Care Quality Commission

Sterling Homecare Limited

Sterling Homecare (Derby)

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We inspected this service on 8 and 15 December 2015 and the inspection was announced. This meant the provider and staff knew we would be visiting the service's office before we arrived.

Sterling Homecare (Derby) provides personal care and support to younger adults, children and older people living in their own homes in Derby and Derbyshire. This included people with learning disabilities or mental health. At the time of this inspection there were 66 people using the service, which included up to 25 people who received personal care.

There was a registered manager in post, who registered with CQC on 31 December 2015. 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

People's care was not being delivered in accordance with their care plan and did not ensure their safety. For example some people told us that their calls were sometimes missed altogether.

We found unsuitable arrangements in place to assess and monitor the quality of the service, so that actions could be put in place to drive improvement as required.

Risk assessments and care plans had been developed with the involvement of people. However these had not been reviewed at regular intervals to ensure they were current. Systems were in place to ensure people received their medicines in a safe way.

Staff treated people in a caring way. However staff did not always maintain people's privacy and dignity.

Complaints were not always well managed and communication with the office had been inconsistent and not resolved issues satisfactorily.

Staff were able to demonstrate on how they would keep people safe. However we found that the provider did not have effective processes in place to ensure all safeguarding concerns were reported to all the relevant authorities in a timely manner.

Current staffing levels did not ensure that there were sufficient number of staff to meet people's individual needs. Recruitment procedures were safe.

The branch manager and staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA). This included staff seeking consent from people before delivering care in accordance with their care plan.

Staff told us that they would alert health care professionals if they had any concerns about people's health and they would inform the office staff if they were concerned about a person's well-being.

People's needs were assessed prior to the service being offered and they had been involved in assessments.

Where we have identified breaches of legal requirements and regulations associated with the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, you can see what action we told the provider to take at the back of the full version of the 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?

Requires improvement

The service was not safe.

People's care was not being delivered in accordance with their care plan and did not ensure their safety.

Peoples risk assessments were not reviewed at regular intervals to ensure they were current and that staff could support people safely.

People were protected from abuse because staff had a good awareness of

abuse and how to report concerns. The provider had a system in place for staff to follow, in an event they had any concerns to raise.

Current staffing levels did not ensure that there were sufficient number of staff to meet people's individual needs. Recruitment procedures provided assurance that the staff employed were suitable to support people.

The provider had systems to ensure people received their medicines as prescribed.

Is the service effective?

Requires improvement

The service was not always effective.

Staff felt confident to fulfil their role because they received the right training and support. However training records showed that some staff were due refresher training which did not provide assurance that they were effectively able to carry out their role.

Staff understood the principles of the Mental Capacity Act 2005 so that people's best interests could be met. Three staff told us that they had not undertaken training in this area.

People were supported to eat and drink enough to maintain their health, and staff monitored people's health to ensure any changing health needs were met.

Is the service caring?

Requires improvement

The service was not caring.

People's privacy and dignity was not always promoted by staff.

People were supported by caring staff.

People were supported to make decisions about their care and support.

Is the service responsive?

Requires improvement

The service was not responsive.

Summary of findings

People were involved in developing their care plan. However some people's care plans had not been up dated to reflect the support they required.

People were not confident that any concerns they raised would be listened to and action would be taken.

Is the service well-led?

Inadequate 

The service was not well-led.

The service had a registered manager in post. However some people using the service and their relatives felt that the service was not always managed effectively.

Some people did not receive appropriate communication from the service and felt that complaints were not always well managed.

Suitable arrangements were not in place to monitor the quality of the service.

Sterling Homecare (Derby)

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 8 and 15 December 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available at the office.

The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert-by-Experience did not attend the office base of the service, but spoke by telephone with people who used the service and relatives of people that used the service.

Prior to our inspection, we reviewed the information we held about the service, which included notifications. Notifications are changes, events or incidents that the registered provider must inform CQC about. We contacted commissioners and asked them for their views about the service. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with 19 people; this was a mix of people using the service and relatives of other people using the service. We spoke with the branch manager, training officer and seven staff.

We reviewed records held at the service's office, which included four people's care records to see how their care and treatment was planned and delivered. We reviewed three staff employment records and other records which related to the management of the service such as quality assurance, staff training records and policies and procedures.

Requires improvement

Is the service safe?

Our findings

Most people we spoke with told us that the communication with the service was not good and when care staff did not arrive on time; they rang the office to establish what was happening. People also said that some care staff did not stay for the allocated call length. Another person said, "The carer was 40 minutes late; they want to get out as soon as they come in." A relative stated, "Two care staff turned up when none were booked." Some people told us that their calls were sometimes missed altogether, which they stated occurred mostly at tea-time calls and weekends. Some people told us that call times that had been agreed on the care plan were not the same as the rota's which were sent to them. A person said, "The time of my call is changed without any explanation." One relative said, "The times on the rota didn't match the time of arrival." Another relative told us that their family member required the support of two carers at each call, but this did not always happen. During such occasions the relative was left on their own to support their family member. This demonstrated that people's care was not being delivered in accordance with their care plan and did not ensure their safety.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed staffing with the care staff we spoke with; they felt the staffing levels were ok. One member of staff stated, "Staffing levels change, we seem to have lost a lot of staff recently." Another member of staff said, "At the moment we are stretched to the limits, due to staff being on leave. Once the staff return to work we will be fine." Another member of staff stated, "I think we could do with more staff, to cover sickness and leave."

Before the inspection visit external professionals raised concerns with us about staffing at the service. We discussed staffing with the branch manager, who told us that there were currently some vacancies, which were being recruited into. The branch manager told us that these vacancies were currently being covered by existing staff. Following the inspection, senior management told us would manage any event where there may be a shortage of care staff to cover calls. Additional staff from other services within the provider group could be used to support the service. The current staffing levels did not provide assurance that there were adequate staff numbers so that people's needs could be met safely.

Prior to the inspection we received information from the branch manager regarding a safeguarding concern, which they had reported to the local authority for further investigation and monitoring. At the inspection we found that the service had not followed this through with other relevant authorities. This did not provide assurance that the provider had effective processes in place to ensure all safeguarding concerns were reported to all the relevant authorities in a timely manner. Due to the nature of the concern we discussed this with the branch manager, who following our discussion made a referral to another relevant authority.

The provider had taken steps to protect people from abuse. Staff confirmed they had attended training in safeguarding, records seen verified this. The members of staff we spoke with demonstrated a good understanding of the types of abuse people might be at risk of. Staff could tell us in detail what actions they would take if they had concerns for the safety of people who used the service.

We looked at risk assessments relating to some people using the service. Potential risks to people's safety, health and welfare had been assessed. However for one person their assessment stated, "Needs assistance first thing in the morning." However there was no further information to confirm what level of assistance or support staff needed to provide this person with. For another person their moving and handling assessments had not been reviewed for over 12 months. We could not be assured that the information in this assessment was relevant. This did not ensure people were supported in a consistent manner to minimise risk.

People's home environment had been risk assessed to ensure that the care and support people required was provided within an environment that was safe for people and staff. Also to ensure that any potential risks were minimised. For instance this included access to the property.

We looked at how staff supported people to take their medicines. Some people we spoke with told us that they were either supported by staff or their family to take their medicines. Staff we spoke with told us that the medicines administration record was kept in the person's home and that this would be signed when people had taken their medicine. This ensured that an audit trail was in place to monitor when people had taken their prescribed

Requires improvement

Is the service safe?

medicines. Staff told us they had undertaken medicine training. However one member of staff told us that since joining the service they had not received training in this area.

One person's relative told us that staff had not administered antibiotic's to their family member as these were not included on the medicines administration record (MAR). Following the inspection we discussed this with senior management, who confirmed that the care staff had followed correct procedure as they are unable to administer medicines which are not specified on the MAR. The senior manager informed us that the care staff should report such issues to the office, so that the necessary arrangements could be made to include additional prescribed medicine onto the MAR. One person said, "I cannot take my medication until I've eaten, so if they don't turn up I'm left in pain. I can be waiting for an hour." This did not provide assurance that medicines were always administered as prescribed.

The provider had suitable recruitment processes in place which checked staff were suitable to support people that used the service. All of the staff we spoke with told us that they provided references and completed disclosure and barring (DBS) checks before they started work at the service. Recruitment records we looked at also confirmed this.

Requires improvement

Is the service effective?

Our findings

People using the service told us that they were happy with the staff who supported them. One person said, "The staff are very nice." Another person said, "My regular carer is great."

Two staff told us they had not received regular supervision. One member of staff told us that they had been working at the service for over 12 months and had only received one supervision. Another staff member said, "There have been staff meetings, but I have not had any supervision sessions." This did not provide assurance that the provider had effective systems so that staff received appropriate guidance and support.

Staff we spoke with told us they received training which was relevant to their role. One staff member stated, "I have received some training updates and some are coming up. Another member of staff told us, "The training I have had has been the best training I have had, it was really good." Staff told us that they shadowed an experienced member of staff before they started to work alone. However training records we looked at showed that some staff were due refresher training. For example out of the 63 staff listed on the training record, 22 staff required update training in moving and handling during 2015. This did not provide assurance the provider had robust systems ensuring that all staff had up to date knowledge and skills to carry out their role effectively. This also meant that staff may not being supporting people effectively with moving and handling.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. The branch manager told us that if they believed a person lacked capacity, a capacity assessment would be completed. Records seen demonstrated that people's capacity to make decisions would be incorporated with their care plans if required. None of the peoples care records we looked at lacked capacity. Staff we spoke with had a good understanding of how to ensure a person consented to the support they received. This demonstrated that the provider had systems to ensure that staff had obtained consent from people they supported. Most staff we spoke with told us that they were provided with training to support their understanding around the MCA. However three staff told us that they had not undertaken training in this area.

Where relevant, staff were required to reheat and ensure meals were accessible to some people who used the service. Those staff who supported people with their meals told us they had received training in food hygiene**.** People's support plans included information as to people's

dietary requirement, which included their preferences. `Some people required support by staff to ensure they received adequate nutritional intake due to difficulties with swallowing or who may be unable to take enough food or fluid to meet their nutritional requirements. One member of staff said, "I have had the relevant to training to support [Name] with the administration of their feed." However the provider was unable to evidence that this training had been undertaken to support a specific person. This is where a person has a Percutaneous Endoscopic Gastrostomy (PEG) tube. This is a feeding tube which passes through the abdominal wall into the stomach so that feed, water and medication can be given without swallowing.

People's health needs were identified in their care records. Staff we spoke with told us that they would seek medical support if they were concerned about a person's health care needs. One staff member said, "I would contact emergency services immediately, if a person required urgent medical support. Also if I had concerns about a person's catheter I would contact the office for advice." This demonstrated that staff monitored people's health needs to ensure that appropriate medical intervention could be sought as needed.

Requires improvement

Is the service caring?

Our findings

People told us that they liked the staff who supported them and that some staff were more caring than others. People who had regular carers were very positive about them.

Staff we spoke with had a good understanding of people's needs and were able to tell us how they cared for people in a dignified way. They were able to describe to us how they would respect people's privacy and dignity when providing personal care to people. Staff told us that they ensured doors were closed when people were using the bathroom. A member of staff told us, "I always make sure people are covered up when going from the bathroom." Staff we spoke with understood the importance of promoting people's independence and enabling them to maintain or develop activities of daily living such as combing their own hair. One member of staff we spoke with said, "I encourage people to do things for themselves, as long as it doesn't impact on their safety." This demonstrated that staff treated people in a dignified manner, respecting their privacy and dignity.

Whilst contacting people using the service, a member of agency staff answered the telephone. The member of staff was not discreet about the person's personal care needs they were supporting the person with. This showed that the staff member did not understand the importance of respecting a person's privacy and dignity.

Staff we spoke with told us that the service met peoples gender preferences, with regards to the staff who supported them. Information seen demonstrated that people's gender preferences with support and care were met.

Care plans had been developed with the involvement of people using the service or their representative. We saw that people or their representative had signed the care record to denote their agreement in the care records we looked at. Entries in a communication book we looked at in the office were written in a respectful manner.

Requires improvement

Is the service responsive?

Our findings

Some people we spoke with raised concerns about the service they received from Sterling Homecare (Derby). For example some people told us that the communication was not good and that the service did not listen to them.

The Branch Manager told us that complaints were logged on people's individual care records which were computerised. As complaints were not recorded centrally it was not possible to establish that complaints received by the service had been investigated and responded to appropriately. Also whether or not the complainant was satisfied with the outcome. This did not provide assurance that the provider had effective systems in place to respond to peoples concerns.

Staff told us that any complaints or concerns shared with them would be reported to the office or the manager.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The branch manager told us that the senior carer's visited people and their relatives as part of the initial assessment process. This was to ensure that the service had a clear understanding regarding the person's expectations of the support they needed so that the person could be confident that the service was right for them. The assessment of need had been used to develop peoples care plans. Care plans we looked at has been signed by the person or their relatives. These demonstrated their agreement and involvement to the initial care plan.

People's care records we looked at were individualised. However we found that some people's care plans were not reviewed regularly. For example one person's care plan had not been updated for over 12 months. We discussed this with the branch manager who confirmed that this person's care plan would be updated to reflect the actual support which was being provided by staff from the service. This showed that the provider was not always responsive in meeting people's needs.

Staff we spoke with were knowledgeable about people's needs, preferences and routines. They were able to describe to us how they met people's care needs and how they supported people to express choices and maintain their independence.

Staff told us they worked well as a team to ensure people were supported according to their needs and preferences.

Inadequate

Is the service well-led?

Our findings

People using the service and their relatives we spoke with felt the service was not managed well. One person said, "When management changes, we have to start again." Another person told us, "Communication appears to be absent or inadequate; they suit themselves it's the way things are run." One relative felt that the communication was not good and that the management got nothing right. A couple of staff felt that the communication in the office was not always very good. One staff member told us, "If the rota is not correct you tell the office and the same mistake will happen again." Another member of staff stated, "If you ring the office with concerns, they don't ring you back." This showed that systems were inconsistent to ensure effective communication between people using the service, staff and management and not responding in a way people would have expected.

The current branch manager had been in post since September 2015; they were in charge of the day to day management of the service and provided support to the rest of the staff team. Following this inspection visit, the branch manager's application for registering as the registered manager was successfully completed on 31 December 2015. A registered manager is a person who has registered with the CQC to manage the service.

Care staff we spoke with confirmed that there had been some changes in the management team at the service and felt that this had impacted on the running of the service. One staff member said, "This is the third branch manager. At mid-point things flopped a little, however the management is picking up." Another member of staff said, "Before the current branch manager, the service was a complete mess and they have been fire-fighting." Another member of staff stated, "We have had too many changes in the office staff and management. Things are still not settled, but I feel eventually things will settle." Following the inspection visit we discussed this with senior management; they told us that there had been a few changes in the management team and some other personnel including care and office staff. The management team felt that following a period of instability, things were now settling at the service.

At the inspection we found that the provider did not have effective systems to assess, monitor and improve the quality and safety of the service. Or to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service and others who may be at risk. For example we were told by management that if staff were not trained to support a person, they were not permitted to support them. However there was no contingency plan in place to ensure calls were covered when trained staff were not available. This did not ensure the safety of people using the service and showed that support or resources needed to run the service were not also available.

We were told by management that complaints were held on people's individual electronic records. We saw there was no analysis of complaints logged on people's individual records. This meant that there was no information on patterns or themes of complaints received at the service. We were concerned there was no documented evidence to demonstrate that in an event the service had received concerns that these had been followed through or actioned. We asked the branch manager to send us information on the complaints procedure, however this information was not provided. This demonstrated a service which was not well-led.

We requested information on the latest feedback from quality satisfaction survey's completed by people using the service and their representatives. We were told that questionnaires were sent out annually by head office to people using the service. We did not receive this information which we had requested. We were told that telephone calls to people using the service and their representatives were carried out as part of the quality assurance process. We saw no evidence to show that this information had been analysed or audited. This showed that the provider did not have comprehensive systems in place to assess and monitor the quality of the service.

We were shown the internal Audit dated January 2015. The current Branch Manager stated that in an event a Branch Manager left the position, it was their responsibility to pass on actions which remained outstanding. There was no evidence to support whether actions identified in the internal audit had been actioned to drive improvement.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The branch manager told us that checks of completed medicine records were carried out; this enabled them to analyse and identify any trends in errors. The branch

Inadequate

Is the service well-led?

manager explained through this process if competency related issues were identified appropriate action would be taken. We were told that communication books were also audited to ensure consistency of care and that the care delivered is in line with the person's care plan.

We saw that accidents and incidents were recorded appropriately and were analysed. This meant that action to prevent incidents re-occurring had been identified.

The provider had notified the Care Quality Commission of events or incidents affecting the service, this demonstrated that the provider was therefore ensuring that legal requirements were met. We saw that people's confidential records and staff personnel records were kept securely in the office. We raised the issue of confidentiality when accessing electronic records; the branch manager told us that staff who accessed this information signed confidentiality statement.

Following the inspection we returned to the service we saw that action had been taken to increase security and the front door to the office was being kept locked.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **Person Centred Care.** **How the regulation was not being met:** People's care was not being delivered in accordance with their care plan and did not ensure their safety. Regulation 9 (1)(a)(b)(c)(3)(b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **Receiving and acting on complaints.** **How the regulation was not being met:** The provider did not have effective systems in place to respond to people's concerns. Regulation 16 (1)(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **Good Governance**. **How the regulation was not being met:** People who use services and others were not protected against the risks associated with good governance because of inadequate systems or processes to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1)(2)(a)(b)(c)(f)

The enforcement action we took: