Care Quality Commission

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All Care

Inspection report

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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**

Overall summary

We inspected this domiciliary care agency on the 20 and 22 January 2015. The agency was last inspected in January 2014 and was compliant with all outcomes inspected.

This agency provides different levels of support to people in their own homes ranging from personal care to helping people with domestic skills and shopping. The majority of people using the service were older people but they do support people with a learning disability, mental health issue or physical disability. There was a registered manager in post.

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.

Summary of findings

The service was not able to demonstrate how they provided safe and effective care. This was because they did not have adequate systems in place to assess, plan and monitor the risks to people using the service. We found poor practices around the safe administration of medicines and people had not given their consent to have their medicines administered.

There were not enough staff or with sufficient skills and experience to meet people's needs. The performance of the agency had been poor with a high number of complaints about the service and late running calls.

Risks to people's safety were not fully assessed and therefore not fully managed. There was not a robust system in place to keep people's needs under review and adjust the service according to people's changing needs.

Staff received training and support but we could not see how effective this was or if all staff had enough skill and experience for their particular roles and responsibilities to meet the needs of all people using the service.

Care records were not robust which made it difficult for us to see what care people were getting and if it was sufficient to their specific needs. Some records were generic and did not reflect people's individual need or care preferences. Records were not kept up to date even when people's needs changed so people were at risk of receiving inadequate care.

The agency responded appropriately to complaints made to them and people using the service were aware of how to raise concerns.

The service was poorly managed because of a lack of systems to measure the quality and effectiveness of the service delivery.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in multiple regulations. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There were not enough staff to cover all eventualities and to ensure people got their care at the required times.

People did not always receive their medicines safety putting them at risk.

Risk assessments were poorly written and did not clearly state how the risk should be managed.

Staff knew how they should protect people from potential harm and abuse and there were adequate processes in place to do this.

Requires improvement

Is the service effective?
The service was not effective

Staff were supported through induction and training was comprehensive. However staff were not always supported to develop their skills and there was a lack of evidence of how all staff were adequately supervised.

We could not see how people were supported to eat and drink enough because people's assessments and care records were not sufficiently detailed.

Most staff had not received training on how to support people where they lacked capacity to make decisions on their care and welfare.

Requires improvement

Is the service caring?
The service was caring.

People told us they received a good service and care staff were kind, considerate and upheld their dignity.

Care plans lacked personal information about how people would like their care needs met.

Good

Is the service responsive?
The service was not responsive.

Care plans did not give enough information about people specific needs and were not kept up to date as people's needs changed.

The agency had an effective complaints procedure but did not always learn from its mistakes.

Requires improvement

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

Requires improvement

Summary of findings

There were a lack of effective systems in place to monitor the effectiveness and quality of the service being provided.

There were inadequate systems in place to monitor staff and to monitor the care they were providing to people to ensure risks to their safety were identified and managed.

All Care

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 took place on the 20 and 22 January 2015 and was announced in line with our methodology for domiciliary care agencies. The inspection was carried out by two inspectors over two days; the first was spent in the office looking at care records and records relating to the management of the building. The second day was spent visiting twelve people who used the service and obtaining their views and checking their care plans to ensure staff knew what care to deliver. We also spoke with four care staff, the manager and office staff.

Before the inspection, we looked at information we held about the service including feedback from the Local Authority, previous inspection reports and notifications. A notification is information about important events which the service is required to send to us by law. We did not receive a provider information return, (PIR) which is a form we ask all providers to complete to tell us how they are managing their service. The reason for this is we brought this inspection forward because of some concerns we had so the PIR had not been requested ahead of this inspection.

Requires improvement

Is the service safe?

Our findings

Risks to people's safety were not appropriately managed. We spoke with one person who told us, "I do not always feel safe when staff assist me in the hoist." Their manual handling risk assessment stated that they required hoisting and that one care staff was required. Another person told us they have specific equipment in place including a hoist. They told us some staff did not know how to use it and they had to tell them. The manual handling plan did not go into sufficient detail about the equipment in place. The manager told us all staff have a comprehensive moving and handling training during their induction and on-going annual updates and were spot checked and monitored in between. We saw evidence of the induction programme which demonstrated staff had adequate training but spot checks of staffs practice were not regularly carried out for all staff.

We saw another person had fallen three times and their needs had been reviewed by the falls prevention team. However their care plan remained unchanged and we could not see what advice or actions had been suggested as a result of the professionals visit. Another person's records told us they needed two staff to assist them with manual handling transfers but they only had one member of staff visiting to them. The manager said this had been agreed with the Social worker, but there was no record of this.

People's risk assessments were not filled in comprehensively and did not fully identify risk either to the person or to staff providing the care. Some risk assessment forms were blank and had just been signed and dated. The manager told us this was because no risks had been identified during the assessment. This was not recorded. During our visits to people using the service we identified a number of hazards which had not been recorded on their risk assessment. We looked at one person's needs. They required multiple visits a day and relied on staff for most of their care. The risks to them were significant as they were unable to get out of bed, needed assistance from two staff for transfers and needed support around taking medicines. They were prone to pressure sores, falls and did not eat or drink enough for their needs unless prompted. Their risk assessment did not identify any of these issues and their care plan did not tell staff how to manage the risks to this person's health, welfare and safety. This was immediately brought up with the manager so they could address the concerns.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The service did not have enough staff to meet people's individual needs and we were not assured that all staff had the necessary skills and experience for their job roles. We spoke with people who used the agency.

We spoke with people who told us the times their calls were provided were unreliable. One person told us they had not always been given their medicines because staff had been late or not turned up at all. We were unable to verify this from their records. The manager told us they had a half an hour window between calls, so if the desired call time was eight o'clock it could be half an hour each side. This was specified in people's contract. However, we saw from people's records that this was not always met and people invariably had to wait for their care to be provided. One person told us their carer was two hours late one day, but said things had improved lately. We established care staff do not get travel time so if they stay the required amount of time they ran late for each call. The manager told us there were tensions around staffing levels and because of this they were selective when taking on extra work. In 2014 there were three occasions where people did not get their scheduled call. This meant the agency were in breach of their contract with the Local Authority and also meant there were not enough staff to deliver the care.

We asked the manager about their contingency plan to ensure that they do not miss calls to people should staff be sick or in times of high annual leave. The manager told us they had agreements with other agencies who were part of the same training consultancy. They could cover shifts if required and alternatively there were senior staff who were not on the staffing rotas so could cover calls in an emergency. The person on call told us that sometimes they had to cover care calls if staff called in sick. The manager said when this happened their on call phone would be diverted to the manager who would then respond to calls.

We spoke with staff about their training and they said it was good and things were improving. However they did say that not all staff had the confidence and skills to deliver the care effectively and needed more support.

Requires improvement

Is the service safe?

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not receive their medicines safely. We visited one person and saw they needed support from staff to take their medicines safety. After a stay in hospital they had been prescribed a blood thinning drug which needed to be carefully monitored. We could not see from their records how the drug was being monitored. When we asked the person they said they no longer took this drug which meant their records were not up to date. They told us they had regular pain and took medicines as required for this. This was not recorded.

We saw another example of changes which had been made to a person's medication. This was authorised by the pharmacist but the person's care plans and medication record had not been changed. This could increase the risk of the person receiving the wrong medicines.

We saw an entry in a person's plan of care where staff had administered medicines to a person which was not a prescribed medicine. Medicines were administered involving an evasive procedure. The person told us they asked staff to assist them. The manager was asked to investigate this immediately and raise a safeguarding alert with the Local Authority. We do not have the outcome of their investigation.

One person's record told us they could take their medicines independently. However staff told us, they dispensed their medicines and left them out for the person to take. There was nothing recorded in their care plan and there was no assessment to show if they were able to take their medicines safely or what support they needed from staff.

We saw daily entries of staff administering external creams. These creams were not recorded on people's medication records so we could not be assured they had been prescribed or were safe to use with other medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The staff we spoke with were aware of how to report concerns about people's welfare and, or safety. Staff had received training to help them recognise types of abuse and familiarise them with the legislation designed to protect people. The service had policies in place which were accessible to staff. There were three on-going safeguarding investigations at the time of our inspection which had not been concluded as the agency were waiting for the outcome from the Local Authority. However they were able to show us what they had implemented as a result of the concerns raised such as more in-depth care reviews.

Requires improvement

Is the service effective?

Our findings

Staff did not always have enough skills and experience to deliver the care to people using the service. One person told us that staff had not been sufficiently trained to enable them to support the person with their leg exercises they needed to assist their mobility. The physiotherapist had made themselves available to support staff but this had not taken place. The person told us this meant, "I am not getting better as quick as I possibly could."

Inspectors were shown a computerized record of training which staff had undertaken and this showed when staff required an update. The manager advised us that the training officer kept a hard copy of all the staffs training records. Staffs knowledge of the training received was verified through an assessment of staffs knowledge to demonstrate their competency. New staff induction was thorough but some training had lapsed for existing staff. We also found senior staff were carrying out assessments and risk assessments and had not had any formal support or training to enable them to complete this effectively.

The agency said training was provided according to the specific needs of people. For example some staff were doing palliative care and dementia care through a distant learning course.

We have received a number of concerns from family members about the care their relatives have received. These were being investigated by the Local Authority and the concerns related to some staff not having the necessary experience and skills. Mistakes had been made resulting in people not receiving the care that they needed.

Staff received support through regular contact with managers and seniors. The manager said staff were allocated mentors to support them through their induction. Training was provided through a consortium provided through the Local Authority which meant it was approved and accredited training. The manager told us they carried out three monthly spot checks of staff to check that they were where they should be and providing the care required of them. However we were not provided a schedule of visits so could not determine the frequency of staff spot checks. Care staff confirmed they took place. The spot checks we saw were not very detailed and there was little by the way of explanation of how the staff member was meeting the person's needs.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Care plans gave very little detail about the support people should be provided to maintain a healthy diet and adequate fluid intake. We saw one person's record said they needed encouragement to eat and drink but no other information was recorded. The person was living with dementia but there was no additional information about how their dementia affected them. We asked what actions would be taken if there were concerns about their food and fluid intake and staff said they would keep more detailed record of what they were eating and drinking. We could not see any analysis of the daily notes to identify any changes to people's needs. The notes did not always record what the person had eaten or drank or any factors which might prevent the person from doing so.

People's health care needs were recorded but there was very little information about the impact a person's disability had on them or what specific support they needed. For example care plans told staff to help the person maintain a healthy intake of food and fluid intake but no other information was included. The staff told us they worked well with other agencies and would report any concerns to other agencies or the GP were required to ensure people's needs were met. The manager reported working closely with the Local Authority and acting on any support and advice provided. They had also established links with other care providers to share ideas and support each other.

We met one person whose family were also there to meet us. This person was regularly supported to access the health care they needed and staff were proactive in making sure appointments were made and met and any follow up actions took place. The family told us they trusted staff and said it was through the staff's vigilance that underlying health issues had been identified and staff had supported the person with subsequent health visits.

Assessments of people's capacity were only completed where someone was thought not to have capacity to make decisions about their care and welfare. We saw examples when people and their families were consulted about their care. Most staff had not received training about how to support people who lacked capacity so we could not see how staff would recognise when they needed to involve other agencies to support the person in their best interest.

Good

Is the service caring?

Our findings

We visited people as part of our inspection to understand their views. People were spoken with and made positive comments about the staff who supported them with their needs. One person said, “All staff are very punctual they phone if they are going to be late.” “All of the staff are caring and polite.” Relatives also told us they were confident and happy with the service.

One person told us. “It’s the little things they know to do without having to ask them, like filling my hot water bottle and leaving the kitchen tidy.” Other people told us that some staff lacked ‘experience ’and needed to be told every time what to do.

We spoke with a person who lived in their own property and had help from a team of carers. They had complex needs but staff were familiar with them and their needs and communicated effectively with the person. We observed strong relationships had developed between the person being supported and staff supporting them. The person was encouraged to do what they could and fully participated in activities in the community. Their relatives visited often and also shared a good relationship with staff. Staff asked the person they were supporting if it was okay to share information about their care with relatives and were respectful of the person’s needs and privacy.

We observed care staff speaking with people respectfully and clearly respecting people’s privacy. We spoke with people about the care they were provided. One person told us they did not wish to have male care staff and this had been recorded and they said it was respected. Another person told us they had male carers and did not mind. They told us they were respectful when providing them with personal care and maintained their dignity.

It was not always recorded in people's records that they or their relatives were involved in making decisions about their care and support. However the manager told us that relatives and advocates were always invited to attend the initial service assessment and on-going reviews. We could not see how often people's needs were reviewed and felt evidence of consultation with people could be improved upon.

People told us they did not always know who was going to help them and some people did not have a regular person to support them. A staff list was not sent out to people to let them know who was coming to support them. Some people said communication was poor and they were not always told who was coming and often they frequently had to ring the office rather than the office letting them know.

Requires improvement

Is the service responsive?

Our findings

We visited people using the agency. Most people told us they were happy with the service they were provided, but most said their care plans had not been updated since they first started using the service as far as they were aware. One person's care plan told us they had four visits a day. When we asked them they said, "No my visits have been reduced to once a day, I needed extra support initially as I was just out of hospital." There was no evidence that a review had taken place before deciding to cut the number of visits and the person was not aware of any reviews.

Care provided was not always responsive to people's needs. People's needs were assessed before a service was offered to them. This included an assessment of risk. People's needs were reviewed at least annually. However the agency was not proactive in monitoring the care people received or ensuring their records were both thorough and accurately reflected their needs. This was because there were no systems in place to do so. The manager explained that reviews were being completely more regularly and all initial assessments were up to date. In between annual reviews they said they were spot checks which should include looking at care records within the person's home. However we saw no evidence this was done

We found evidence that care records were not up to date and without regular monitoring of staff or record audits we could not see how care was delivered effectively. For example we looked at one person's care that had very high needs. The only recorded review of their needs was dated August 2013. Another record showed us that although the person had already been using the service for six months no review had taken place. A third person had support over twenty four hours and their needs had not been reviewed since 2013 month. We identified another person with a life limiting condition and complex health care needs which had not been reviewed in the six months they and been using the agency, which included a stay in hospital. From speaking with them we learnt their needs had changed but their care plan had not been updated.

The provider's policy states that care plans and risk assessments must be updated at least annually or sooner if a person's needs have changed. There was no system in place to ensure this happened.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People's care records did not give enough information about people's needs or identify particular risks to their health, safety or welfare. This would make it difficult for staff not familiar with people's needs to know what was expected of them, or to know what the person could do for themselves. For example we looked at one care plan; this was for a person with a long term condition. There was no information about how this condition impacted on the person's independence. Their care plan was not explicit about the support the person required. It just said, 'assist' with washing, dressing, mealtimes without any further description.

There was nothing recorded about how the person would like their care to be provided. There was no information about their preferences or preferred routines.

People knew how to complain and who to speak with. Everyone was familiar with the manager as they said they sometimes delivered care themselves when they were short staffed. We saw from the agency record that a log of complaints was kept and the manager had attempted to resolve each complaint and kept of record of this.

Requires improvement

Is the service well-led?

Our findings

This was a poorly managed service. Concerns about care were not acted upon robustly and there was a lack of transparency. The provider did not learn from complaints. We saw 40 complaints logged for 2014 and a record of how people's concerns had been addressed. However there was no real analysis. Themes or trends had not been identified to avoid a repeated concern and improve the overall service. A lot of the complaints related to late running calls, problems with care staff and missed calls. This meant people did not receive a reliable service which met their needs.

The manager told us the rotas were now colour coded to determine where staff lived and where people lived to match them up in an attempt to reduce staff travelling time and make the service more effective. The manager told us in the past staff had not been mindful of the half an hour either side of calls but this had been addressed. When we spoke with people receiving a service they told us when they had two people delivering their care, they did not always turn up together. One family member said. "If they don't come together I end up helping out." They told us this was not very helpful. This meant that staffing rotas did not always focus on the needs of people using the service or show us that the service was well managed.

Before the inspection we were told of a number of events affecting the well-being and, or safety of people using the service. These resulted in local authority safeguarding investigations which were not instigated by the service. The manager failed to notify CQC of these events. Information of concern might prompt us to carry out an inspection to the service. Failure to notify us meant we cannot accurately monitor the service and means the provider was not fulfilling their legal obligations.

There were poor systems in place to monitor the care provided to people. The manager was unable to provide us a schedule of reviews so we could not see if these were all up to date. This meant there was a lack of systems to monitor risks to people's health and safety.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People using the service had little or no say in how the business was run. For example we asked for the last quality assurance survey and were told one had not been completed in the last year. The last one was completed in 2013 and including some analysis of what people said. People we met generally had no concerns but were not aware of how often their care should be reviewed and told us they had not been consulted about the service.

There were enough senior staff to support the business, but there were a number of vacant posts. Some staff were relatively new to their posts so were learning their job roles. Job descriptions were being revised but we were not clear what job roles each staff member had and how they were held accountable for their performance. The manager told us a number of staff members had left recently and it was found after they had left that they had not performed as expected. This meant we could not see how they were monitored in their job role to ensure they delivered high quality care. We saw other examples of where staff had not delivered a high quality service and their performance was not being monitored.

The manager said staff were supervised through one to one support, group supervision and spot checks on their performance. However due to vacancies in the office it was not clear how well this was organised. There was no schedule in place for meetings and this was something the manager planned to do. In the absence of formal meetings it was difficult to see how the manager shared the visions and values of the service.

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
Accommodation for persons who require nursing or personal care Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The agency did not fully assess people's needs or keep them under review to ensure care needs and risks to people using the service were properly planned for . Regulation 9**

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were not enough staff or staff employed at all times to meet the needs of people using the service. Regulation 22**

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People did not always receive their medicines safely because staff did not follow best practice guidance. Regulation 13.**

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **There were not effective systems in place to measure the quality and effectiveness of the service delivery or ensure risks to people's safety were adequately planned for and monitored. Regulation 10.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff training was not effective and we were not confident staff were adequately supported. Regulation 10.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Records were not accurately completed; neither did they demonstrate the care required or how it should be given. Regulation 20.