Independent Living Service Limited

# Shirebrook Miners Welfare Charity Centre ILS

## Inspection report

Central Drive
Shirebrook
Mansfield
Nottinghamshire
NG20 8BA

Tel: 01623742351

Date of inspection visit:
06 January 2017
10 January 2017

Date of publication:
01 March 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 6 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk to staff and review records. Phone calls to people were completed on 10 January 2017.

The service provides personal care and support to people who live in their homes in and around the Shirebrook area of Derbyshire. At the time of this inspection 35 people received support from the agency, 28 of those people received support with their personal care needs.

The service is required to have 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 service could not demonstrate all the required pre-employment checks had been completed on staff employed at the service.

The service could not always demonstrate an accurate and complete record of medicines administered for people. In addition, not all audits designed to monitor the quality and safety of services were effective.

The provider did have a policy in place on the Mental Capacity Act 2005 however the service had provided restrictive care to a person without demonstrating the principles of the MCA had been followed.

There were sufficient staff deployed to meet people's needs. Staff were organised to ensure people who required the support of two staff received this support and staff were organised to cover specific geographical areas.

People felt safe with the support they received from the service. Staff had been trained and understood their responsibilities for safeguarding people.

Risks in people's homes were identified and assessed. We identified where risks to one person were known about by staff, however these had not been recorded in a risks assessment. The registered manager sent a completed risk assessment through shortly after our inspection. Procedures were in place for the reporting and investigation of accidents.

People commented that infection prevention and control practices had been improving. We saw this was an area monitored by the registered manager and senior staff to ensure staff practice continued to meet standards.

Staff had maintained up to date skills and knowledge in areas relevant to people's care and support,

including safeguarding people and assisting people to mobilise safely.

Staff understood how to support people with their nutrition and hydration needs. Staff provided care and support to help people with their meals and drink in a way that met their known preferences.

Staff felt supported by the registered manager and senior staff and had regular contact with them.

Staff were mindful of people's healthcare needs and supported people to access other healthcare provision when required.

People were cared for by staff who were caring. Staff knew the people they supported and provided regular support to people. Staff promoted people's dignity and privacy. People were involved in planning and reviews of their care and support.

People knew how to raise any worries or concerns. People received personalised and responsive care and their views and preferences were respected.

The service promoted an open and inclusive culture. The registered manager demonstrated and open and inclusive style of leadership.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection. You can see what action we told the provider to take at the end 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.

The management of medicines was not always effective. Required pre-employment checks on staff had not always been completed. People were supported to live safely as their needs had been risk assessed and managed. Sufficient staff were available to meet people's needs.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

The service did not always follow the principles of the Mental Capacity Act 2005 (MCA). Staff training was up to date and included areas relevant to people's needs. Staff felt supported by their managers. People were supported to have good health and nutrition.

### Is the service caring?

**Good**

The service was caring.

Staff were caring towards people using the service and respectful of their needs. Staff promoted people's privacy and dignity. People were involved in planning the care and support they required and their views and decisions were respected.

### Is the service responsive?

**Good**

The service was responsive.

The views of people and their preferences were respected. People knew how to raise feedback or complaints and any complaints received were investigated. People received personalised care, responsive to their needs and were involved in planning and reviewing what support they needed.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Policies and procedures were not always followed. Records of medicines administration were not always complete. Quality assurance measures were not always effective. The management and culture of the service was open and inclusive.

# Shirebrook Miners Welfare Charity Centre ILS

**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 6 and 10 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk to staff and review records. The inspection team included one inspector and an expert by experience. An expert by experience is a person who has personal experience of using for caring for someone who uses this type of care service.

Before the inspection we looked at all of the key information we held about the service. We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service. We also checked whether we had received notifications sent to us by the provider. Notifications are changes, events or incidents that providers must tell us about.

In addition, during our inspection spoke with eight people and one person's relative on the telephone. We also spoke with the registered manager and provider. We spoke with one team supervisor who had responsibility for training, two senior care staff and two carers. In addition we spoke with one health care professional and one social care professional.

We looked at three people's care plans and reviewed other records relating to the care people received and how the agency was managed. This included risk assessments, quality assurance checks, staff training and recruitment records.

Requires Improvement

# Is the service safe?

## Our findings

We looked at how the provider recruited staff. Whilst some pre-employment checks had been completed on staff, including obtaining information from the Disclosure and Barring Service (DBS) and references, some required checks had not been completed. Not all staff had completed an application form and the registered manager confirmed they had not always required staff to complete one. There were no details of some staff member's previous employment history; and no information to show consideration of any staff health to inform their employment. The registered manager confirmed they were not aware of their requirement to check any gaps in a staff member's employment history. The registered persons had not ensured that staff employed were subject to all the required recruitment checks. This meant not all steps had been taken to help ensure people employed at the service were suitable to do so.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "My carer helps me with my tablets in the morning. If they are running slightly late, we will make sure I have my tablets before we do anything else. Ordinarily though, I take them when I'm having my breakfast just before they go and then they write in the records to say I've taken them." Another person told us, "Whilst I can give myself the tablets that I need, I have to ask the carers to separate them out into my daily doses for me. They do that under my direction and then they write in the book to say they've done it. I can then take my medication at the times that are right for me." Staff we spoke with told us they had been trained to manage and administer medicines. They were clear on their responsibility to record the administration of people's medicines on their medicines administration record (MAR) chart. However, records for the actual medicines given, when MAR charts had only recorded 'dossett box' had not been retained. This meant the service had not kept complete records of medicines administered. There is a risk that checks on medicines to provide assurances they are managed and administered safely cannot be fully undertaken when records kept are not complete. For example, identification of errors and reconciling medicines given to those not given. In addition the MAR charts did not record the dose of medicine prescribed. For example, the MAR chart recorded two paracetamol were to be administered. This meant staff could not be assured they administered the correct dose of medicine to people as prescribed. The registered manager sent us information to confirm full records would now be retained.

Although some people we spoke with felt some staff had to occasionally rush their call times people told us they had not experienced any missed calls in the last four to five months and carers were usually on time. People felt that the service had improved in communicating if a call was running late. One person told us, "The carers can occasionally run late if traffic is bad or there has been a problem with the previous client. Until recently, it was always me that had to ring the office to find out what was happening, but lately I have been getting a phone call from either the carer themselves or the office to let me know what has happened." People felt they were informed if their call had been delayed.

People told us there were enough staff to provide them with a service. People told us staff arrived together when their care required two care staff to assist them. One person told us, "I have two carers at a time

because I need to use the hoist to get in and out of bed. I can't say as it's ever been a problem as the two carers always seem to get here together." Staff told us their care calls were coordinated so that when a person required two care staff this was planned to ensure the carers would arrive together. People were supported by sufficient staff who were able to meet people's needs.

People we spoke with told us the service helped them to feel safe. One person told us, "I know that if I didn't have carers coming in, I would not be able to stay here in my own home any longer. My family do worry about me but they know that I am safe as long as I have the support that I do at present. It's really important to me that I can manage to stay here at home for as long as possible." One person's family member told us, "My [relative] really doesn't like to be hoisted, however the carers are really patient and make a point of asking if they are comfortable and whether the sling needs to be moved at all before they start to lift. I know [my relative] has told me that this helps them feel more confident and therefore much safer." Staff we spoke with told us, and records confirmed they had been trained in safeguarding people from harm and abuse. They told us they knew how to identify any potential signs of abuse and how to raise safeguarding concerns with the local authority. The provider had taken to steps to reduce the risks of abuse and preventable harm to people using the service.

One person told us, "The first time I met somebody from the agency, they had a good look round my home and talked with me about a few things that needed changing because they were likely to cause me difficulties in the future." Records showed risks around people's homes had been assessed, such as risks from lighting. Other recorded risk assessments identified specific equipment was to be used to help people mobilise so as to help reduce risks from falls. Out of the three care plans reviewed, staff identified one person with more complex risks and had documented these in file notes rather than in specific risk assessments. This meant specific risk assessments with clear actions for staff to follow were not in place. We discussed this with the registered manager who reviewed the care plan and shortly after our inspection sent through revised risk assessments for this person. This ensured staff had clear guidance on what steps to take to reduce any identified risks to people.

We asked people about the steps carers took to prevent and control the spread of any infection. For example, one person told us, "It can be a bit hit and miss, depending on how rushed the carers are. I do try my best to remind them to put their gloves and apron on, but to be honest I don't really think it should be my job. They have got better lately, and there are certainly less times I have to remind them now." Another person told us, "I used to have to remind them constantly about gloves and aprons and it was really making me cross because it should be basic hygiene. However, of late they have got much better and it is only occasionally now that I still have to remind them." Staff told us they always had access to gloves and aprons and stocks were held at the office. Measures were in place to reduce the risk from infection, prevention and control, however people told us at times, care staff had not always followed these. Records showed actions had been taken to improve infection prevention and control practices, for example infection prevention and control practices were spot checked by senior staff when they observed carers practice. This meant the provider was taking steps to reduce the risks from infection prevention and control.

Staff told us any accidents or incidents would be reported to the registered manager. The registered manager told us no accidents or incidents had occurred and therefore no records had been submitted. They confirmed they would review any accident and incident form submitted to identify if risks could be further reduced.

Requires Improvement

# Is the service effective?

## Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. The service had policies in place that covered what actions to take when a person lived in the community and lacked capacity to consent to their care, and in addition, what actions to take should there be a dispute about decisions about their care taken in a person's best interest. This included where an application to the Court of Protection may be relevant. Applications are made to the Court of Protection when people require restrictions on their liberty in order to keep them safe.
We were concerned that the service had been involved in providing care that restricted a person's freedom when they lacked the mental capacity to agree to that decision, and without the required formal authorisation for this. Although the registered manager was clear that they were no longer involved in providing any restriction to this person, we could not see any evidence that the principles of the MCA were followed for the person's care that was provided in this way during this time. We made a safeguarding referral to the local authority over this historical restriction. Staff had not fully understood or followed the principles of the MCA to obtain people's consent for their care. This meant people were at risk from not having their rights upheld by the service and experiencing unauthorised restrictions on their freedom.
This was a breach of Regulation 11 o the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff were competent at meeting their needs when providing their care. One person told us, "For the time they have with me, I think they do remarkably well to remember everything that I need doing and how I like them to be done." People also told us any new staff were shown what to do by more experienced carers before they provided people's care. People's comments included, "Usually a new carer will come along with one of my regular carers first," and, "I will usually meet a new carer before they are let loose on their own."

Staff told us their training was helpful, for example, training on assisting people to mobilise included practice using a variety of equipment such as a hoist, stand aid and slide sheets for this. Staff told us other training they received was based on completing workbooks and covered other areas relevant to people's needs, such as understanding dementia and safeguarding. Records showed staff received regular training in a range of subjects, which the provider had identified as required for their role.

Staff told us they received support from the registered manager and senior staff at the service and saw them regularly for support. On the day of our inspection we saw staff visited the office and spent time talking with the registered manager and senior staff while picking up their rotas. The registered manager told us there

were no regular recorded supervision or appraisal sessions held with staff. They told us if discussions with staff were needed regarding their performance or any changes to their contracted hours these discussions would be recorded formally. The registered manager told us they felt this was the best way of appraising staff in a small organisation. Records showed senior carers observed aspects of staff practice to ensure their competency and provided feedback to staff on where they had done well and any areas that required improvement. This meant staff were supported to improve and had good areas of practice reinforced.

People were happy with the care they received for their meals. who received care from staff with their meals had sufficient to eat and drink. One person told us, "We have nearly an hour at teatime so that we can have a properly cooked meal. The carers are very good and because we have regular carers who know us, they also know how we like our meal to be cooked." Another person told us, "My carer will always make me a drink first thing in the morning when she arrives and then she will leave me with a jug of cold drink so that I have something that I can reach until the next carer comes." Records showed people's dietary needs and preferences. People were supported to have sufficient to eat and drink.

People were supported to access other healthcare services when required. One person told us, "I have been taken ill when my carer has been there and at the time they called the ambulance and stayed with me until it arrived. They also called the agency who then told my [relative] so that they could meet me at hospital and lastly the carer wrote it all up in the notes. I was very pleased with how they supported me." records showed the service had contacted social workers and GP's when required with any concerns they had identified. The service helped people to maintain good health as staff identified when access to other healthcare was appropriate.

Good

# Is the service caring?

## Our findings

People told us staff treated them and their home with respect. One person told us, "My carer always knocks on the door and calls out before coming in." Another person told us, "I was worried about things getting broken, but so far so good; I am relieved."

People told us staff took the time to show them care and consideration. One person told us, "Even though they are really busy, they always make time to have a chat before they go." Another person told us they felt cared for as, "[Care staff] always make sure I have some drinks prepared for the time until my next carer comes to make me lunch." People felt staff had a caring approach when they visited.

People told us staff promoted their dignity. One person told us, "My carers would never dream of starting to undress me until the curtains are shut in my bedroom each evening. They insist on closing me bedroom door, even though they know there's nobody else here with us." Staff we spoke with understood how to respect people's privacy and promote their dignity when they provided care in their day to day work. People's care was provided in a way that respected their privacy and dignity.

People told us they knew about their care plan. One person told us, "I know I can read my care plan anytime, but I only really look at it if someone is here from the agency." Another person told us how they were involved at the start of their care plan, they said, "We just chatted about my care generally." A third person told us they involved a family member in the meeting to discuss their care plan.

Records showed details of people's social history and life experiences had been discussed with them. In addition, contact details for family members and other people important to the person had been recorded. Records showed staff used this information by offering care that met their preferences. For example, we saw staff had offered to take a person on a walk. This showed people's involvement in their care planning helped staff to provide a caring service that met their expressed preferences.

People told us they felt listened to. One person said, "Everyone's very willing to listen to me." Another person told us, "I've never been made to feel that my views aren't important." Records showed people's views and preferences had been gathered and used to plan their care and support. People, and other people when appropriate, were involved in planning what care and support was needed.

Good

# Is the service responsive?

## Our findings

People contributed to the assessment and planning of their care. One person told us, "I had a review a few months ago. I was asked if I had any problems or if anything in the care plan needed to be changed." Another person told us, I met with someone before Christmas. They looked at all the notes that the carers had been completing and then some new pages were put in my folder. Records showed care plans had been regularly reviewed. People contributed to their care plans and reviews.

People told us when they wanted to make any changes to their care and support this happened. One person told us, "I occasionally have to change the time of a visit. Whenever I've phoned the office, they've always been able to sort things for me." Other people commented, "If I want something doing differently, I'll tell my carers. At my age I'm not going to put up with just anything," and, "My carers know me and they also know that I'll soon tell them if I'm not happy about anything." People told us staff responded to requests they made for any changes to their care. People received personalised and responsive care.

All the people we spoke with told us staff knew them well and understood their views and preferences. One person told us, "My carers know I like a cup of tea before we start in the morning. I don't have to ask them as they put the kettle on as they go by." Records showed people's choices and preferences, for example people's preferences for food and drink.  Staff provided personalised and responsive care and respected people's views and preferences.

People we spoke with told us they had no reason to complain about the service, however should they need to they told us they would feel confident to. One person told us, "There's information about how to complain in my folder here." Another person also told us "It tells you how to complain in my folder where my care plan is." People received information on how to make a complaint if they needed to.

Other people told us they felt confident talking to the care staff or calling the office. Records showed the manager had investigated any complaints raised with the service and that these had been resolved. Records also showed any learning and improvements to the service had been identified by the registered manager as part of their investigation to resolve any issues raised. Complaints were responded to and investigated by the registered manager.

Requires Improvement

# Is the service well-led?

## Our findings

We saw monthly  checks were completed at people's homes on staff conduct, performance and record keeping. In addition, medicine administration notes were checked on these visits and we were also told MAR charts were audited when they were completed and sent to the office. However, these audits were not always effective. This was because the last MAR charts returned for one person had been dated April 2016. This meant no audit of MAR chart records had been completed since this date by office staff. Systems and processes designed to assess, monitor improve and reduce risks to people using the service were not always effective.

Systems and processes designed to reduce risks to the health, safety and welfare of service users were not always operated effectively. This was because policies and procedures to cover the governance of the service were not always followed, or fully known about by the registered manager. For example, the recruitment policy stated the use of an application form detailing a person's employment history and the use of a form for checking employment continuity and for identifying where further investigation was necessary. The registered manager told us not all candidates completed job application forms and they were not aware of the requirement to obtain satisfactory written explanations where any gaps existed in candidates' employment history. In addition, the medications policy and procedure stated the MAR for a person will include the dose of any medicine prescribed. This was not recorded on the MAR charts we reviewed. Although policies and procedures were in place, these had not always been fully implemented.

Records of medicines management and administration were not always accurate and completed. This was because medicines administration record (MAR) charts had recorded some medicines as just 'dossett box.' Dossett boxes help organise a person's medicines and usually have a separate compartment for each day of the week. Where MAR charts only specify 'dossett box' providers are required to also retain a corresponding record to say what medicine was contained in the dossett box for each time period specified on the MAR chart. This is so there is a record retained of the actual medicine administered to a person. This corresponding record was not available. The provider could not therefore always demonstrate what medicines had been administered to a person where the MAR chart had just recorded 'dossett box.' The registered manager agreed to review their current practice and implement changes so that an accurate record of medicines administered to a person would be kept.

In addition the service had not maintained a list of staff signatures so that they could check which staff had signed the MAR chart to confirm medicine had been administered. We discussed this with the registered manager and both senior carers who agreed to take the required action to address this. Shortly after our inspection the registered manager sent an updated MAR chart that included the strength of medicine to be administered and a template for recording staff signatures.

MAR charts did not consistently provide a list of codes for staff to record if a person had not had their medicine for a particular reason. For example, if they refused medicine or if it was not required. We looked at three people's MAR charts and found days where no staff signature or code had been recorded to explain if the medicine had been refused, not required or whether it had been administered by relatives.

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

The service is required to have a registered manager and one was in post at this inspection. The registered manager was aware of their responsibilities and to send statutory notifications to CQC when required. Notifications are changes, events or incidents that providers must tell us about.

The manager was supported by two senior managers. The registered manager and senior managers demonstrated an open and approachable style of leadership. People and staff told us they were comfortable talking with them. One person told us, "[The managers] seem very genuine, so I'd be comfortable talking to them about any difficulties." One member of staff told us their managers were, "Approachable and fair." The service was being led with an open management style.

Staff we spoke with told us they enjoyed their role. One staff member told us, "We all get on; I love my job." We saw staff meetings provided opportunities for staff to share their views about people's care as well as receive information from senior staff on good or required care practice in such areas as confidentiality. We saw the last staff meeting minutes were dated July 2016. Staff told us they found the meetings useful. These meetings helped to provide support and reinforce good practice. However, one member of staff told us they would like them to be held more frequently as they, "Would like to communicate more."

People we spoke with told us they were satisfied with the service they received. The service also collected people's views on the service through a survey type questionnaire. We read the responses to the last survey questionnaire and found these were positive. People's views were gathered and people were involved in the way the service operated.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>Restrictions had been placed on a person who lacked the capacity to consent to their care and the principles of the MCA had not been followed. 11 (1) (2) (3) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Records of medicines administration were not always complete. Systems and processes were not always operated effectively to assess, monitor, improve and mitigate risks. 17 (1) (2) (a) (b) (c) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment records did not demonstrate the provider had checked people could properly perform their role, as required through any reasons of their health after any reasonable adjustments had been made. Neither had any gas in people's employment history been checked and a satisfactory explanation sought as per schedule 3. 19 (1) (c) (3) (a) |