Nova Payroll Management Services Limited

Pinpoint Health & Homecare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an announced inspection which took place over two days 21 and 22 November 2016. The last inspection took place in July 2016. The service was not meeting the regulations at the last inspection and submitted an action plan to us describing the measures they planned to take to become compliant. The service had failed to ensure that staff were supervised and that effective leadership of the service was in place, two warning notices were issued. The service had also failed to ensure that care was delivered safely; that peoples consent was sought; that complaints were managed; that confidentiality was protected and that risks and medicines were managed safely. Requirement notices were issued against the provider. The provider also agreed to a voluntary suspension of new work with the CQC.

Pinpoint Health and Homecare is a domiciliary care service that is registered for the regulated activity of personal care. The service provides care and support to people in their own homes in the North East. The care offered varied from short support visits to 24 hour care. There were 28 people using the service at time of inspection.

The service did not have a registered manager in post. They had recently appointed a new manager who intended to apply to register with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had recently recruited to a number of key posts and most senior staff had been in post for around two months. This meant that most of the new procedures and checks the provider had implemented had either just started, or were about to start.

We found that people's medicines were still not being managed as required. We found that staff had undergone recent training and a new policy had been implemented, but that action was not taken where recording errors were found. This meant people may not have received medicines as prescribed.

People still told us that support calls were late or missed and that they were not told if there was to be any delay in support arriving. Staff and people told us that consistency and timeliness of staff support remained an issue.

Staff were now receiving regular supervision, but annual appraisal of staffs training and development needs had still not taken place for staff employed more than a year. We have made a recommendation about this.

People or their representative's consent was still not being consistently sought or recorded in peoples care plans. Where people lacked the mental capacity to make decisions it was not always clear that staff followed the correct processes when making decisions on their behalf.

A new complaints process had been implemented and more recent complaints were being managed effectively. However some complaints made since our last inspection had not been completed and staff were not managing all complaints in line with the new process. We have made a recommendation about this.

A number of issues we found at previous inspections had not been acted upon, or completed in a reasonable timeframe; the leadership and governance of the service had changed a number of times in the last year resulting in intermittent progress. Information submitted to the CQC by the provider before inspection was inaccurate. A voluntary agreement with the CQC to suspend new work had been missed by staff and new people had been assessed and provided with a service. However the service had made improvements in a number of areas in a short time period following the appointment of new senior staff and care staff recruitment.

Risk assessment and contingency plans for the delivery of the service were now in place. Staff felt able to raise any concerns they may have about the safety of the service and felt these would be acted upon.

New staff had been recruited safely and staff had been subject to thorough checks and a revised induction programme. New staff felt supported and adequately trained before they started work with people. Supervision had started for all staff and they told us they felt supported by senior staff to do their jobs well. Staff told us they could seek support from office staff and felt this was responded to quickly.

Arrangements were in place to request support from health and social care services to help keep people well. External professionals' advice was sought when needed.

People and relatives told us the staff were caring towards them and treated them with dignity and respect at all times. Staff gave us examples of how they helped people maintain their independence and choice through supporting them as they wished and working in collaboration with family carers.

Care plans were more person centred and detailed how best to support people in a manner of their choosing. Reviews of care had been conducted and people's feedback sought as part of the review process.

People, relatives and long standing staff told us the service leadership had improved recently. They felt the service had 'turned a corner' following changes in senior management and other changes to how the service was delivered and managed.

Newly appointed senior staff were open and transparent with us about the issues affecting the service. Where action was needed they took this quickly and supplied us with information requested. The provider was willing to work with the CQC to help improve the service further.

We found breaches in relation to safe care and treatment, consent and good governance. You can see full details of the actions we have asked the provider to take in the full report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The arrangements for medicines management and of audits were not acted upon promptly to ensure that people's medicines were handled safely.

People did not always receive timely and consistent support.

Risks to people were assessed and managed effectively by the service.

Records showed that the service safely recruited new staff to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received supervision but had not all received appraisal on their performance and to help identifying training needs.

People, or their representatives consent, was not always recorded. Records did not demonstrate that staff were using the principles of the Mental Capacity Act.

Arrangements were in place to request support from health and social care services to help keep people well. External professionals' advice was sought when needed.

Is the service caring?

Good

The service was caring.

People and family members told us staff were very caring and respectful.

Staff were aware of people's individual needs, backgrounds and personalities. This helped them provide individualised care for the person.

People were helped to be involved in daily decision making

wherever possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People could raise any concerns with staff and these were now being dealt with in an appropriate manner.

People had their initial needs assessed and care plans had been recently reviewed to make sure they best described how best to support people.

Is the service well-led?

Requires Improvement

The service was not always well led.

All actions required in response to the last inspection had not been acted upon or completed in a timely way. There continued to be a period of time where there had been a lack of clear leadership and quality assurance of the service. This had started to be addressed through new senior leadership within the organisation.

The new manager had already taken steps to recruit to key posts to support the development of the service and improve the supervision and development of staff. People and staff felt the service had improved following these recent appointments and staff were willing to work with the CQC to improve the service further.

Pinpoint Health & Homecare

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 checked if improvements to meet legal requirements had been made following our last inspection in July 2016.

This inspection took place on the 21 and 22 November 2016 and day one was announced. We gave the service 24 hours' notice as it is a domiciliary service and we needed to be sure people would be available. The visit was undertaken by an adult social care inspector and an expert by experience who telephoned people and their relatives to gather feedback. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted two commissioners of the service for feedback. We reviewed the action plan the provider submitted to us after our previous inspection of July 2016.

During the inspection we spoke with five staff including the new manager, we had written feedback from two further staff. We spoke with six people who used the service and five relatives of a person using the service via phone.

Seven care records were reviewed as was the staff training programme. Other records reviewed included, safeguarding adult's records and accidents and incident reports. We also reviewed complaints records, six staff recruitment files and nine induction, supervision and training files. The manager's quality assurance process was discussed with them as was learning from accidents and incidents. We also reviewed the provider's progress against the action plan they submitted to us after the inspection of July 2016.

We also met with the provider after the inspection to discuss our findings and they agreed to share information about further plans and improvements they are making to the service following our inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2016 we found issues relating to staffing and safe care and treatment. We issued a warning notice around managing risk and medicines and a requirement notice to the provider in relation to recruitment practices.

At the last inspection we found that people had missed or delayed calls for planned support. We looked at how the service ensured that staff were deployed to meet people's needs. We saw the service had recently initiated steps to ensure that missed or late calls were detected, analysed and reacted to. However we found that some people were still not getting support at the required times or not being made aware support was going to be late. One person told us, "The regular carers come now and again late. They do not tell us if they come late, sometimes I will be waiting for an hour. I have told the office but they do not seem they listen". Another person's relative told us, "The lateness of the care workers does have a knock on effect on my relative taking his medication. By the time they have finished with my relative it is lunchtime, my relative has missed breakfast medication". Another person told us, "95% on time, the 5% they do not tell me when they are late. The office does not call; they can be late as much as one hour". Most people told us that staff deployed were regular staff and on time. Others told us that staff arrived who they had not met before without any warning. We discussed this with senior staff who advised that a number of new staff had started recently and they were working to ensure that people had familiar staff in future.

At our last inspection we found that people's medicines were not managed well, and that processes to check these were not working effectively. At this inspection we saw that people had clearer care plans in place to support them with their medicines. We saw that all staff had attended recent training on handling of peoples medicines, which included how to keep effective records. The provider had just completed a new policy and procedure for handling medicines. However we saw from records of medicines administration that people were still not receiving their medicines as required. From the medicine administration records (MAR) we looked at we saw gaps in records without explanation, these included for continuous pain relief and for 'as and when required' medicines. Staff were not consistently recording or following the recording guidance on the MAR's. These MAR's had been subject to review by senior staff but action had not been taken promptly. There was also a safeguarding alert raised where staff identified a medicines error and failed to report this as required to the service's office for action. This meant that people were at risk of not receiving medicines as prescribed and that the service was not managing medicines well. After we brought these issues to senior staff attention they took immediate action to identify staff who were not following the correct procedures and supervise or re-train them.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the service's training records and saw that staff had attended safeguarding adults and other health and safety training. The service had raised a number of safeguarding alerts, about their own conduct as well as about familial and other possible abuse towards people. Staff we spoke with and supervision records showed that discussions took place about safeguarding people from risk.

As part of the initial assessment process for new people we saw that risks from their environment, such as trips on rugs, were assessed and that action was taken. We also saw that risks around the delivery of care were assessed, for example moving and handling where two staff may have been deployed to ensure people had the correct support.

We looked at the service's contingency plan for a possible emergency, such as a fire at their offices (possibly resulting in loss of written records and inability to plan and monitor visits) or extreme weather. We saw this had been recently updated to reflect the new management structure and that action had been taken following our last inspection.

Supervision records we looked at for staff showed that a discussion point was any issues or concerns they might have, either about people or about the service as a whole. Records of staff meetings also showed that staff were encouraged to raise any concerns or issues they might have. As the senior staff team had all been recently appointed not all care staff had met them yet. However senior staff we spoke with told us they intended to meet staff over the coming weeks via planned team meetings.

We saw the service had a process for the recording of accidents and incidents, this had only been in place and operating effectively in the last few weeks. We looked at the records and could see that these included events such as falls or other issues affecting people. These records demonstrated that the new manager took action where needed and that care plans were adjusted if required. Some older incidents, prior to the appointment of the new manager, did not have full records of their outcomes in place. When we brought this to senior staff's attention they took immediate action to ensure records kept were complete and to check that action had been taken.

Staff were vetted for their suitability to work with vulnerable adults before they were confirmed in post. The application form included provision for staff to provide a detailed employment history. Other checks were carried out by the provider and included ensuring the receipt of employment references and a Disclosure and Barring Service (DBS) check before an offer of employment was confirmed. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helped support safe recruitment decisions. Records we checked for the most recently recruited staff members showed appropriate documentation and checks were in place for them. They had not been confirmed in post before a DBS check and references had been received.

Training records told us that had all staff attended appropriate infection control training, and staff told us that the service always ensured that disposable gloves and aprons were supplied to the person's home for their use. People told us they did not have any issues with cleanliness and the appropriate gloves and aprons were always worn by the care workers.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2016 we found issues relating to supervision and consent. We issued a warning notice around staff training, supervision and appraisal and a requirement notice for failing to assess and record consent to the provider.

We looked at staff supervision records and asked staff how often they were now being supervised. Staff told us they had received recent supervision and we saw records which showed that staff were receiving supervision and there was a timetable in place for the future. However we saw that staff who had been employed more than a year had still not been offered an annual appraisal, some staff employed since 2014 had never received an appraisal. When we brought this to senior staff's attention they then created a process to ensure that appraisals would be provided for all staff employed more than a year. Supervisions and appraisal had been highlighted at our last inspection and whilst supervisions were now in place, appraisals were not. This meant staff were not receiving appraisal necessary to enable them to carry out their duties.

We recommend the provider ensures that appraisal processes are in place for all staff.

At the last inspection we found the provider was not seeking and recording consent correctly. At this inspection we looked at seven peoples care plans to see how consent was now being sought and recorded. Of the seven we looked at only one had been correctly completed. Others were blank, incorrectly signed by relatives who did not have authority to do so, or were signed by people who lacked the capacity to consent according to the providers' assessment. We discussed these with senior staff as the documentation used was not easy to understand and they took immediate action to confirm that people, or their representatives, had consented. Some of the people and relatives we spoke with were not clear if they had been consulted as part of the care planning process, but the majority told us they had been involved in recent reviews and given their consent. However the action taken by the provider following the last inspection had not been robust as it was not always clearly recorded if consent had been sought or given.

CQC monitors the operation of the Mental Capacity Act 2005 (MCA). This is to make sure that people who do not have mental capacity are looked after in a way that respects their human rights and they are involved in making their own decisions, wherever possible. The provider had recently produced a new policy and procedure for identifying where people may have lost their capacity, and for staff to follow if this occurred. However staff we spoke with did not have a clear understanding of the principles of the MCA, or of how to intervene if required in someone best interests. People told us that staff asked permission and sought their consent before doing anything with, or for them, for example carrying out personal care. But staff did not have training or skills to support them where a person may have lost the capacity to consent to their care. Care plans had involved families and external professionals when being drafted, but this had not followed the best interests process required under the MCA.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with mostly felt the service was effective at meeting people's needs. One person told us, "Yes I am satisfied with the training and skills" when talking about the carers abilities. However some people told us that newer staff appeared to have less understanding of their needs. One person told us, "No issues with the regular care workers. The new care workers I have to tell them what to do, they are not up on it, the files are there but feels like they have not read them".

We looked at the provider's induction and training programme and saw they had recruited new training staff to support this. We discussed the induction programme with one of the training staff and they showed us a robust process, which included face to face training. Feedback from staff was they found the induction training useful and could access refresher training as required. We saw the provider maintained a record of all staff and where training was due they took action to remind staff to attend. Where they failed to attend essential training they took further action, such as suspending staff until they attended.

We saw that the provider had taken recent steps to improve communication with carers, creating a mailing list to communicate with staff. An example of this happened after inspection where feedback on medicines issues was fed back to staff via a memo. We also saw the service was starting to hold regular meetings with staff, offering different dates so that staff could attend one that suited them. Notes of staff meetings would then be circulated. Staff told us that they were kept up to date with recent changes in the management structure, and felt they could raise issues and they would be addressed.

We saw that staff supported some people with eating and drinking, this included helping people to maintain a healthy weight. We checked how the staff met people's nutritional needs and found people were assisted to access food and drink appropriately. People told us staff were helpful in ensuring they had plenty to eat and drink. They said staff would prepare snacks or hot meals for them. Staff also told us they would support people to make their own meals and snacks in order to promote their independence.

People who used the service were supported by staff to have their healthcare needs met. Staff told us they would contact the person's General Practitioner (GP) if they were worried about them. People told us they had access to other professionals and staff worked closely with them to ensure they received the required care and support. People's care records showed that staff liaised with GPs, dieticians, occupational therapists, nurses and other professionals. The relevant people were involved to provide specialist support and guidance to help ensure the care and treatment needs of people were met. One person told us, "Yes they certainly know what they are doing. Once I was poorly, they were excellent; they got in touch with the doctor. They made me feel confident".

Good

Is the service caring?

Our findings

At our last inspection in July 2016 we found an issue relating to confidentiality. We issued a requirement notice to the provider to ensure that people's personal data was protected.

People we spoke with all told us they found the care provided was done so with compassion and respect. Peoples comments included, "Definitely caring, they are very polite without a doubt"; "Always respectful, always treat me with dignity"; "Very respectful. Utmost respect and dignity. I have male carers, they treat me with the same care one would expect from female carers"; and "Very friendly, like family to us. They give me respect; I give them respect, two way processes. I am so pleased they are there for me, it is important they have a conversation with me, at all times they do".

Relatives told us a similar picture of the caring nature of the staff. Relatives told us, "We get on with all carers, they get us involved, and it is like team work. My relative is extremely happy" and "No problem when they are here, respectful, polite, very friendly indeed with us and our relatives".

The new manager and other senior staff were clear about their values and approach to caring for people by supporting the staff who carried out hands on care. They told us this had not always been in place in the past, and this had been reflected in the behaviour displayed by former staff. They had taken steps to change these attitudes and supported existing and new staff to adopt a more person centred way of working. Feedback from commissioners was that there had been issues in the recent past about staff behaviours, but this was not found at this inspection. Staff told us that if they had concerns about another staff member's behaviour they would report this and felt action would now be taken.

When a person started using the service for the first time senior staff explained how they gave them information about how the service would operate and what to expect from the service. They also ensured they knew how to contact the office or senior staff if they had any issues. Feedback from people was that if they had any questions they would either ask care staff or call the office and they would get a quick response. Some told us that the new management had made a difference, but one relative felt the provision of information and explanation from senior staff had not changed.

People told us that staff respected their privacy and dignity. People described how personal care was carried out with staff ensuring they were always kept covered with towels or blankets and doors of rooms and curtains being closed. Staff and people told us they always sought permission before doing anything for the person.

We saw from records and talking to staff that people were supported to maintain their wellbeing. They supported people to access healthcare services, sometimes supporting family members to ask for additional support or advice, such as a care review if they were not managing. Staff were aware of advocacy support that could be accessed to support them with any conflicts or issues. We saw that issues of behaviour or mental health had been referred for external support to ensure that the needs of the each individual were recognised.

People were supported at the end of their life, and the service worked with external specialist healthcare agencies to ensure that appropriate support was available.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found issues relating to person centred care and complaints. We issued two requirement notices to the provider.

The service kept records of complaints made by people about the service; we looked at these and found that there had been 12 complaints made since April 2016. We saw that recent complaints had been responded to in line with the providers' new policy and process and had been managed correctly. However we found records labelled as 'legacy' which related to before new senior staff had started work in the last two months and since our last inspection. We saw that people had letters saying their complaint was under investigation and that the deadline stated for a final response had passed. It was unclear what action had been taken as the records kept were not complete or in chronological order. When we asked senior staff about this they took immediate action to check what work had been completed in these 'legacy' complaints and then followed the correct procedures to ensure that they were responded to, albeit after a period of delay. When we returned on the second day of inspection we found that progress had been made already. However the provider had not ensured the complaints process was robust following the findings of our last inspection.

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

People and relatives told us that care staff were generally responsive towards their needs, but there were still areas of improvement in the office staff's response to queries. One relative told us "Previously it was bad, no one listened", they went on to tell us with new managers it had greatly improved. However some people and relatives still had recent issues about communication. They told us that if carers were late they were not contacted. The provider already had action in place to manage late and missed calls and agreed to take actions to improve this issue as the new senior team 'settled in'.

We asked relatives if they knew how to raise concerns or queries about the service they received. People told us that they felt comfortable telling someone at the service if they were unhappy about any part of the service.

We saw that as part of the initial assessment there were questions for people about their interest and previous work or occupation. These had been completed to give some background information about how best to support them. Initial care plans were used to arrange the initial support plan and then over time a fuller care plan was developed and recorded.

We looked at peoples care plans and saw that action had been taken since our last inspection. Peoples care plans had been reviewed and a new format was in use. Care plans were now more personalised and contained greater details about how to support people in a manner of their choosing. People told us that staff had visited their homes and involved them in reviews of their care. We saw that details of recent professional advice had been added to peoples care plans. For example a speech and language therapist

(SALT) had given advice about how best to support a person to eat and drink safely. Staff told us that the care plans had been improved and were easier to navigate and find key issues.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July 2016 we found an issue relating to governance of the service. We issued a warning notice relating to the leadership and governance of the service to the provider.

Since our last inspection there had been a number of senior posts replaced with new staff, as well as additional training and quality assurance appointments made. However these staff had not yet had the opportunity to comprehensively respond to the issues found at our previous inspections. We found audits had been robust. For example actions and records were incomplete for 'legacy' complaints and medicines audits had been completed which identified recording errors made by staff. However three weeks later no action had yet been taken to remedy this. Despite being raised at two previous inspections, staff appraisals had not yet started. The provider information return (PIR) submitted to the CQC by the provider contained factual inaccuracies. Calls to support people were missed as the care staff were not always sent new rotas promptly or confirmed they had been received meaning people had missed calls. We also found that the voluntary suspension of new work the provider had consented to had been breached by staff. Five new people had been assessed and started to receive care and support from the provider. Staff we spoke with about this were initially unclear if the suspension was in place until this was clarified by a more senior staff member. We discussed these issues found with senior staff and they took immediate action and by day two of the inspection a number of these issues had either been resolved, or had a clear plan of action in place to resolve them. When we met with the provider on the 21 December 2016 they demonstrated that further action had been taken with regard to all the issues raised at inspection and shared further governance information to assure us that people were receiving safe care.

However a number of these issues around the leadership and governance of the service were longstanding and action taken by the provider had not been prompt or complete, meaning people had not received a well led service for a sustained period of time.

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

People and relatives of people told us the service had started to improve in the last few months, and that leadership of the carers had improved. People commented that, "All depends on the management. There is a total change now, they listen. I am so happy now"; "Never been let [me] down" and "Well done to the company. Doing well now". Relatives we spoke with expressed similar views, they commented that "At first the company was upside down, but now settled" and "The company has gone through a lot of changes, lost staff. Now got some good people, good routine, good change".

Staff also commented that the recent changes to leadership and oversight of the service had made the service better. They told us that they felt supported and well led. Staff who had been with the service more than a year felt the service had "Turned a corner" as one told us. Staff told us they could now raise concerns, felt they would be listened to and action taken. Staff still felt that the service could do more to ensure consistent staffing for people and more advanced training opportunities, but they now felt able to raise

these issues at supervision.

The new senior staff we met as part of the inspection were open and transparent with us about the issues they found when they joined Pinpoint. They recognised that a year of changing senior staff had meant that improvements had not been sustained. When we brought issues to their attention staff worked late into the night of the first day of inspection in order that action could be evidenced by day two.

The manager who was applying to register with the CQC was knowledgeable of the requirements of registration and was able to tell us their vision for the service and felt they now had the correct support in training and quality assurance to improve the service. The services quality lead continued to send us information about audits and actions taken after the inspection and was open to working cooperatively with us.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure that care and treatment of service users only be provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to assess the risks to the health and safety of service users of receiving care or treatment and do all that is reasonably practicable to mitigate any such risks. The provider had failed to ensure the proper and safe management of medicines. Regulation 12 (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The registered person had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and

others who may be at risk which arise from the carrying on of the regulated activity.
The registered person had failed to evaluate and improve their practice in respect of the processing of the information referred to above.

Regulation 17 (2) (a) (b) and (f)