tries to be helpful." People at Trinidad Village, where the registered manager was based, greeted the registered manager by name and evidently knew her. A relative had earlier in the year had difficulty contacting on call and had resorted to calling the registered manager directly. One member of staff said they were able to speak with managers; they had not needed to contact managers out of office hours. However, a night worker said it was sometimes difficult to contact managers, for example if a care worker had gone sick. Another member of staff commented, "I don't think all managers are responsive and do not do much about any of the concerns that carers have."

The service sought to engage and involve people who used the service, their relatives and staff. Someone with protected characteristics including their disability had been involved with interview panels for new

staff. They told us how the operations manager had regular contact with them and sought to involve them in developments at the service. There had been a survey of people and relatives over the summer. This had highlighted concerns about continuity of staff and consistency in call times. The service had responded with an action plan that highlighted plans to reduce agency usage by recruiting more staff and that the recruitment of 12 staff was in the pipeline. There were monthly staff meetings, where staff were kept informed of developments at the service, and received feedbacks from audits, such as being prompted to sign medicines administration records when they had administered medicines.

The service worked in partnership with other agencies. Both the registered manager and the operations manager met regularly with the housing providers for each complex to discuss any issues that had arisen from joint working. The service had a memorandum of understanding with the housing providers, to clarify what each party was responsible for and how they should respond to issues such as safeguarding concerns and anti-social behaviour within the building. The service was working closely with the local authority commissioners to develop and improve the service.

When required to do so, such as if they were made aware of a safeguarding concern, the service had notified CQC.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment was not always provided in a safe way as medicines were not always managed properly and safely. There was a shortfall in the service's processes for ensuring medicines administration records (MAR) were accurate and up to date. Regulation 12(1).