Cambridge Care Company Limited

Cambridge Care Company - Haverhill

Inspection report

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Date of inspection visit:
02 October 2017

Date of publication:
20 December 2017

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service between 7 March 2017 and 28 April 2017. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 18 on staffing and Regulation 12 medicines.

We undertook this unannounced focused inspection on 2 October 2017 to check that they had followed their plan and to confirm that they now met legal requirements. We also telephoned people over the next three days and awaited further information from the provider that arrived on 18 October 2017. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cambridge Care Haverhill on our website at www.cqc.org.uk.

We had been contacted by people's representatives who used the service and staff who worked for Cambridge Care who shared concerns about care delivery. The team inspected the service against one of the five questions we ask about services: is the service safe.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our on going monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, younger disabled adults and supported living for adults with a learning disability. This inspection focused upon Haverhill and we were told that they provide approximately 1300 hours per week to 100 people. As well as staffing two bungalows 24 hours for adults with a learning disability.

The service had an appointed manager in post that was in the process of applying to become registered with the CQC as the registered manager of the Haverhill location. 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.

At the previous inspection there was a breach in staffing because there was not always enough staff deployed in a timely manner. This remained the same at this inspection. People told us they were generally happy with the service, but people could not rely upon Cambridge Care to meet their needs when they needed them met. People experienced an inconsistent service delivery with staff changes made that led people to experience a service that was well meaning but erratic for some people. Therefore we have found an on going breach of regulation because the service did not have sufficient staff to keep people safe and

meet their needs.

At the previous inspection we found a failure to manage people's medicines safely and the inadequate risk management placed people at risk of harm. At this inspection some people fed back they were generally satisfied others were deeply unsatisfied and said people were at risk when they did not receive their medicines. We found that medicines were not safely managed. Staff had not consistently followed policy and procedure when a prescriber of medicines verbally communicated a change in amounts of medicines to be administered. Nor had they been given written instruction when medicines needed specific administration methods. Audits were not consistent an thorough. But of concern was that some important medicines had gone missing. We did not see that an investigation and report into the matter had been conducted to learn from the events to ensure all concerned learnt from the incident. Therefore we have found an ongoing breach of regulation because medicines were not as safely managed as they should be.

We found a breach in regulation relating to the assessment of risks and the actions taken to mitigate these and keep people safe. This was because peoples risk assessments were not individualised and specific to the person and did not always adequately inform staff on how to keep a person safe. Examples we have used relates to a moving and handling assessment that was inadequate and left both the person and safe at potential risk. People were not consistently protected from issues relating to infection control.

We found a breach relating to safeguarding people from abuse and improper treatment because systems and processes were not effective to investigate, immediately upon becoming aware of any allegation or evidence of abuse.

You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

Staff had not always followed policy or best practice guidelines when administering people`s medicines.

People told us they were not always informed of which staff would support them and at what time.

Risks involved in people`s daily living were recognised but mitigation was not individually documented for staff to follow.

People were not consistently protected from the risk of abuse as staff knew how to recognise but not consistently respond to concerns in a timely manner.

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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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by people's representatives and staff who contacted us about care delivery. This came from four different sources.

This inspection took place on 2 October 2017 and was unannounced. Two inspectors conducted this inspection. We visited the office location to see the manager and office staff; and to review care records and policies and procedures. We also visited five people that lived in their own home the same day. We went on to telephone 12 people in receipt of the service who had not contacted us. We spoke to nine staff and four health and social care professionals. Records we examined included four administration records and five care files. We reviewed eight staff files.

Inadequate

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns about medicines and staffing found during our previous inspection between 7 March 2017 and 28 April 2017.

People had varying experiences with staff reliability and consistency. One person said, "Sometimes we have had 18 different carers in a week. This week on the roster they sent we have 14 different carers." A different person said, "They fluctuate with their times. You cannot plan when they will arrive." A different person said. "They leave a lot to be desired. Never arrive on time. Sometimes they are so young and inexperienced that I have to help out by telling them what to do." People explained that this impacted upon them because they could not plan their day, especially if they had an appointment to attend and needed to be ready for transport arranged. Others said that with the changes in staff made them feel less confident and made them more vigilant of the care and support being provided to ensure it was correctly done. There were some positive comments about regular carers and how nice staff were but in the main comments were that the service was not consistently reliable with changing staff supplied. People told us that they also did not like it when there was a change of carer to the one they had been told about and they were not informed of the change made. This means that people could not rely upon Cambridge Care to receive care from the same team of carers that they know.

One staff member said, "We often have service users complaining about late or missed visits. There just is not enough staff and we have to work really long hours." A different member of staff said that their roster had showed them in three different places at the same time. We had also received information from staff prior to our visit that told us that they were double booked on their visits. When we put this to Cambridge Care managers they explained that the system could be overridden by senior staff to allow this to happen but that it was not the norm and they would take steps to change the code so that it could not happen again. At the last inspection we were informed of plans to invest in a system which would enable carers visit arrival and departure times to be captured using their mobile phone. This tracking system would mean staff could be monitored remotely and give assurances to the provider and registered manager that staff were arriving when they were expected. The monitoring system would also enable them to take action should they become aware of issues where for example staff were running late. We were informed that this system was not adopted at this location because the soft ware had failed to deliver as promised at another service and the provider was not willing to risk that it would not work as promised here. However, we found that the management had no oversight as there were no systems to replace this.

When we examined rosters we found that Cambridge Care did not allow staff time between calls to travel from one location to another but that call times ran concurrent no matter the distance to be travelled. This meant that by the end of a run of calls they would run late and need to cut call times to keep to a schedule. When we put this to the agency they told us that this was what happened and had always happened and therefore was the norm. They also said this was acceptable to the local authority and for calls that were 30 minutes then a minimum of 20 minutes with a person was acceptable. We spoke with the local authority and they told us this could occur if staff made up their allocated time elsewhere with the persons agreement. Despite this fact we would like to draw the attention of Cambridge Care to NICE Guidelines on

Home care: Delivering Personal care. The service should consider current guidance that states scheduling sufficient travel time between visits.

We have concluded this was an on going breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people required assistance with their medicines some people told us that they were satisfied with the arrangements. One person said, "Yes all is fine." However, a person's representative and a health and social care professional told us that medicines were not managed well. On occasion medicines were not given or on occasion too much was administered. These medicines were needed to maintain health and without them the person was placed at risk. A staff member contacted us about some important medicines that had gone missing, they said that they had reported the matter to mangers in the office, but as far as they were aware, no action had been taken. When we visited two weeks after this had been reported to managers we found that insufficient actions had been taken. We would have expected, in line with NICE guidance, for Cambridge Care to have 'robust process for identifying, reporting, reviewing and learning from medicines related problems'. These would include possible misuse or diversion of medicines. In practical terms, and in line with the above, we would expect the agency to have undertaken a thorough investigation. There might also be follow up activities depending on what the investigation had found. We were told that matters were looked into by a manager, but despite requesting this we were not provided with any evidence and staff fed back they had not been given any feedback on matters.

Care workers were provided with training and had medicines competency checks. We looked at medication administration records (MAR) that had been returned to the office and records in peoples own homes. We found that staff had not consistently followed policy and procedure in terms of verbal orders received. This means when a prescriber of medicines verbally communicated a change in amounts of medicines to be administered. The policy and procedure stated this should have only been for one days treatment and thereafter staff should have obtained written instruction. When this was brought to the attention of a manager they agreed to make alterations so that both people and staff were protected and follow the agreed procedure in future. We examined records where specific instructions were required to guide staff on administration. For example the administration of alendronic acid. We found no instructions on MAR charts or care plans. This placed people and staff at potential risk. There were audits in place on medicines to ensure people received medicines as intended, but these were not consistently completed for all people. Therefore errors such as missed medicines were not able to be consistently addressed with staff. Systems in place were not robust and effective with people receiving medicines as intended by the prescriber.

The failure to manage people's medicines safely was an on going breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoken with told us that they felt safe using the service and with their care workers. One person said, "Yes I feel safe. The staff are kind." Another person said, "I feel safe. They are good staff I trust them." A relative said, "Yes I think it is safe care. But I do feel nervous when new staff come."

Records showed that the service's recruitment procedures were satisfactory. Systems in place to check that care workers were of good character and were suitable to care for the people who used the service could be further improved. Whilst we found that checks such as references and criminal records checks were in place not all managers were aware to follow their own policy in relation to criminal checks with a positive record. Their own policy 5.21 stated that 'any decision should be recorded and able to be justified'. We were unable to find any risk assessment that showed that positive criminal checks had been assessed, mitigated and conclusions drawn that the person was suitable to work with vulnerable people in their own homes.

There were systems in place designed to minimise the risks to people in relation to avoidable harm and abuse. Care workers were provided with training in safeguarding people from abuse. We asked staff about this training. One staff member said, "It was covered on the induction training and we were given all the numbers needed to call. There is a section at the front of peoples care plans that covers such an event if needed." Some staff understood their roles and responsibilities regarding safeguarding, including how to report concerns. One staff member said, "I would report to my line manager, use the body maps and get all the information fresh and write it down. If they did not act I would go higher in the organisation and then if needed call the police." We saw evidence in staff files that this knowledge was checked within supervision sessions and information was visible in the main office. However, we concluded that not all staff consistently were confident enough to raise issues in the correct manner and in two cases we believe that action by managers was not as timely as it should have been. We received whistleblowing information about one incident that was only appropriately processed through local authority safeguarding once we became involved. One recent investigation conducted by the local safeguarding team recommended involvement of the provider support team to deliver some training to staff. However, this was cancelled by the agency as there was insufficient staff available to attend. Staff interviewed during our inspection and a relative told us about another incident from some months previous. When a concern was raised within the service we found evidence of delay in reporting matters to external bodies in line with policy and procedures. Both matters related to the conduct of staff and the service did take action and those staff were no longer with the agency. Staff who said they had reported matters felt they had not been kept informed and updated that action was taken to keep people safe. We found a lack of timely reporting and a degree of reticent to involve external bodies.

We conclude there had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems and processes were not effective to investigate, immediately upon becoming aware of any allegation or evidence of abuse.

People's care records included risk assessments and guidance for care workers on how the risks were minimised. However, these risk assessments were the same for each person in each setting we visited. Risk assessments associated with moving and handling, eating and drinking, accessing the community, finances and risks that may arise in people's own homes were not individualised. We examined the moving and handling risk assessment of one person and found that this did not give the required detail of the sling size to use, the loops to use for managing the persons position or named the equipment that was to be used for each move. The moving and handling risk assessment was not designed for each individual that the service supported. Staff did not have specific instruction to guide them. Therefore people and staff were placed at potential risk. One health and social professional raised concerns about hygiene. They described visiting their client to find that the person had been served their meal on a commode that contained human waste. This was not just a health hazard but also compromised the person's dignity. We spoke with a social/health care professional who told us, "Despite raising issues with them care did not improve. They made promises to improve but consistently failed in the basic care standards required of them."

We conclude there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks to people were not adequately assessed with all reasonable in place to mitigate those risks.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at potential risk because there was an on going failure to manage people's medicines safely. People who use services and others were not protected because risks to people were not adequately assessed with all reasonable in place to mitigate those risks.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were placed at potential risk because systems and processes were not effective to investigate, immediately upon becoming aware of any allegation or evidence of abuse.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient staff were deployed to meet peoples assessed needs.