Care Avenues Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 13 December 2016 and rated it 'Good' in all domains. On the 10 October 2017 we received information of concern from a person who worked at the service. They included concerns about the skills and knowledge of some staff who worked at the service, people's call times and how the leadership team responded to information of concern.

As a result of this information we undertook an unannounced focused inspection on 18 October 2017 to identify if the service kept people safe and was well-led. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection in December 2016, by selecting the 'all reports' link for Care Avenues Limited on our website at www.cqc.org.uk. We also alerted other agencies to some of the concerns we received. As a result this inspection did not examine the circumstances of these other concerns.

Care Avenues Limited provides personal care to 130 people in their own homes. At the time of the inspection the service had a registered manager although they were absent during our visit. We were accompanied during our inspection by the nominated individual for the service and the area manager. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider did not operate effective systems and processes to assess, monitor and improve the quality of the service. Staff were unable to confirm if all the people who used the service had received calls in line with their care needs. Audits had not identified that people's care records lacked detailed or contained contradictory guidance for staff. Systems to store and retrieve information and records was not effective. This meant during our inspection visit staff were unable to tell us about any incidences which had occurred and any action to prevent similar incidences from reoccurring. The provider's systems had not ensured that their latest inspection ratings were displayed on their website or that we received a formal notification when the registered manager left the service. The provider did not always fulfil their legal responsibilities to the commission.

Although people who required support to receive their medicines safely said they were happy with how they were supported we saw that people were at risk of not receiving their medicines as prescribed. Some people's medication records were incomplete or contained contradictory guidance for staff.

People spoke affectionately about the staff who regularly supported them and said they attended their calls in line with their wishes. However several people said they were occasionally supported by staff who were not familiar with their care needs. We could not be assured that the provider's systems for ensuring there were enough staff on duty to meet people's care needs was robust.

Staff we spoke with did not consistently demonstrate they were aware of the action to take should they suspect that someone was being abused. Members of the management team had notified the local authority when they were concerned that people might be at risk of or experiencing abuse.

People said staff would respond promptly if they became unwell or their condition deteriorated. Staff could describe people's specific conditions and how they managed any potential risks they presented. Records sampled did not always contain sufficient details for staff about how they could reduce the risk of harm for people.

There was clear leadership at the service. Staff told us members of the leadership team were accessible and would listen to their concerns. There were staff meetings and supervisions but it was unclear how frequently it was planned to hold them. There was no evidence that feedback from staff at supervision was used to improve the service.

People who used the service were generally pleased with how it operated and several said it had improved in the last few months. People received visits from senior staff but several people told us they had experienced poor communication with the office staff.

During this inspection we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff did not consistently demonstrate they were aware of the action to take should they suspect that someone was being abused.

We could not be assured that the provider's systems for ensuring there were enough staff on duty to meet people's care needs was robust.

Some people's medication records were incomplete or contained contradictory guidance for staff.

People said staff would respond promptly if they became unwell or their condition deteriorated.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider did not operate effective systems and processes to assess, monitor and improve the quality of the service.

There was clear leadership at the service however the provider did not always fulfil their legal responsibilities to the commission.

People who used the service were generally pleased with how it operated and several said it had improved in the last few months.

Care Avenues Limited

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 undertook an unannounced focused inspection of Care Avenues Limited on 18 October 2017. This inspection was done to in response to concerns we had received from a person who worked at the service. We inspected the service against two of the five questions we ask about services: is the service safe and well-led? The inspection team consisted of two inspectors who visited the service's office and an expert by experience who spoke to people who used the service on the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

As part of planning the inspection we reviewed the information we had received from a member of staff who worked at the service. We shared information with the local safeguarding authority when we felt a person who used the service was at risk of abuse. We reviewed any information we held about the service. We also checked if the provider had sent us any notifications. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We spoke to the person who had raised concerns and a person who commissions packages of care from the service. We used this information to plan what areas we were going to focus on during our inspection visit.

During our inspection we visited the service's office and spoke with the nominated individual for the service, regional care manager, two care co-ordinators, five care staff and two administrators. We sampled the records, including seven people's care records, four staffing records and quality monitoring documents. We also spoke with six people who used the service and relatives of 11 other people. We spoke with five care staff.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we received information that people who used the service were at risk of harm. Information we received suggested the people were supported by staff who did not know their specific care needs. People did not receive calls from staff in line with their care plans and some people experienced missed calls. There were concerns that some staff were not suitable to support people or received suitable training to meet people's specific needs.

At our last inspection we related this domain as, 'Good'. We found the provider had not maintained this standard as further improvement was required to ensure people were kept safe from the risk of harm.

People who required support to receive their medicines safely said they were happy with how they were supported. One person told us, "I'm diabetic. I have to have my breakfast when it's due so the time matters. They are mostly on time or they let me know. They make sure I take my tablets with my breakfast". One person's relative told us, "They put creams on at times they call. They do her tablets in the day and in the evening". Although we found no evidence that people did not receive their medicines, incomplete medication records and inconsistent guidance for staff did not reassure us that people would consistently receive their medicines safely.

Staff we spoke with told us they had received medication training and were confident to support people with medicines in line with their care plans. We saw that care co-ordinators had conducted spot checks to ensure staff were safe to administer people's medicines. However when speaking with a care co-ordinator it was clear they did not understand that prompting a person to take their medicines was a process of medicine administration. This meant we could not be sure that senior staff had the skills to identify when staff required training in medication administration.

Systems for recording how people needed support with their medicines required improving because medication administration records (MARS) did not contain detailed information for staff. In one instance a person's records stated, "Liquid medication", was administered each morning. A care co-ordinator was unable to confirm what this was. Staff had also recorded in the person's daily records that, "creams applied", but there were no further details to identify the cream or where it had been applied. This lack of information meant it was impossible for us or the provider to check if the person had been supported to take their medicines appropriately. We found other people's medication records were also incomplete or contained contradictory guidance for staff. The records for one person stated they needed, "all help" with medication but the care co-ordinator told us the person did not require support. The records of another person who staff were to prompt to take medication did not contain details of the medications staff were to support the person to take. The person's care plan instructed that, "Staff to complete MARS chart" but the care co-ordinator confirmed no MARS chart had been supplied for staff to complete. Failure to provide detailed instructions and maintain clear records meant that the provider could not check if people had received their medication as prescribed.

Prior to our inspection we received information there was not sufficient suitable staff to attend people's call

times as planned. People spoke affectionately about the staff who regularly supported them and said they attended their calls in line with their wishes. One person's relative told us, "Yes, they seem well enough trained. They use gloves and an apron". However most people said that staff who did not attend their calls regularly did not know how to support them in line with their care plans or stick to their agreed call times. One person told us, "It should be two carers and they often don't arrive together. They stagger their arrival and we wait until they both get here. They should arrive together but once or twice a week they don't. A few times one runs late". Another person said, "The main one [carer] is very very good but some others are doing the minimum". The relative of another person told us, "When the regulars are away the service does not do things right. Any change to the usual carer and the service breaks down some times." Another person's relative told us, "Their time keeping is not good. The carers get stuck. They run late by quite a while but if it's going to be a lot they will call me". Staff we spoke with said they felt they had enough time to get to people's calls on time and all said they were supported by a colleague when a person was required to be supported by two carers. A recent supervision record for one member of staff showed they had raised concerns at having to wait one and a half hours before a second colleague attended to help them support a person with their mobility. There was no evidence in the record about how this issue would be addressed.

We reviewed the provider system for monitoring if there were enough staff on duty to support people at their agreed times. Most people's calls were recorded on an electronic database which identified when people had not or were at risk of not receiving their calls as planned. We saw that the provider maintained a log of these incidences and of the actions taken to minimise the impact on people. However not all calls were monitored by this system. We reviewed the records of two people whose calls were not monitored electronically and the care co-ordinator could not find any records such as staff time sheets or daily logs to identify if these people had received the appropriate calls. We could not be assured that the providers systems for ensuring there were enough suitable staff on duty to meet people's care needs was robust.

Staff we spoke with did not consistently demonstrate they were aware of the action to take should they suspect that someone was being abused or the factors which may make someone more vulnerable to abuse. This action is referred to as 'safeguarding'. One member of staff told us, "I would tell the manager. I would look out for bruising. I would tell [the person's] case worker and CQC". Two members of staff we spoke with said the principle of safeguarding was to protect staff from abuse by the people who used the service. Another member of staff who told us that they had received training in safeguarding procedures was unable to identify external agencies they could notify if they felt a person was at risk of abuse. A care co-ordinator told us there was regular safeguarding refresher training for staff however it was not possible from training records to identify how frequently staff had received safeguarding updates. We could not be assured that all staff would recognise or respond appropriately to signs of abuse.

The registered manager and care co-ordinators had assessed and recorded the risks associated with people's medical conditions as well as those relating to the environment which may have posed a risk to people using the service. We saw there were systems and processes in place to protect people from the risk of harm but the assessment of risks needed to be more robust. The records sampled did not always contain sufficient details for staff about how they could reduce the risk of harm for people. For example, care plans to reduce the risk of falling for several people instructed staff to use a 'sling' and to 'assist with moving' but not how staff were to undertake these tasks safely.

Assessments for a person who was at risk of falls and another person who was at risk of developing skin sores identified that it was necessary to refer both people to specific health care practitioners for further assessment. The referrals had not been made. A care co-ordinator told us that they felt these people did not require referrals but there was no evidence recorded to explain why they had not followed the provider's guidance. The care co-ordinator had not taken action to review the assessment tools to ensure they

provided accurate and appropriate guidance for staff. The care co-ordinator was unable to supply us with a care plan for a person who used a catheter and there was no evidence that some staff who supported this person had training in catheter management. The care co-ordinator told us some staff had recently undergone catheter training but could not produce evidence this had occurred. A lack of sufficient guidance puts people at risk of receiving inappropriate care from staff who may be unfamiliar with their needs.

The provider had not ensured there were enough staff available who knew people's specific care needs and how to report concerns of abuse. Records did not contain detail guidance about how people were to be protected against the specific risks associated with their conditions or supported to take their medicines safely. This put people at risk of receiving unsafe or inappropriate care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with and their relatives said they felt people were safe using the service. One person told us, "It's all safe enough, they are not nasty". Another person told us, "I feel safe with them. I feel at ease when they are around". A person's relative told us, "She's safe and at ease with them".

People told us that staff kept them safe from the risks associated with their conditions. One person who required support with mobilising told us, "They know how to use it [hoist] okay and they don't send two novices. A person's relative told us, "They use a hoist. They know how to do that safely for mum". Another person's relative said, "Its' working well so far. Mum has had a risk of bed sores and they are doing well".

People told us that staff would respond promptly if they became unwell or their condition deteriorated. One person told us, "[Staff] alert me to get the doctor if needed". A person's relative told us, "If they spot things, they alert us to get the doctor". Another relative said, "The care staff now directly call the nurses but they also keep us in the picture".

Staff we spoke with told us they regularly supported the same people. They could describe people's specific conditions and how they managed any potential risks they presented. Staff said they were confident to support people safely in line with their care plans.

We had received concerns that staff did not always have the necessary skills to be able to speak with the people they supported in their preferred language. People we spoke with did not feel this to be an issue. One person's relative told us, "We can speak the language of the carers and they can speak English as well". Another person told us, "There's no language difficulties. They double up and always one is able to speak to us and with [the person they were supporting]". A care coordinator told us they would always ensure when possible people were supported by staff who understood their cultural heritage and beliefs.

Records sampled showed that senior staff had notified the local safeguarding authority when they were concerned that people might be at risk of or experiencing abuse. A social worker who had recently investigated some concerns about a person who used the service told us there was no evidence to suggest the person was at risk of neglect or abuse. Records of a recent staff meeting showed the provider had reminded staff about how they could raise concerns about people's care in confidence.

The registered manager was supported by the provider's human resources department to conduct a robust recruitment process. Staff told us and a review of five staff records confirmed that staff had undergone interviews and checks had been carried out before staff started work. These included Disclosure and Barring Service (DBS) checks to identify if applicants had criminal convictions and obtaining suitable references. On one occasion however we noted that no further action was taken to assess potential risks identified during a member's of staff's recruitment process. This did not assure us that the member of staff was suitable to

support people who used the service. The area manager acknowledged our concern and said they would follow this up.

Requires Improvement

Is the service well-led?

Our findings

Prior to our inspection we received information that managers at the service did not respond appropriately to staff concerns or have robust systems for managing the quality of the care people received. We were also told the registered manager no longer worked at the service.

At our last inspection we related this domain as, 'Good'. However we found the provider had not maintained this standard as further improvement was required to ensure care records contained sufficient detail and guidance for staff and were stored appropriately. Processes to monitor that people received calls in line with their care plans were not robust. Audits had failed to identify when records were inaccurate or incomplete. Audits had failed to identify when staff had not followed the provider's policies.

The provider did not operate effective systems to monitor the quality of the service. During our inspection visit the care co-ordinator was unable to confirm if all people who used the service had received calls in line with their care needs. We found many records such as medication and risk assessments were not fully completed. Audits had not identified that people's care records lacked detailed or contained contradictory information for staff about people's medication and how they required supporting in order to remain safe. Systems had not ensured further recruitment checks had taken place after information of concern was received about care staff or when new staff had not shadowed experienced staff in line with the provider's policy. Records identified when staff were due training and supervision sessions but did not identify when they had taken place. Therefore it was not be possible to identify if these events were happening regularly or in line with the provider's policy.

Systems to store and retrieve information and records were not effective. The service had relocated to a new office about two months before our inspection visit and we saw that records were still stored ad-hoc in boxes. On several occasions staff were unable to find information we requested. This included staff time sheets, daily logs and training records. Without access to this information the provider could not monitor or review if the service was meeting people's care needs. We were unable to access information such as safeguarding investigations, incident reports and quality reports because this was stored on the registered manager's computer and could not be accessed by other staff. This meant that during our inspection visit staff were unable to tell us about any incidences which had occurred and any action to prevent similar incidences from reoccurring. We told the provider that they could send us this information after our inspection visit however none was received. Failure to operate effective systems and processes to assess, monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us members of the leadership team were accessible and would listen to their concerns. One member of staff told us, "Whatever concerns I have, they (mangers) respond to". Another member of staff confirmed they could get advice, "At nights and weekends". All the staff we spoke with said they felt they could express their views about the service without fear of retribution. We saw the registered manager had recently made staff aware of the provider's whistle-blowing policy. We saw there were staff meetings and supervisions but it was unclear how frequently it was planned to hold them. One member of staff told us

they had regular supervisions but two other members of staff said they had not had a supervision with senior staff for over a year. We looked at three members of staff supervision records. We saw that when staff had raised concerns about the service there was no evidence of a response from the supervisor about how the issues would be resolved or if any action was taken. There was no evidence that feedback from staff at supervision was used to improve the service.

People who used the service were generally pleased with how it operated and several said it had improved in the last few months. One person told us, "I feel involved in my care and confident to ask". Another person told us," If there's a problem I can get in touch with them but I've not needed to. We've had no complaints". Several people told us that staff from the office would visit them at home to conduct quality checks. One person's relative told us, "They come out each year and do a check-up. And they do a spot check every few months". The relative of a person who had recently started to use the service said, "They've been to see us and did a risk assessment. It's been reviewed and they have checked up on it four times already to see how it is". A person who used the service told us, "They've not done many spot checks but in the last two months they came round with a form. They did the review then as well. In the last two weeks they have also got in touch and checked things with me".

Several people said they had been dissatisfied with the service but felt it had improved. One person told us, "Now it's improving, but before that it was not good at all. It was about two months ago when it got better". Several people said they had experienced poor communication with office staff not responding to their calls. One person told us, "The office doesn't always pass on the message so now the carers let me know [if the call will be late]. Sometimes I don't know what time it is before they call". Another person told us, "At the start they could be over an hour late. Nothing happened for hours and I called back on to answerphones. At times they would not answer me when I kept calling. I would recommend them now, but not before".

There was clear leadership at the service. The registered manager had been absent for two weeks prior to our inspection visit and the nominated individual for the service was aware of their responsibility to notify us if they did not return to work within 28 days. They told us the registered manager's role and responsibilities would be covered by themselves and the regional care manager. After our inspection we were informed the registered manager had left the service and the area manager would apply to register. However the provider failed to submit a statutory notification formally informing us of this change within the required timescale. We found the service's current inspection ratings were displayed in their office, but not on their website. The nominated individual was unaware of this and suggested a recent update to their website may have resulted in the display being removed. This was rectified during our inspection visit. The provider did not always fulfil their legal responsibilities to the commission.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not adequately assessed the risks to the health and safety of service users of receiving care. Regulation 12 (2)(a) The provider had not done everything that was reasonable and practicable to mitigate risks to service users. Regulation 12 (2)(b) The provider had not ensured that persons providing care to service users had the qualifications, competence, skills and experiences to do so safely. Regulation 12 (2)(c) The provider had not ensured that staff responsible for the management and admiration of medication were suitably competent. Policies and procedures about managing medicines were not in line with current guidance. Regulation 12 (2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems and processes to assess, monitor and improve the quality of the service. Regulation 17 (2)(a)