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Carrington Home Care

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This announced inspection took place on 10, 15 and 24 January 2019. We gave the service 48 hours' notice of the inspection visit. This is because it is a small domiciliary care agency and the provider works as part of the management team. Carrington provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. Not everyone using Carrington Home Care receives a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'. This includes help with tasks related to personal hygiene and eating; we also consider any wider social care provided.

At the time of our inspection, the service was providing personal care and support to 38 people living in their own homes. The last CQC inspection took place in June 2016 when it was rated as Good. However, on this inspection we judged improvements were needed in how the provider managed and ran the service. The provider has registered with CQC as an individual and therefore does not require a registered manager.

There were aspects of the service which were not well led. The registered provider had not carried out regular quality assurance audits to ensure the service was providing good quality care.
During our inspection, we found a number of areas needed to improve to maintain the safety and well-being of people; these had not been addressed by the provider. Quality assurance systems were not effective in recognising areas for improvement and there was not a timely response to initiate changes.

People were supported by staff who treated them with kindness, respect and compassion. Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives. People were supported by staff who respected them. However, there were gaps in staff training and records relating to observations of staff practice and supervision.

People said the staff made them feel safe because they were kind and reliable. The management team understood their safeguarding responsibilities. Staff ensured there was a consistent approach to involving people with their care plans.

Systems in place for the recruitment and selection of staff were poorly managed by the provider. They did not ensure new staff had appropriate documentation in place to confirm they were suitable to work with people using the service. Recruitment checks were not routinely carried out before staff started their employment at the agency.

Action was needed to improve medicine training and auditing staff practice to ensure they worked in a safe manner. Potential risks to people's health and well-being were assessed and documented.

Equality and diversity was understood to support people's individuality. There were systems in place to gain people's views and to address concerns and complaints. People were supported to access health care professionals to maintain their health and wellbeing. The service was reliable and staff understood the

importance of good infection control practice.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this 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.

People were not protected by robust recruitment practices. However, people said staff made them feel safe.

Poor documentation meant the provider could not demonstrate medication practice was safe.

The service was reliable and staff understood the importance of good infection control practice.

Staff understood their safeguarding responsibilities.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff inductions, supervisions and training were not well managed. Staff did not receive regular training to cover all aspects of their role to ensure the support they were delivering was safe and effective.

Steps were not consistently taken to ensure people's legal rights were protected.

People were supported to maintain good health and had access to appropriate services, which ensured they received on-going healthcare support.

Is the service caring?

Good

The service continued to be caring.

Is the service responsive?

Good

The service continued to be responsive.

Is the service well-led?

Requires Improvement

The service was not well led.

There was a lack of oversight by the provider regarding auditing and reviewing how training and recruitment were managed.

The overall governance of the service needed improvement. Quality assurance systems had not been fully developed to regularly monitor the service and assess the care provided to people.

Carrington Home Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection site visit started on 10 January 2019 and was announced. The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service. We gave the service 48 hours' notice of the inspection visit because it is small and the provider works as part of the management team. We visited the office location on the 10 and 15 January 2019 to meet with the provider and staff. On 11 January 2019 we spoke with people and their relatives to gain their views on the service. On 24 January 2019 we gave feedback to the provider.

Before the inspection we reviewed all the information we held about the service. We spoke with the provider and five members of staff. During the inspection, we spoke with six people using the service and five family members. We reviewed three people's care files and medicine records. We looked at three staff records and their training certificates. We looked at a range of records related to the running of the service. These included staff rotas, supervision, training records and quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. This was because recruitment and aspects of medicine practice were not safely managed. However, people unanimously said they thought the service was 'very safe' 'safe' or 'generally safe' and the care staff were kind and caring in all respects. One person said, "They keep me safe, so I don't need to worry about living alone."

The provider did not ensure there was a consistent approach to recruitment, this potentially put people at risk of harm. Several members of staff had been involved in different aspects of recruiting new staff. The provider had not overseen how recruitment was managed and their own practice needed to improve when they were involved in recruitment. New staff were introduced to people using the service before appropriate checks had taken place to assess their suitability for the role. For example, staff recruitment files were incomplete as police checks had not been undertaken, and some references and identification documents were missing. Reasons for gaps in people's employment history had not been explored or recorded. Where recruitment processes had highlighted potential areas of concern, these had not been addressed through risk assessments. Further reassurances had not been sought to assess new employees' suitability.

This is a breach of Regulation 19 of the Health and Social Care Act (2008) 2014.

In response to our feedback, the provider took the decision to halt the recruitment of new staff until the appropriate documentation for existing staff was in place. The introduction of several new staff to people using the service was halted until all appropriate checks were in place. By the second day of inspection, the provider and management staff had created a best practice recruitment folder complete with updated forms. They identified how several checklists and the good practice on previous recruitment forms had been lost over time and needed to be reinstated.

Most people said they managed their own medicines or had help from their family. However, some people did require support to take their medicine. One person commented "I was finding it too much, so now they do most of my daily tasks including the medicines which is much better for me … I know it'll be done correctly every day now."

Senior staff said they often worked alongside new members of staff so they could observe their medicine administration practice. However, there was no record of these observations as part of staff inductions or appraisals. Senior staff said medicine administration records were also regularly reviewed to check on staff practice but there was no record of these audits or the action taken if there was a problem. Senior staff said some staff did not recognise the importance of consistently signing medicine records. People were potentially at risk of poor staff practice which could result in harm or discomfort to them. Actions to address poor practice were not recorded, for example in supervision records.

People were positive about the quality of the care staff and their professional attitude. For example, they said "We know the carers very well and I don't get too many new carers being introduced, so it feels very safe knowing we can trust the people who are coming into our home to look after my husband" and "The carers

are polite and respectful. It's impossible for them to do too much for [my relative]. Nothing is too much trouble for them." Most staff had worked at the agency for a number of years which meant the core staff group provided continuity of care for people using the service. Care staff said they worked an acceptable number of hours each week and were not under pressure to undertake extra hours.

Staff stayed the time allocated to them. People said, "The staff always have enough time not to be in a rush and have the time to talk to me a bit to see how I am, or chat while they work" and "They can help with little extra jobs some days, and if [my relative] falls or something they can end up staying quite a lot longer." People did not feel rushed and staff made them feel safe when they used equipment. For example, "I have a visit twice a week and the main reason is to be able to have a proper shower. The carers make sure I'm safe in the shower and help me wash to maintain my health and personal hygiene and make sure I don't fall again" and "The staff help me to use the bath and the swivel stand safely."

There was a mixed response from people regarding staff arriving on time; they recognised traffic and emergencies could impact on staff punctuality. The management team said they advised people there had to be a flexible approach to staff visits, especially if staff were off sick and other people were covering for them. Some people said their care staff could often arrive a bit late or very late (more than an hour). One person said, "Occasionally they will come a bit late. It can be a nuisance, but it's not the end of the world for me." Most people said they usually received a call from the office if a staff member was going to be more than 30 minutes or so late. However, several people said this was not their experience and they sometimes had to ring the office for reassurance that they had not been forgotten. The management team explained how they tried to keep people notified if there were delays. They would also step in to cover a visit if there was an emergency, such as a person falling and needing company until the ambulance arrived.

The management team described how they monitored staff whereabouts to try and eliminate missed visits. One person said they had experienced a missed visit once in the last six months. The management team explained how they had responded to a missed tea time visit by collecting a takeaway meal of the person's choice.

People's assessments recognised risks to people's health and safety including their mobility. Senior staff also ensured information from commissioners was included in their documentation. Records showed senior staff completed the agency's own risk assessment to identify and help reduce risks within people's homes.

People were protected from abuse because the management team demonstrated they understood their safeguarding responsibilities. They shared examples with us which demonstrated they knew when to make referrals if they had concerns about people's safety. Staff knew to report concerns within and outside of the service but were not sure of external contact details. The management team had worked with people and health, legal and social care professionals to help prevent them from being financially exploited. They decided to update their safeguarding information to ensure there was clearer guidance for staff.

Staff were provided with infection control equipment, which was stored at the office; staff visited the office for their weekly rota collected supplies. People said care staff always wore a smart uniform, used gloves and washed their hands as appropriate.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. Staff did not receive training or updates to cover all aspects of their role to ensure the support they were delivering was safe and effective. Further work was needed to ensure representatives signing care plans on people's behalf had been involved appropriately and were acting in their best interests.

Staff inductions, supervisions and training were not well managed. The provider could not demonstrate how they had assessed all new staff as being competent for their role. Senior staff said they carried out spot checks, if they were in the area, or worked alongside staff when people needed two staff to support them. However, there was not a consistent log of their observations regarding the competency of care staff. A few observations that were recorded were not dated. Senior staff said they had a plan to address the backlog of staff supervisions, which were not taking place on a regular basis.

An overview of staff training showed updates for food hygiene, first aid, medicines and safeguarding were overdue for 20 care staff. The provider explained this had been due to the external trainer not being available for the planned sessions. However, the provider had not been proactive in sourcing another training company. This meant staff may not have been up to date with best practice guidelines.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said they were normally supported by a core group of staff who they described as competent and skilled. A third of the care staff held a national qualification in care. People said, "The staff know what needs doing and how it should be done, so I let them get on with it" and "The [carers] are very good with me and just do their job in a straightforward way which puts me at ease in their company."

New staff were introduced to people using the service before they started providing care on their own, which people confirmed. For example, they said "New people when they first come to us do a shadow shift the first time" and "I mostly have the same carers each time but when a new carer comes, they come together, and the old carer teaches the new carer what to do and how to do it." One new staff member had undertaken the Care Certificate as part of their induction; this is a nationally recognised qualification for people who have not worked in care before. Despite people's positive feedback, there were no records kept to show how new staff, with some experience in care, had been observed to check if their practice was safe and based on current guidelines.

There was a consistent approach to gain people's consent to care and treatment in line with requirements of the legislation and guidance. For example, care plans were signed by people receiving a service. Senior staff gave examples when they had contacted health and social care professionals to assess people's mental capacity to consent to their care. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

However, the provider did not routinely check if people had the legal authority to be involved in decisions relating to health and welfare or finances. This meant people's legal rights were not protected. During the inspection, the provider began to take steps to address this omission. However, people said care staff gained their permission for day to day support. For example, a relative said "They quite often ask for permission to do things, especially if it's a personal thing like washing, but not if it's the same thing they do every time. They're all quite polite and treat [my relative] with respect; as an individual person."

Staff recorded the support they provided at each visit. For example, people said "My carers write up their visits in their book after each visit." They recorded other relevant observations about the person's health and wellbeing. This showed us staff were knowledgeable regarding what action they should take to ensure people's health care needs were met. However, further work was needed to ensure that care plans were reviewed and audited regularly to ensure these observations were considered and used to update the care plan.

People received ongoing health care support and referrals were appropriately made to health care services when people needs changed. People said "The staff are very much caring people. They are concerned for my welfare as much as for getting their work done." Referrals were appropriately made to health care services when people needs changed. One person said "The carers are so good, and they take the time to listen and check my husband is doing well. If they think we need a doctor - or if we ask - they'll get one and they do everything like that."

Records showed staff worked with a range of community professionals to maintain and promote people's health. Some people had support with their meals and shopping; they appreciated staff being observant when they were running low with supplies. For example, "The people who visit me understand me and know my personal needs and preferences. They do everything for me, even popping to the local shop for a loaf or a pint of milk if they notice I'm getting low."

Good

Is the service caring?

Our findings

The agency continued to provide a caring service. People praised the caring nature of the staff who supported them in their own homes.

People said the staff were exceptionally caring and compassionate people who treated them as individuals and took the time to listen to them. People said, "They are the loveliest people; just brilliant and always smiling and cheerful. They always brighten my day" and "The staff do more than enough. They are very caring and are more like friends than carers. They understand the emotional burden and that they are looking after a real person with real needs and feelings."

People using the service and their relatives were happy with the care and support their received. For example, "The [carers] are very good with me just do their job in a straightforward way which puts me at ease in their company" and "We have been with Carrington for a while. I know the manager, and the carers are like friends. They are able to talk to [my relative] about their care needs in an honest and sympathetic way."

People had good relationships with the care workers and felt that they were treated with respect. Staff spoke warmly and respectfully about the people they supported. Staff understood the need to respect people's confidentiality and to develop trusting relationships. People said, "It's so important when people are coming into your own home that you can trust them and that you know yourself and your home will be safe. I absolutely feel I am safe with the carers."

The service supported people to express their views and involved them in making decisions about their care. Our conversations with staff demonstrated they recognised how they needed to work alongside people so their visits were accepted by people and their relatives. Relatives said they had a good relationship with staff, who they said recognised when they needed support and reassurance.

Good

Is the service responsive?

Our findings

The service continued to provide responsive care.

Senior staff explained their role in a meeting with people before they started using the service This meant they had agreed to provide a service after assessing people to ensure they could meet their care needs and after assessing potential risks.

Discussions with staff showed they had a good knowledge about people they were supporting in regards their preferences, daily routines and their likes and dislikes. Staff said there were no surprises when they visited a new person using the service as they were provided with key information. People said, "When they come to see me, we just talk about what I need them to do. If there's washing to do, they'll do it. That sort of thing really. That's how we go on" and "The staff know what needs doing and how it should be done, so I let them get on with it." Staff confirmed there was always a care plan to refer to and they would seek the views, opinions and wishes of people they cared for daily.

People were involved with informal reviews of their care plans to ensure their wishes and preferred routines were included as part of the detail of the plan. This helped ensure staff could provide the care and support in a personalised way taking people's wishes into account. However, they were less clear if there were regular formal reviews. For example, they said "We were asked about needs and wishes for the Care Plan when [my relative] first started with the service but not since then" and "We just discussed care needs at the very start. I suppose Carrington's keep it up-to-date."

Staff said, where possible, they supported people in their homes with end of life care. They described worked in partnership with community nurses to deliver compassionate end of life care. Senior staff with experience in this type of care provided this support and worked with less experienced staff to build their confidence and competence. Senior staff said they viewed this type of support as rewarding and took their role seriously to help people feel safe and comfortable. Senior staff ensured people's choices regarding medical treatment and intervention (Treatment Escalation Plan) were kept in people's care files in their home to advise medical professionals of their wishes in an emergency.

The service was responsive to people's changing needs. For example, if a person was quickly discharged from hospital, staff ensured the heating was put on in their home and provided basic food supplies. They ensured they were there to welcome them home by liaising with other agencies, such as the hospital discharge team. People said, "When my carer went on holiday, they arranged for me to have a visit every day … so the carers checked I was still okay, and it was no bother for [the service] to arrange to do that" and "They've asked before if anything extra needs to be done and due to [my relative's] condition they sometimes offer some light support to allow [my relative] to exercise as much as they can."

Equality and diversity was understood to support people's individuality. For example, staff gave examples of how they had adapted their practice in recognition of people's faith, cultural beliefs and respecting the relations with people who were important to them. The provider and care staff knew people using the

service well and recognised what was important to them. For example, the provider has intervened to ensure a person still had their daily newspaper delivered, despite problems with an overdue bill. They took on this role until the person's financial situation was resolved. For another person, care staff recognised the importance of a person's pet to their mental well-being and supporting them with caring for it.

We looked at how the provider complied with the Accessible Information Standard (AIS). This is a framework put in place from August 2016 which made it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We discussed with the provider how they made information accessible to people. A relative said "We have a number to call the office and they are used to my mother's voice now and give her the time to communicate with them in her own way." Care staff confirmed the person rang regularly, and they recognised her voice, when she did not introduce herself. They explained how they offered reassurance allaying the person's worries.

There were systems in place for receiving and investigating complaints. Clear written information was provided to people using the service as to how to make a complaint. People were confident any concerns would be dealt with appropriately. Everyone stated that they would be willing and able to make a complaint if they felt this was necessary. They also said things were easily sorted out by talking through their concerns, usually in the first instance with care staff during a regular visit. A typical response was "I have never needed to complain about my care, so I don't know what the complaints policy is; but if I wasn't happy with everything, I'd just tell the staff and they'd sort it out for me."

Requires Improvement

Is the service well-led?

Our findings

Aspects of the service were not well led. During our inspection, we found a number of areas needed to improve to maintain the safety and well-being of people; these had not been identified by the provider. Quality assurance systems were not effective in recognising and addressing areas for improvement. The provider had not carried out regular quality assurance audits to ensure the service was providing safe care of a good quality.

People's safety was potentially put at risk from staff who had not been trained or updated in all aspects of their roles. For example, monitoring medicine practice. During the inspection, we asked the provider how they ensured staff had the necessary skills to meet the range of care needs they had registered with CQC. They did not routinely monitor if inductions and training courses were being completed. Therefore, they could not assure us staff were confident and competent in all the tasks they carried out. The provider had not addressed problems with delays in external training being delivered. They said a staff member who had been employed to manage staff training had left unexpectedly in early 2018. However, they had not acted to ensure care staff received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the tasks they were employed to perform.

Since the last inspection, the registered provider had become more involved in managing the service. During the inspection, the registered provider and senior staff identified how the service would benefit from them having clearer role definitions to ensure staff could focus on their strengths. For example, there had been no overview of the management of staff recruitment. The provider had not ensured their service's recruitment practice was safe and robust.

The provider had not taken action to improve the quality of recording in the running of the service. For example, governance arrangements, such as auditing and reviews of the quality of the care provided.

People's legal rights were not consistently protected, although people said care staff gained their permission for day to day support. The registered provider did not routinely check if people had the legal authority to be involved in decisions relating to health and welfare or finances. Further work was needed to ensure care plans were reviewed and audited regularly.

Some areas for improvement highlighted at previous inspections were repeated at this inspection. For example, staff training and quality assurance processes.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People using the service and their relatives were complimentary about the calibre of staff and said they would recommend the service to other people. They trusted the provider and were confident if they had any concerns they would be addressed. Senior staff said because they provided hands-in care, they spoke with people on a regular basis and therefore gained feedback on an informal basis. They said they were

committed to continue to provide personalised care. Written feedback was also sought from people to help improve the service.

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 17 HSCA RA Regulations 2014 Good governance People who used the service were not protected against the risks associated with an ineffective system to regularly monitor and assess the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who used the service were not protected against the risks associated with poor recruitment practice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who used the service were not protected against the risks associated with poorly managed staff training, supervisions and inductions.