Care Quality Commission

Community Care Direct Limited

Community Care Direct

Inspection report

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Date of inspection visit: 23,24,25,26,27 November 2015, 4 and 18 December 2015
Date of publication: 30/03/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

Community Care Direct Limited is a 24 hour domiciliary care provider based close to the centre of Southport. At the time of our inspection the agency were providing personal care to approximately 63 people in their own homes. We were later informed by the service that the number of service users reduced to 37 in December 2015. The agency provides care to people who have complex care needs such as palliative/end of life care, spinal injury and neurological conditions such as Parkinson's Disease and Multiple Sclerosis.

A registered manager was not in post at the time of inspection due to termination of their employment by the provider which triggered the inspection. '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 last inspection dated 14, 15 and 20 January 2015 there was a breach of Regulation 21(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 for not having safe recruitment

Summary of findings

practices. By not having robust systems in place to assure the quality of the service was a breach of Regulation 10 (1) (a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A focused inspection dated 21 July 2015 was undertaken to check if Community Care Direct Limited were meeting legal requirements. The domains 'Safe' and 'Well-led' were covered during the inspection. Following the inspection the manager had submitted their application for the position of registered manager. At this inspection we found improvements had been made in all areas and the previous breaches had been met. Recommendations in some key areas to improve practice had also been implemented.

At this latest inspection the provider told us they were recruiting for a manager and for additional staff. We determined how many staff were working within the service by the staff list handed to us during inspection. We then asked for the staff list to be reviewed and revised as we found some staff were on the list who were no longer working there or new staff had not been added to the list. We established from the revised list there were 45 staff working for the service. Not all staff had received safeguarding training including two new staff, one of whom had no previous experience working in care.

We looked in staff recruitment files and we found that robust checks had not been put in place to ensure people were always safeguarded from potential harm or abuse. Staff training was incomplete with some new starters who were not receiving monitoring of their performance during their probationary period to ensure they were performing well in their role. Staff we spoke with were not receiving supervision and there was no appraisal system in place to enable staff to seek support and continuous improvement of their practice.

Risk assessments for people who received a service were either absent or incomplete with basic information for people with complex health care needs placing them at high risk. Risk assessments which were present in the care plans were not dated/signed or did not provide detailed person specific information to mitigate the risks.

We visited four people who used the service with their permission and they all told us the staff were pleasant and they had confidence in the staff who they receive care from. As part of the inspection we also contacted people by telephone. Some people told us they were happy with the service they received and others expressed concerns about the service. All the people we visited told us of late calls, calls not lasting for the duration of time planned to receive care or missed calls.

Some staff expressed they were happy with the service Community Care Direct provided to people. However, other staff told us they were unhappy with the rota system. They told us they were not provided with adequate travel time in between calls. Other staff and also people using the service we spoke with said further calls were added into the rota on the day resulting in staff being late to provide care to each person.

We found systems which were in place including the on call system and complaints system were not robust and did not meet people's needs.

The service had no policy regarding consent and consent documentation we found was not completed, signed or dated.

The service lacked good governance as we did not see any evidence of audits being completed. We did see evidence of a quality assurance questionnaire sent to service users in March 2015.

You can read about what action we told the provider to take in the action section at the back of the full version of this report.

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

Summary of findings

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.

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?

Inadequate

The service is not always safe.

We found the systems in place to safeguard people were not keeping people safe.

Some staff lacked safeguarding and manual handling training.

People with complex health care needs did not have emergency procedures in their home for staff to act promptly and appropriately in the event of an emergency. Risk assessments were basic and not person centred and in some cases risk assessments/plans were absent.

The recruitment checks in place were not robust to protect people from potential harm or abuse.

Is the service effective?

Inadequate

The service is not always effective.

Staff were not receiving supervision or appraisals.

Staff who had recently started had not had an induction. There was no management of their induction to ensure that they were trained and safe to work with people.

Consent to care was not routinely obtained. One person who had no means of communication due to mental impairment did not have a mental capacity assessment to demonstrate carers are acting in her best interests.

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 were not included in their care planning. People informed us the times of their calls were changed without any consultation.

Is the service responsive?

Inadequate

The service was not always responsive.

The system in place for receiving, handling and responding to complaints was not robust.

Some people reported concerns and saw improvements but other people often reported the same complaint.

Summary of findings

People's care plans contained information about the person's care requirements but lacked information about the person's background, likes or dislikes, wishes or aspirations.

Is the service well-led?

Inadequate 

The service was not well led.

There had not been a registered manager in post for over a year. A new manager has been employed in the service whilst we were undertaking our inspection.

We found no written record made of telephone calls received during evenings and weekends that needed to be actioned by the 'on call' person.

Community Care Direct

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.

We carried out an unannounced inspection of this domiciliary care agency on 23, 24, 25, 26 and 27 November 2015, 4 and 18 December 2015. The inspection team comprised of two Adult Social Care Inspectors and an Inspection Manager. A follow-up visit was undertaken on 18 December 2015 to check that the service had put in place what we requested to ensure people were safe.

Prior to the inspection we gathered information from the Local Authority who had received a Safeguarding referral. Following a whistleblowing alert we spoke to two staff members who were raising concerns but no longer work in the service. The Continuing Health Care service who commission Community Care Direct Limited to provide a service were also contacted.

Before the inspection we had not asked the provider to complete a Provider Information Return due to the limited time between planning the inspection and undertaking the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did however, collate the concerns raised including whistleblowing's since July 2015, when the service was last inspected.

We looked at 15 care plans some of which were in the Community Care Direct office and some were in people's homes.

Four people who used the service were visited in their own homes and we spoke to eight people who used the service by telephone.

We spoke with two health care professionals.

We spoke with eight members of staff out of the 45 staff members working in the service at the time of our inspection.

Inadequate

Is the service safe?

Our findings

People's experiences were mixed, some people said they felt safe with staff and others told us they didn't.

One person said, "some people haven't got a clue when they come." One relative told us that they had provided training for staff to ensure the care they provided was safe. Another relative told us they had confidence in the staff's abilities who were providing care.

Risk assessments were not always in place to ensure the safety of people. This meant that staff were providing care without the knowledge associated with the risks involved to reduce the risk to the person using the service. It was brought to the attention of the provider on the first day of inspection that we could not find a risk assessment for someone who was reliant on oxygen at night to ensure they could breathe. The provider agreed this was not acceptable and told us a risk assessment would be put in place. This was followed up with the provider on 27 November and again on the 4 December 2015 as the risk assessment was not in place in the person's home.

We found that risk assessments put in place following our inspection were generic and not person specific. This was brought to the attention of the manager and provider during our visit on 18 December 2015. The manager and provider agreed these would be put in place. We were assured that outstanding risk assessments including for Diabetes and for positioning/turning whilst in bed will be put in place.

We looked at one person's care plan who had complex health care needs including lack of communication, manual handling and double incontinence. Staff were visiting four times each day to include manual handling and personal care including catheter care and bowel management. We were unable to find a manual handling risk assessment, manual handling care plan or a continence management plan in the person's home which provided specific information related to how to support and assist them to meet their needs.

In the absence of risk assessments and manual handling care plans, staff providing care had no information in the people's 's homes to inform them how to reduce risks and mitigate the risks, thereby placing people at uneccessary risk of harm.

This was a breach of Regulation 12 (1), (a), (b), (c) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found unsafe recruitment practices. The Disclosure and Barring Service are contacted as part of the recruitment process to check if staff have previous convictions in order to protect people from abuse and potential harm. We informed the provider of our concerns that one staff member had a poor reference from a previous employer and another staff member had previous convictions with no risk assessment in place. The manager agreed they should not have been employed.

By way of not ensuring there are robust recruitment systems in place there was a breach of Regulation 19 (1) (a), (b) (2) (5) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two new staff had not received safeguarding training and one out of the two had no previous experience of working with vulnerable people. Nine staff had not received safeguarding training. We found that only one out of eight staff we spoke with could describe the types of abuse staff are responsible for reporting. One staff member we spoke to told us they reported a safeguarding months after the event, clearly not understanding their role to report safeguarding concerns immediately.

The agency had no system to record or log safeguarding concerns or incidents and did not recognise that missed calls constituted neglect if people were not receiving the calls planned to provide personal care, food and drinks.

We spoke with a nurse who informed us of a Safeguarding Alert sent to the Local Authority on 20 October 2015 due to safeguarding concerns that a person who was at the end of life has been neglected and not received their care, resulting in the person not having personal care, food or drinks. This had not been reported as a notification by the provider to the Care Quality Commission.

There had been reports of multiple missed calls. One relative we spoke with told us they changed care provider approximately six weeks prior to our inspection due to them not receiving calls to provide care at the correct time. Another relative we spoke with said they had not received care for two consecutive weeks. They said when they spoke to the office at Community Care Direct they were informed they were not on the rota. The person was

Inadequate

Is the service safe?

waiting for personal care and received a call to provide personal care the following day. A relative told us they complained of a missed call to the provider and since making their complaint things had improved. We found an entry in the message book detailing some missed calls being reported but there was no documentation specifying what action was taken in the message book or complaints file.

These examples are breaches of Regulation 13 Safeguarding People from abuse (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

On the day of our inspection we were concerned there were not adequate staffing levels. We noted there were 63 staff employed at the time of our last comprehensive inspection in January 2015 to support 50 people receiving care and there were 45 staff members employed at the time of our inspection in November 2015 to support 63 people receiving care. On the day of our inspection we found the provider was covering care calls on the rota due to staff sickness at short notice. Whilst we were aware the provider had a 'hands on' approach within the service, it is our understanding there were no other staff to cover sickness at short notice. Although the provider ensured the service continued to run and to our knowledge people received their care we were not informed of a contingency plan in place to provide for cover when staff phoned in sick.

Staff told us they received the rota on Fridays for the weekend and Tuesdays for the rest of the week. The information they needed to visit a new person using the service was written on the rota. Other information was texted to the staff. Six out of eight staff we spoke with told us they had problems managing the rota system. All staff were required to visit the office and collect a rota sheet using a key code to access it from the key safe. One staff member who was not a driver told us they found this difficult. Other staff said they were unable to plan ahead as they were required to be on standby for the weekend.

We did not see a staff structure in place and the provider told us they had recently asked two staff members to step up into care coordinator roles. This role involved time spent providing hands on care and another part of the role was to be office based reviewing care plans and risk assessments. One staff member told us they had worked '14 hours per day 8 days straight' the week prior to our inspection and although the staff member was not concerned about people's safety, they were concerned about the quality of the service being provided to people.

The people we spoke with told us they had either experienced a missed call whereby a carer did not arrive at all or the call was not at the expected time. One person we visited told us staff were not present for the duration of the time in which they expected to receive care and staff were rushed . Six out of eight staff we spoke with complained about the rota system and that they were not allocated enough time to travel in between calls or were asked to take on more calls on the day.

The provider did not have sufficient numbers of suitably experience or skilled staff.

This was a breach of Regulation 18 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Some people we spoke with who received a service said they had confidence in the staff providing care. Other people told us they "see different faces all the time and staff don't always know what they are doing.

People told us staff contacted other health professionals and ensured they passed on information such as pressure care. This was cooberated by a health care professional we contacted as part of the inspection. One health care professional told us 'staff are good at feeding back if there's a problem with pressure areas'.

We did not see any evidence from the staff files we looked at that staff who had recently started had received an induction. The manager had left recently and we did not see that anyone was overseeing their induction period, ensuring they had completed the training required or offering any supervision to ensure they were managing their role. Although staff said they had received training including safeguarding and Mental Capacity Act training, one staff member had not heard of the Mental Capacity Act. Other staff who had heard of the Mental Capacity Act were unsure how it applied to their work. We asked the provider to send us a training matrix which we received following the inspection. Based on this information 35 staff had received Mental Capacity Act training. We could not ascertain if one person we visited who lacked capacity had received a mental capacity assessment.

One staff member said they had asked for bowel management training as they were providing care to a service user requiring bowel care but told us this hadn't been provided to date. According to the training matrix nine staff had not completed safeguarding training, 33 had not completed manual handling theory and 18 had not completed manual handling practical training. Five staff had not received either manual handling theory or practical training but were carrying out manual handling tasks. Due to the previous manager not being in post longer than approximately six weeks and the lack of consistency of a manager, there had not been a thorough review of training for staff.

We found no evidence that staff had received supervision or annual appraisals recently and there was no 'spot check' system in place to ensure staff are administering medicines and delivering care in an appropriate and safe way.

We were assured on 18 December 2015 by the manager that the outstanding training required would be provided to staff and a review of the training matrix demonstrating when training expires is implemented.

The staff were not provided with adequate training or supervision to carry out their jobs roles safely.

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

People who were receiving care including food and drinks were not always receiving care around meal times due to missed calls. People who did receive care at meal times said they had a choice of food and staff ask people what they would like to eat and drink.

Most people we spoke with reported they did not see the same carers and often do not know who was coming to provide care. They told us the carers were often not arriving at the times expected and some people were unhappy the morning call was so late that it was lunch time before they were receiving personal care. One person who had bowel management problems told us they were soiled on the occasions when the carers arrived close to 12 midday to provide the first call of the day. The impact of this on the person had been that they were left soiled for a number of hours unable to move which was a risk to their skin viability and pressure areas. Another person we spoke with said they phoned the office to ask who was coming to provide care. One out of eight staff we spoke with said they were providing care to the same people consistently.

We did not find people's 's signatures on consent forms within any of the care plans we looked at during our inspection and we found the forms were left blank. Therefore, we could not ascertain if people had consented to receive care. We asked the provider about this as we also found there was not a consent policy in the service policies file. The provider acknowledged this.

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

Requires improvement

Is the service caring?

Our findings

We visited four people in their own homes as part of our inspection and all four spoke highly of the staff. A relative told us- 'on the whole staff are superb'. Another person told us ,"The carers themselves are very obliging and offer to wash up and make the bed." Another person said, "The girls are very good."

Other people we spoke with told us staff did not always act respectfully when people contacted the office to ask for information or to check who was providing care for them. On one occasion the person receiving care told us they phoned the office to ask who was coming to provide waking night care. The person was asked to phone back several times as the office staff were unsure who was on the rota for the following morning. The person phoned back a third time and reported that they could hear staff laughing and shouting inappropriate comments in the background. The person receiving care told us the staff member put the phone down and ended the call.

One person receiving 24 hour care told us they had complained and asked for staff to not 'lean on them' whilst providing bowel care and they continued to do so and were not listening. The person had asked the provider to ensure those staff members no longer provided care but the same staff were reported to keep visiting the person. This has been reported to the provider by the person directly.

We were informed that staff who called the office were also not always supported.

People we spoke to told us staff are rushed and are late, often not providing care for the duration of the time expected. People felt sorry for the staff and told us they are often late because of their workload. People described staff being rushed due to being late often and staff reported they – 'get sick of apologising for being late'.

By not treating people with dignity and respect this was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People told us they were not receiving care at their preferred time. Most people told us they frequently see different staff and do not have a choice over who comes to provide their care.

We found some people's care plans were missing on the first day of our inspection and the provider could not explain where the care plans were. We asked the provider to complete an audit check of the care plans for our return a few days later but this had not been completed upon our return.

The care plans we looked in contained basic information about people's day time/night time routines to assist staff to support them in their preferred way. We did not find information pertinent to the individual person's background, interests, likes/dislikes or aspirations. People we visited told us that their wishes were respected. The care plans contained review dates but we could not ascertain if a review had been completed or not.

The provider told us it was not always possible for people to be visited and assessed in their own homes prior to them receiving a service, as short notice was given to start providing the service. In these cases an assessment of need was received from the commissioners of the service which contained sufficient detail to start the service and support people safely. Community Care Direct completed their own care plans and risk assessments approximately ten days after the commencement of the service. However, we found one person with complex health care needs who had received a service for two and a half years still didn't have a manual handling risk assessment or manual handling care plan in the home. Other people told us they had received a visit prior to their service starting and had been informed about the service's requirements.

Everyone using the service we spoke with said the staff were late and on some occasions staff did not arrive to provide care, resulting in a missed call. One person we spoke with said, "You can't tie them to a time and they only stay 15 minutes when they are supposed to be here for 30 minutes." Another person told us ", "Sometimes the carers get calls on the way and then are late." Staff do not have work mobile phones but the provider expects staff to phone the service users if they are running late. People we spoke with told us they don't receive a call letting them know if a staff member is running late. The staff we spoke with told us they rely on the office staff to inform the people if they are expected to take on another call at short notice resulting in them being late. People told us they ring the office and often are unable to get through to find out information. The impact of this system is that people were left not knowing if they were to expect to receive care or not on the day and often did not know which carer was coming to provide care.

We did not see a system of reviewing the information in the care plans to review the changing needs of people receiving care and so we could not ascertain if the information was current and in date. This would have an impact on the care being provided to people as staff rely on the information in the care plan to ensure the care they provide meets the person's needs.

This is a breach of Regulation 9 (1) b (3) (a) (c) (f) (g) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns and complaints people told us about that they had made to the provider were not all recorded. Staff told us the system of recording the initial concern was such that it was written in the message book. We asked to see the message book. We asked where missed calls would be recorded and we were informed 'in the message book'. We were assured by office staff 'we don't have missed calls'. We found not all messages are passed on and we did not see actions logged next to messages in the message book.

We did not see a system in place which allowed people to provide the service with feedback such as an annual questionnaire. This was highlighted during our last inspection. We found this had not been implemented.

The process for making a complaint was in the handbook for people to read but we could not be sure how many people had a copy of the handbook. The service had no system in place to undertake reviews on a regular basis to obtain feedback and explain the system of complaints to people.

Some people told us they had seen improvements after making a complaint but one person who made a complaint told us the problem is continuing and they are not being listened to.

Inadequate

Is the service responsive?

This was a breach of Regulation 16 (1), (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post. The last registered manager left the organisation in November 2014. Other managers had been appointed but had not remained in post and had not registered with the Commission. We found that managers had been appointed and introduced their ideas and management structure to the agency but the lack of a consistent manager meant that many of the managerial responsibilities were not being carried out consistently.

We found no evidence that audits were being carried out. Having a quality assurance system in place monitors performance and drives continuous improvement. We found that care records were not checked and updated to ensure the information recorded enabled safe care to be provided.

We found evidence that staff meetings had taken place in April and July 2015 and were chaired by different managers who were in post at the time.

The agency had an 'on call' system in place to address emergencies out of office hours. This was currently being managed by the provider and one other staff member. We found no written record was made of telephone calls received during evenings and weekends that needed to be actioned by the 'on call' person. Having a written record would give an audit trail for the emergencies addressed and why. The manager would then be able to review the incidents for any patterns or common themes and improve the service if required. A written record would also mean that an accurate record of the emergency was kept, which might have been a safeguarding and may have required notifying to the local authority. The 'on call' policy held by the provider stated that a log should be kept, detailing the incident and the actions taken.

We looked at some other policies held by the provider. We found that some other procedures were not being carried out as written in the policy. For example, the medication policy stated that risk assessments should be carried out for everyone requiring support with medication administration. We did not find medication risk assessment in people's care records. In another example, we found that the policy for Disclosure and Barring checks it stated that the provider would renew the check every three years, to help ensure that staff were still suitable to work with vulnerable adults.. We found that this was not taking place. Complaints and concerns raised by people who use the service reporting missed calls or issues relating to the behaviour of staff were not always being recorded effectively or fully investigated with outcomes demonstrating that the service was being monitored for quality and to ensure learning from mistakes was taking place.

There were no effective systems in place to ensure that care being provided was monitored and that risks were managed safely.

This is a breach of Regulation 17 Governance (1), (2) (a), (b), (c), (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not submitted a notification of a Safeguarding alert to the Commission, as they are required to do by law. The safeguarding alert occurred on 20 October 2015 due to missed calls and the person not receiving personal care, fluids or food. It was reported to safeguarding by the Continuing Health Care staff.