Local Solutions

Scotland Road Branch

Inspection report

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22 March 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This announced inspection took place between 14 and 22 March 2016. The previous inspection in October 2013 found the service to be compliant under our old methodology for inspection.

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.'

'Local Solutions' Scotland Road Branch is a not for profit social enterprise, predominantly operating across the North West of England. The organisation is a registered charity and it does not recruit nurses. The organisation provides personal care and support for people living in their own homes.
At the time of our inspection there were 892 people using the service and 349 care staff.

We saw the service had implemented a robust recruitment system. Disclosure Barring Service [DBS] checks were undertaken on staff to ensure they were able to work with vulnerable people. Staff had an induction programme in place.

Most staff members we spoke with had heard of the term Safeguarding and described how they would report an incident but only one staff member we spoke to mentioned abuse when asked about Safeguarding. Therefore, we were concerned staff only had a basic awareness of Safeguarding. For example, one staff member told us Safeguarding is "Making sure vulnerable adults are safe as possible in my care and respecting them and everything".

Staff were receiving supervision but not consistently to demonstrate continuous on-going improvements and developments were being made. There was an appraisal system in place. We received information from a staff member who informed us that they were, at times sent to deliver care without having the appropriate information about the person to be able to deliver care.

We looked at the care records and found risk assessments were either absent or did not contain detailed enough information to keep people safe. Staff who were providing care to people with complex needs had not been trained adequately. We could not find medication risk assessments or medication care plans.

Care plans were not being reviewed according to the changing needs of people and checks were not in place to ensure people were receiving care for the duration of their calls. We found there was no system in place for checking if incidents reported by staff were then dealt with and reported to the Local Authority. During the inspection, we found examples of incidents which had not been reported.

Staff we spoke with demonstrated a caring approach and were observed interacting with people in a caring manner. Most people we spoke with provided positive feedback about the manner in which they were

spoken to and felt listened to.

People were not always receiving care at a time which suited them and told us they fitted around the needs of the service. We found the system of care delivery did not allow staff travel time in between their calls which meant staff were either having to leave early to enable them to arrive at their next call on time, or be late for their next call. This was impacting on people who received the care as they were not receiving care for the duration of the call.

We could not find a system in place which ensured people who lacked Mental Capacity to consent or make decisions were supported through the Best Interests process. Staff across the service from management to staff delivering care, were unable to demonstrate a thorough understanding of the Mental Capacity Act and associated legislation to be able to implement good practice across the service. There was no consent documented in the care records and the service did not have a consent policy.

Policies were not always being followed and documentation was incomplete. We were informed that the Registered Manager was on site on average twice each month and in view of the issues highlighted as part of the inspection did not have a full oversight of the day to day running of the service. The systems in place to document information were not robust. We found pertinent information had not always been entered into the documentation and at times was missing. This precluded accurate and thorough investigations of events. We found a list of 10 complaints within a year and evidence of them being looked into and an outcome, however, three relatives we spoke to told us they had made complaints and no action was taken.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

You can see what action we told the provider to take at the back of the full version of the report. The concerns we identified are being followed up and we will report on any action when it is completed.

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.

We found risk assessments were either absent or did not contain detailed information to ensure people were safe.

Most staff had a basic understanding of safeguarding. Other staff either did not act to keep people safe or had not heard of the term safeguarding.

Incidents were not always reported placing people at unnecessary risk.

The staffing levels were a problem. People we spoke with were not always receiving care for the specified time allocated with staff rushing to their next call.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent to care was not routinely sought and there was no evidence of the service following the principles of The Mental Capacity Act and best interests for people who lacked capacity.

Staff were not always trained to provide the care they were delivering for people.

Staff supervisions we viewed were not taking place regularly. An annual appraisal system was seen in the records.

Documentation regarding care delivery was not completed effectively. Information regarding amounts of fluids and food given to people were not always recorded.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always providing care for the duration of the call, leaving the person's home earlier than planned.

People informed us that they were not always informed if the carer had been changed and a new carer was coming to provide care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care needs were not always being assessed or reviewed according to changes in people's health and wellbeing.

People told us calls were at varying times and not always when they needed their care. Some people reported missed calls.

Care plans contained some information about the person's background. Care plans we looked at were signed by the person receiving care or their next of kin that they agreed to the care plan being shared.

Is the service well-led?

Inadequate

The service is not well led.

We found the staff were not always following the policies written by the service.

The service has strong links with the local community.

The Registered Manager does not always have a full oversight of the day to day running of the service.

Audits undertaken were not always effective.

Scotland Road Branch

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 from 14 to 22 March 2016 and was announced, seven working days. We received information of concern prior to our inspection.
The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to be sure that the people we needed to speak with would be available.

The members of the inspection team were two Adult Social Care 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. Information was gathered prior to the inspection and there were concerns highlighted. A PIR was completed by the provider on 6th March 2015.

During this inspection we looked at nine care plans/support plans as well as other documentation relating to the running of the service. With permission, we visited 5 people in their homes to speak to them and their relatives. The Expert by Experience made phone calls to staff and spoke to nine members of staff and also spoke to seven people who use the service and one relative over the telephone.

We contacted Health watch, The Local Authority and Continuing Health Care to gather additional information. We spoke to three professionals who were staff from the Local Authority and NHS Community Health Care Professionals.

Inadequate

Is the service safe?

Our findings

Staff were not always aware of safeguarding or when to take action. We were shown a training matrix which included Safeguarding training and all staff listed on the matrix had received safeguarding training within the last three years. Staff we spoke to had a basic understanding of safeguarding however, two staff members had not heard of the term safeguarding. The staff who had heard of Safeguarding only had a basic awareness. For example, one staff member was asked if they had heard of Safeguarding and they responded – "Yes, that they are safe in their own house." We asked how they would report a Safeguarding incident and the staff member said - "To my Care Co-ordinator. A lot have trip hazards and wires and collect lots of newspapers." The staff member could not recall receiving Safeguarding training but was aware of Protection of Vulnerable Adults Training. Another staff member was asked how they keep people safe and responded – "What do you mean? I've had all my training. I'm up to date with all that. Trip hazards, I'm a stickler for all that." We asked the staff member to explain Safeguarding and they responded – "Yes, it's just Safeguarding the person and for me I've had Safeguarding training and refreshers just had SOVA training up to date with it."

Not all staff had acted in accordance with their safeguarding responsibilities. For example, we found they had had not reported a pressure sore which had been graded by the District Nurses as a Grade 3 pressure ulcer. We could not be sure from talking to staff that they were competent or knowledgeable enough to ensure people were safeguarded appropriately. We also found details of incidents which had not been reported to the Local Authority Safeguarding Team. Information which had been passed onto the Local Authority was not always thorough and an accurate reflection of the incident. When we contacted the Safeguarding Local Authority Team they had not received all the information pertaining to one service user. The Local Authority had not been informed of all incidents and were therefore, not fully aware of each occasion when the service user was at risk.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not see any care plans being reviewed according to when changes occurred to people's details, health and wellbeing. We found one person's address had not been updated in their care plan which was held at the office. One person's records we saw contained entries which provided information that the person had been deteriorating since July 2015. We looked at the care plan which was last reviewed on 19 November 2015. Despite there being entries in the records from July 2015 that the person had become agitated and lashed out we could not find a review of the care plan being undertaken until November 2015. When the care plan was reviewed in November 2015, no behaviour risk assessment or behaviour management plan was put in place. This meant that staff were providing personal care without any guidance of how to respond or react to a situation if the person became agitated or aggressive towards them. We were informed by the Registered Manager that a behaviour risk assessment was undertaken in February 2016. The documentation we saw indicated that the person's mobility fluctuated. The service requested a review by a moving and handling trainer who visited the person in October 2015. The Moving and Handling Trainer made recommendations to mitigate the risk of falls. However, we saw no evidence

that a falls risk assessment had been put in place. This would have ensured the recommendations were communicated to all staff and for any new staff providing care. The records we saw said the person "had good times of the day and bad times of the day" but there was no further information to explain what the person was able to do when it was a bad time of the day. Therefore, this placed the person at risk of being asked to mobilise when they may not be able, thereby also placing staff at risk.

Risk assessments were either absent or not detailed enough to provide staff with the information they would require to mitigate risks for people. For example, we viewed a care plan for someone who has complex health care needs and was prescribed thickener in their drinks due to swallowing difficulties. There was no risk assessment for staff to follow which set out the risks of choking. This is important for someone who has swallowing difficulties as the risk of choking is greater than for someone who has a normal swallow. This was brought to the attention of the registered manager who agreed this was needed and they took action immediately.

We also saw that this person's care plan stated 'thicken all drinks' but did not specify the name of the prescribed thickener or provide clear guidance stating to which stage thickness of fluid. The care plan also stated to provide the person with 'milkshake', again it did not state if this was a supplement drink or whether to thicken the drink to a required thickness stage. Another section of this persons care plan also stated 'fork mash diet' but made reference to supporting the person to consume biscuits. This information was unclear as fork mash diet usually means the person requires lumps in food to be mashed in order for them to swallow the food safely. Biscuits are not usually part of a fork mash diet plan.

This information was not clear as to what consistency of food or drinks staff were being asked to provide for that person. This therefore, placed the person at unnecessary risk of harm if the person was provided with an inappropriately thickened drink or consistency of food which either resulted in aspiration (whereby a substance enters the lungs) or choking. We raised concern that the care plan needed reviewing with the Dietician and Speech and Language Therapist involved in the person's care. We also found other documentation related to a fall which had occurred outside the person's home whilst a staff member providing care was inside the person's home. We saw the incident had been reported as a safeguarding but no risk assessment was put in place following this. This was brought to the attention of the registered manager who agreed to ensure a falls risk assessment was written in the care plan.

Medication risk assessments for administration of prescribed medication including controlled drugs were not seen in the care plans we looked at. Risks associated with the administration of medication and controlled drugs were not in place. This meant that there were no guidelines for staff to follow to ensure they were aware of the risks related to the prescribed medication for people. Medication Administration Records (MARs) were being used to record when prescribed medication had been administered. However, we saw in one person's records that prescribed medication to reduce the risk of fractures was not listed on the MARs. This placed the person at increased risk of harm to their health and wellbeing as they may not receive the medicines they needed. The person was at risk of falls and had sustained a fracture following a fall in the past. By not ensuring the correct prescribed medication was listed on the MARs raised concern the systems in place for ensuring people receive their medication were not effective.

We looked at the medication policy which incorporated the National Institute for Clinical Excellence (NICE) Guidelines. The medication policy did state people would have a medication assessment and care plan in their homes which was not the case from care plans we looked at. Therefore, staff were not following guidelines with regards to how to store, handle and administer medicines pertaining to individual people, placing them at unnecessary risk.

This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were informed that the person had suffered a Grade 3 pressure ulcer last year and this had not been identified by the staff providing care. The person remained at risk of pressure ulcers and staff were applying Cavalon cream. We spoke to a District Nurse who said they contacted Local Solutions to raise concern their staff had not reported the pressure ulcer and requested staff receive training around pressure area care. The District Nurse also told us they sent a safeguarding alert to the Local Authority as it was a Grade 3 pressure ulcer which had not been reported by staff visiting the person three times each day. On inspection we were unable to see a care plan regarding pressure care or a body map to demonstrate to staff providing care where to apply the cream. There were gaps in the daily records with no explanation whether care had been delivered and if not the reason why. Therefore, we could not be sure the person was receiving their care as planned, Documentation was not being completed and a pressure care plan was not in place. This raised concern that the service had not learnt from the safeguarding alert raised by the District Nurse last year and was placing the person at risk of harm.

We visited one person receiving 24 hour care at their home who had complex health care needs such as a Percutaneous Endoscopic Gastrostomy tube (PEG)which meant they were receiving nutrition through a tube. We were informed by the staff present that the person had been unwell and had a chest infection. The General Practitioner had visited the person and requested the staff to increase the amount of fluids. We looked for the person's fluid chart to view the amount of fluids being offered to the person but found the fluids were being recorded. The entries made by staff in the communication book provided a basic narrative of the care delivered that day with amounts of fluids amongst the written text. We could not see a system in place whereby staff were keeping a record of the total amount of fluids being given to ensure the GP's request was being followed. We counted the daily totals written in the communication book which varied and not in line with the GP's request. Staff told us they don't always record the fluids flushed through the PEG when administering the person's prescribed medication. They said they had used a fluid chart in the past but had stopped using one. We also could not find a repositioning chart to record the amount of times the person was repositioned to alleviate pressure. Repositioning is vital for a person who is unable to move themselves as skin breakdown can result from persistent pressure which can then lead onto a pressure ulcer. Recording how frequently a person is repositioned is important in order for health professionals to be able to review and reassess the risks to keep people safe from harm. We also viewed in the records in the person's home that there were occasions when staff were writing they had provided a drink but no fluid amount stated. From the documentation it was unclear if the person was receiving an appropriate amount of fluids per day. The care plan did contain information explaining what care tasks were required. We could not find a detailed manual handling care plan sufficient to provide staff with detailed information how to safely transfer the person who was being hoisted for all transfers. This was discussed with the registered manager who agreed to send a safeguarding referral to the Local Authority and review the systems and documentation in place.

During the inspection we also spoke to a District Nurse who explained there had been some issues with staff not following their recommendations to ensure the person sits in the wheelchair for a specific time period and no longer to alleviate pressure. The nurse told us they were able to identify that staff were not moving the person frequently enough by the deterioration and damage to the person's skin.

We viewed the accidents and incidents system in place and how incidents and accidents were recorded in the service. It was noted that for a period of one year, there were seven incidents recorded. This was a low number of incident's considering the scale of the service. We were informed the number of people using the service at the time of our inspection was 892. The accident / incident log provided a chronology of

occurrences, rather than a detailed form. There were incidents which we had seen in the records which were not logged on the incident form in relation to one person. Based on the documentation seen, we considered there was an under reporting of incidents. There was no evidence of any analysis taking place, and if the service was aware of any emerging trends or patterns this was not clearly evidenced from these logs. For example we viewed details of an incident recorded where a person had become agitated and struck out, injuring a staff member. There were no further details to say how this was reported and what had happened as a result. For example, new risk assessment completed, care plan updated, social worker /Local Authority informed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staffing levels. We saw in the documentation that the service had a contact time of 80% set from the Local Authority, however we saw this was not being achieved by any staff. Missed calls were investigated and reported to the contract officer. Rotas showed staff were not allocated time to travel between calls. This was placing undue pressure on staff to meet the needs of all the people they were delivering care to. We were told by one relative staff were rushing and were often not providing care for the duration of the time specified for the call which suggests there are not adequate staffing levels to ensure the service can provide care for the times specified. During one visit, we observed two staff leaving one person's home ten minutes early and when asked why they told us they were leaving early to travel to their next call. One relative we spoke to told us – "Not had problems but staff are always saying they are short-staffed."

We provided feedback to the managers about this issue during the inspection and we were informed by Local Solutions that this was agreed with the Local Authority and deemed acceptable. We asked for evidence of this and were informed it was not a written agreement. The impact of this was that people were not receiving care for the period of time specified.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe. One person said 'Very confident and safe'. Another person said 'Yes, they do look after me very well.'
Staff were recruited safely. The recruitment files we saw contained application forms, DBS (Disclosure Barring Service) checks and references from previous employers. One person who had a previous conviction had a risk assessment in place. This meant that the service was ensuring appropriate checks had taken place before staff commenced work.

Requires Improvement

Is the service effective?

Our findings

The service offered a seven day induction training programme for new staff. We saw evidence of the Care Certificate being implemented by the service and a training matrix. A Quality Workforce Development Officer had been in post for approximately one year who's role was to support new starters for the first three months to sign off competencies.

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.

There was also no evidence of consent or Mental Capacity being considered in the delivery of care to the person. Staff were able to tell us they were providing choices and seemed person centred in their care approach, however, the documentation did not reflect this. This was brought to the attention of the registered manager and we were asked not to expect that the documentation will be written in a way which demonstrates staff have an understanding of the Mental Capacity Act and Best Interests. We were informed that further training regarding the Mental Capacity Act legislation and how this needs to be applied is needed across the service.

We visited another person in their own home with a relative present. We had established the person lacked Mental Capacity from the records which stated –'fluctuating capacity', 'confused and not orientated to place'. Despite several entries in the care records of incidents whereby the person had become agitated and become aggressive towards carers and declining care at times, we could not see that any evidence of best interests or involvement from relatives had been considered. Consent to receive care or support to have medication could not be seen in the documentation. There were records pertaining to staff administering medication but there were no records around consent to do so. We viewed an entry in the records stating – 'refused meds and breakfast'. There were no other entries about what action was taken following this raising concern that staff are not following the service's Mental Capacity Policy which states the General Practitioner must be informed if a person refuses their medication. In view of the GP not being informed of these incidences the GP was not being provided with an accurate full picture of the difficulties in relation to the care being delivered. This could then mean a decision would have to be made in their persons best interests due to them refusing their medication.

We reviewed the policies and could not see a service policy specifically for Consent. There was a Mental Capacity Policy which stated – 'You must record all conclusions and why you have made that decision that capacity is lacking for the particular decision at that particular time'. It also states – 'The Care Coordinator will ensure the Service User's consent has been obtained and recorded in the care plan. If the service user refuses to give consent to assistance then none must be given by the care support worker. Inform GP if refusing support to take medication. Where service user lacks capacity to consent to assistance with medication, consent is sought from carer/advocate on grounds assistance is in best interests. On each

occasion carer must seek consent'. There was no evidence of staff recording information regarding whether they have sought consent or considered if a person has the Mental Capacity to consent in the documentation viewed. We could not see consent being sought to support people with their medication.

We viewed the policies folder and found there was no policy for consent. The documentation viewed also did not contain information such as consent to receive care from Local Solutions. Consent to receive care involves staff being provided with consent by the person for staff to enter their home including use of a key safe. In the event a person who lacks capacity is unable to provide consent, a Best Interests Process would need to be followed. We did not find evidence of consent to care or consent being sought to receive support around administration of medication from the documentation viewed. We were provided with a Consent policy by the Registered Manager following the inspection.

This was a breach of Regulation 11 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who were undertaking nursing based tasks had not received regular training to ensure they were following safe and best practice. We were informed by the staff they learnt how to change the stoma bag and use the suction machine and PEG from a previous experienced carer and they had not received any formal training. The staff also told us that they were responsible for training any new staff and explaining how to change the stoma bag. The staff also told us that they were asked to take over administering medication through the PEG and District Nurses supported them by observing staff when administering prescribed medication until they became competent. No training had been provided by Local Solutions despite this being requested by Continuing Health Care. We raised concerns with the registered manager that care staff were undertaking nursing tasks without formal training and are learning 'on the job' which is not sufficient when caring for someone with highly complex nursing needs. Training is required to ensure staff are all following best practice. The Registered Manager agreed to source appropriate training. The registered manager agreed to source training for the staff.

We asked staff if they had undertaken any relevant training around the MCA: Some of the responses from staff included 'What is that. No haven't had that, you are using a different name.' From discussions with the registered manager we raised concern that as a service they were not demonstrating an understanding of the Mental Capacity Act or that they were following the Best Interests Process. We spoke to staff regarding their knowledge of the Mental Capacity Act (MCA). One staff member who we spoke with about the Mental Capacity Act stated – 'Is it to do with dementia? Not heard. Not come across. Not needed.' Another staff member who we spoke with said – 'No?" when we asked whether they had heard of the Mental Capacity Act.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff supervision records and also viewed the supervision policy. The policy states 'Staff are supervised regularly via: one to one work based supervision in the service user's home, one to one office supervision, one to one performance development review and quarterly team meetings. We were given a supervision schedule, which included a yearly review, and 6 monthly reviews and the registered manager told us staff were supervised in the office two yearly. We found no other more regular supervisions. We viewed work based supervision forms and office based supervision based forms and found in seven out of nine staff files viewed there were supervision records. However, these dated back to 2012, 2013 and 2014. The remaining two staff files seen were of staff who were recruited in 2015 and contained no supervision records. Although the policy states 'staff are supervised regularly', this was not seen in the records viewed.

Staff we spoke with told us they receive supervision from the Care Coordinators. We did see an annual appraisal system in place.

We saw in some people's records that the service were working alongside health care professionals. One health care professional we spoke with told us they had raised concerns that the staff had not reported a person who had a sore which had developed to a Grade 3 pressure ulcer. The health care professional told us they raised concerns with Local Solutions directly and requested staff had training in pressure care. Another health care professional told us they had problems historically with staff not following their recommendations for another person regarding pressure care. We asked people how they were supported to access health care services. One service user told us they were pleased with the way they were supported to access District Nursing services for their leg ulcer dressings to be changed.

People were being supported to have drinks and meals by staff. Of the people we spoke with, we were told meal times were at a time to suit the staff and not the person. For example, one person told us – 'Not really a choice about meal times, it just fits in with their schedule.' A relative told us they were concerned their relative was not eating and staff were not encouraging the person to eat. The relative told us they were regularly throwing away already prepared meals. We were also told staff did not have the time to be flexible and wait with the person to encourage them to eat. We also read in the records one person had said – 'some carers come too early for a lunch call'. Due to gaps in the daily records it was not always possible to see if people had received enough to eat and drink.

We were told that the organisation received on average of 20 referrals for care packages for people each week. Local Solutions were also running the 'The Carer's Service' for unpaid carers. We were informed the service have links with universities such as The University of Cambridge, and have taken part in research projects. We were told the service had introduced Skills for Care in 2014 and in March 2015 they were awarded Best Employer of over 250 staff at the Skills for Care Annual Accolades Awards. We were also informed by the Registered Manager that the service had strong links within the Liverpool community including Liverpool City Council and take part in the Older People's Conference, Older People's Awards and the Winter Assistance Partnership Campaign which aims to support elderly and vulnerable people. They said they also held a Carer of the Month/Year award organised by senior management for Care Support Workers who go above and beyond or demonstrate best practice. Every April the 12 carers of the month are put forward for the Carer of the Year award. Care staff who are presented with an award meet with Directors of Local Solutions and are then presented with a small gift, a certificate and carer of the month badge to wear on their tunic.

Requires Improvement

Is the service caring?

Our findings

We visited five people in their own homes and spoke to seven people who use the service over the telephone.

One person we spoke to said the staff were "Kind, polite, understand and respect me." Another person told us the staff were "Caring and empathetic". When asked if staff were respectful another person said- "They respect me when I am in the shower". One relative we spoke with told us –"They respect privacy and dignity. Help remain independent." Another person told us –"Staff support me to make me independent".

Other people we spoke with told us the staff were rushed and were often on their mobile phones whilst delivering care. One relative told us they had overheard a staff member arguing with an office staff member over the phone whilst delivering care. People told us they were not always kept informed as to who was going to provide care and reported a number of different carers visiting them. We were told people were opening their door to staff they had not met before. We were informed by one staff member that they had been sent to provide care not always knowing the person's care needs. One relative said "X is lovely but inexperienced". Another relative told us they sent a carer away due to them not having the appropriate information or experience to provide care.

The care being delivered was task based and the documentation in the care notes reflected this. For example, in one person's care plan there were entries such as - "Cleaned shed, sleepover. Watched film." Another person's daily records stated for example – "X was fine on arrival, made dinner and cup of tea, dishes done, all fine on leaving". We raised this style of documenting information with the Registered Manager who agreed staff were documenting in a task orientated manner.
People said they felt listened to and they knew what to do and would contact the office or speak to the carer if they needed to speak to someone about their care. We asked staff if they were aware of advocacy services for people and staff informed us advocacy was provided by family members usually.

We looked at the telephone quality assurance checks which had been undertaken with people who use the service. The style of questions on the form were respectful and were written in a way to establish if people felt cared for. The comments we read were mixed. One comment was – "All staff are very caring", another comment from another person was – "She's a ray of sunshine, as soon as she walks in the door she has a smile on her face". Another comment we saw was – "She is no good, last night carers did not turn up".

Requires Improvement

Is the service responsive?

Our findings

People were not always receiving person centred care. One person we visited had their relative present who told us all their medical information was not included in their care plan. We found that the care plan did not specify the person's medical diagnoses such as diabetes type 2. We were informed by the person that the medical conditions which were not detailed in their care plan were diagnosed a number of years ago. Therefore, this information would be expected to have been identified as part of the person's assessment and plan of care. The care plan did not provide an accurate description of the person's medical diagnoses which meant that staff who were caring for the person were not aware to look out for signs such as drowsiness or slurred speech, which could be related to the person's medical conditions. This placed the person at further risk of harm unnecessarily. Also, we could not find a manual handling care plan which provided staff with step by step guidance of how to safely transfer the person using a stand aid hoist. The person explained to us that there had been an incident whereby a staff member hadn't appropriately positioned the stand aid hoist the right way round and this was pointed out to the staff member by the person. We could not find any specific instructions for staff to follow to provide guidance how to position the stand aid hoist.

When we visited a person in their own home who had 24 hour care we observed the person had difficulty with communication and verbalising sounds/words. During the visit we did not observe the person using any verbal communication. We did observe the person was able to track with their eyes when someone was close to their bedside but was not responding when spoken to either by verbal communication or gestures. We also observed this when staff who were familiar were interacting with the person. The staff told us they were able to understand the person's wishes by their facial expressions and the person could vocalise some words at times. We could not see a communication plan for this person to support staff to know how best to communicate. We were informed that the person had a team of carers who knew the person well.

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

Two staff members described person centred care in their approach to providing support but the documentation did not reflect this and either contained goals which were out of date and/or the entries in the care records were task orientated. For example, one person told us their carer took them to a disco which is what the person enjoyed doing. The staff member confirmed this but agreed it was not documented anywhere.

We asked people if they felt listened to and most people told us they did. One person told us – 'I've had to complain. They dealt with it. The carer was stopped after I reported it. It was dealt with to my satisfaction. They took it on board.' Another person told us – 'Yes they are pretty good if you complain'.

We found the complaints procedure was well documented and there was a clear procedure which was followed by senior staff at local solutions. This procedure included the recording of the complaint in a table, a brief description of the complaint and who made the complaint. We were able to track the complaint

through using the date provided in the complaint table. We saw that most of the complaints were responded to within seven days which included a member of the senior management team contacting the complainant to inform them of what would happen next. We saw the same person who had been investigating the complaint wrote to the complainant once the investigation had been completed to inform them of the outcome. During the inspection relatives told us they had made complaints to the office but they were not dealt with. We highlighted this to the registered manager who agreed to look into the complaints.

We found people did not always have choices. People using the service told us they had a choice of male or female carers but did not always have a choice of which male or female carers provided care. This was discussed with the registered manager and we were informed this was not always possible due to the size of the service. We asked people if they had choices over when they got up or when they ate. One person said – "We have a timetable, they come at 9.00 or 10.00 in the morning. I had a choice. If I go to my volunteer job they come early to suit me, or anywhere special like hospital they'll work round." Another person told us – "I fit it in with carers, getting up they come to help me get washed, I cook my own meals." Another person told us – "the morning carers are supposed to be here at 8.30 am but they arrive closer to lunch time". Someone else said – "some carers come too early for a lunch call". Someone else said - "Not really a choice about meal times, it just fits in with their schedule." One person told us – "They come on time and look after me very well, one comes at the morning one at tea-time".

We found people using the service or their relatives had signed a care plan to say they agreed with the plan of care proposed and for it to be shared with others. However, people were not always involved in decisions made to changes to their care such as times of calls and the carers providing care.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who had been there for approximately 13 months We were informed that the registered manager was on site approximately twice per month. In view of the findings of the inspection, we were concerned the managerial oversight from the registered manager of twice per month was not be sufficient to ensure the registered manager had a full and thorough understanding of the effectiveness of the systems in place. We were told that the operations manager was on site but does not have overall responsibility for managing the service. This raised doubt over the robustness and effectiveness of the management structure and oversight.

People we spoke with told us they had contacted the office if they had any problems and spoke to Care Coordinators and other staff. During the course of our inspection, no one mentioned they had spoken to the Registered Manager or had met the Registered Manager.

From the care plans and risk assessments we saw all nine contained missing information, information was not detailed enough or the care plan had not been reviewed according to changes. We also found the systems in place to report incident's was not effective. We viewed the care entries typed by the care coordinators based at Scotland Road Branch and there was no documentary evidence in the records to confirm the reporting of an incident by a staff member which occurred on 19 February 2016. The service sent a Statutory Notification about this incident but had not recorded the phone call had been received in the office with details of what the staff member alleged had occurred. Furthermore the service had not informed the Local Authority Safeguarding Team of other incidents such as an incident which occurred on 29 February 2016. We found the service had not kept a contemporaneous record of when an incident occurred, what happened and what action was taken.
We were provided with a copy of an audit titled 'Quality Assurance Service User File Audit Report', dated 5 May 2015. We were concerned that the audit undertaken did not highlight the concerns we found on the inspection. For example, the audit report did state – "The risk assessments should be more descriptive and detailed" but there was no evidence risk assessments we saw were being reviewed following this audit. There was also a recommendation from the audit as follows – "A review to be completed for the paperwork / documentation format for service users files, care plans and risk assessment documentation." We saw a new template care plan on inspection which the service had recently compiled. Daily records were not mentioned as part of the audit. We did not see any audit of the systems in place to record information. Therefore, we found that systems in place to monitor the quality and safety of the service were not always effective and this had the potential to place people at risk.

We were informed a medication audit dated September 2015 to March 2016 was undertaken which involved a review of 52 service users who have medication management. We viewed the service's medication policy which stated – 'The assessor will complete a risk assessment and risk management plan in relation to medication. The care plan should reflect support needed around taking medication.' We found there were no medication risk assessments or management plans and the audit had not identified this.

We found there were no systems in place to monitor whether incidents reported by staff to the office were

being acted upon. For example, we found examples where incidents reported by staff to the office had not been reported to the Local Authority. This led to a breakdown in communication as the Safeguarding Team in the Local Authority were unaware of all the incidents pertaining to the person.

We looked at the overall culture in the service and found it to be task focused. We found a lack of leadership regarding implementation of the Mental Capacity Act legislation across the service and there was no system in place to ensure people who lacked Mental Capacity were being recognised and assessed appropriately in accordance with the Mental Capacity Act 2005.

We found the systems of documenting information were not robust and found gaps in the documentation in people's homes. We could not see an effective system in place whereby the service had oversight over the daily records held in people's homes in order to monitor the care being delivered for people. We highlighted as part of the inspection that MARS sheets were missing for one person leading up to a fall which occurred one month prior to the inspection. We could not see a system in place of reviewing daily records/MARS sheets.

We raised concern to managers during feedback regarding the 'call cramming' and no travel time in between calls from one person to another. The service had a system called Electronic Call Monitoring whereby staff were required to log in when they arrived in a person's home to provide care. We were told that the Electronic Call Monitoring information was checked monthly and staff are highlighted to them if they were not logging in. We could not see a system in place of dealing with this as a service despite staff not achieving the contractual requirement of arriving at their call on time for 80 percent of the time.

We were informed it was an unwritten agreement with the Local Authority. This raised concern there was an expectation within the service they were exempt from providing staff travel time in between their calls to people when this may not be the case. The impact of this was that staff were arriving late to their next call or leaving early to arrive to their next call on time. We therefore, could not see a system of delivery of care which is achievable for staff to deliver which would meet people's care needs.

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

We saw evidence of dignity and respect audits which had taken place periodically involving a random sample of staff. These audits consisted of questions about how staff maintain people's dignity and respect when they are supporting them. There was also Monthly Quality Assurance telephone calls to service users to request their views about staff.

There was evidence of external audits. For example, the service achieved a ROSPA Gold Standard for Health and Safety in 2016. However, this was not reflected in what we found during the inspection.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always receiving person centred care. One person we visited had their relative present who told us all their medical information was not included in their care plan. We found that the care plan did not specify the person's medical diagnoses such as diabetes type 2. We were informed by the person that the medical conditions which were not detailed in their care plan were diagnosed a number of years ago.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff who were providing complex nursing based tasks for a Service User had not received formal training and we therefore raised concern staff may not be following best practice. Supervision of staff was not frequent or regular with no recommended/agreed time frame stating how often staff require supervision in the Supervision policy. Staff were not providing care for the duration of the call time allocated due to no travel time in between calls.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent We reviewed the policies and could not see a service policy specifically for Consent. Consent to receive care or support to have medication could not be seen in the documentation. There were records pertaining to staff administering medication but there were no records around consent to do so. There was no evidence of staff recording information regarding whether they have sought consent or considered if a person has the Mental Capacity to consent in the documentation viewed.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users either did not have appropriate risk assessments in place or the risk assessments in place were not detailed enough. Care plans were not always containing pertinent information about the service users medical conditions and risks. Daily records were not consistently completed with information missing. Incidents were not always being reported to the appropriate authorities.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents not always being reported or when

incidents were reported to the Local Authority staff did not provide an accurate account of the events as detailed in the daily records. Service users were at risk due to under reporting and staff had not identified one incident constituting neglect. Not all staff were aware of safeguarding when we spoke to them and staff who were aware had limited knowledge of safeguarding.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The Registered Manager was only on site twice per month and does not have overall oversight of the service on a day to day basis. Policies were not always being followed and there was no policy on Consent. During the course of our inspection, no one mentioned they had spoken to the Registered Manager or had met the Registered Manager.

The enforcement action we took:

Warning notice