Two Counties Community Care Limited

Two Counties Community Care Limited - Isle of Wight

Inspection report

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Ratings

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

Overall summary

Two Counties Community Care Limited - Isle of Wight is a domiciliary care agency providing personal care for a range of people living in their own homes. These included people living with dementia, older people and people living with a physical disability or learning disability. The inspection was carried out over the 8 and 12 January 2015 and at the time of our visit the service supported 156 people.

The service has not had a registered manager in post since before October 2013. 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

Summary of findings

requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We have asked the provider to tell us the action they are taking to comply with this condition of their registration.

Although people told us they felt safe, we found the recruitment process was not safe or effective and did not ensure staff recruited were fit to work with people using the service.

Staff were issued with a 'code of conduct for support workers', which contained safeguarding information including, confidentiality and accepting gratuities and gifts. They had received appropriate training and were able to demonstrate an understanding of the service's safeguarding policy and explain the action they would take if they identified any concerns.

There were enough qualified, skilled and experienced staff to meet people's needs. Most people had a regular team of care staff; some had formed close attachments and looked forward to their visits whilst others said they enjoyed the variety of having different people calling.

Appropriate arrangements were in place to support people with regard to their medicines management. However, the recording of when medicines were administered was not always completed correctly. We made a recommendation with regard to the provider's approach to recording medicines administration.

People using the service and their relatives told us they felt that the service was effective because people were well matched with care workers who had the appropriate skills to care for them.

Before commencing with the service a pre-assessment was completed for the person to identify their individual needs, their personal preferences and any risks associated with providing their care. People's risk assessments and those relating to their home's environment were detailed and contained strategies to enable staff to minimise any risk.

Staff received an induction into their role and had also completed specific training to meet the needs of people they were supporting. Staff were aware of how to use the training they had received for the benefit of people. Senior staff had conducted competency checks for care support workers in people's homes to ensure staff were appropriately skilled to meet people's needs.

People's views and decisions were respected. When appropriate people's care files containing information about their capacity to make decisions. Care staff liaised with other healthcare professionals to seek advice and support for the service users.

People using the service and their relatives were very positive about the care they received. The comments by people included "They are so lovely to me, they treat me just as my daughter treats me" and "Having been a carer myself I know what good care is and that is what I get; it is superb, fantastic, everything that I need is being done for me".

People and their relatives had been involved in the planning and review of their care. People were treated with dignity and respect. People received personalised support and care plans were reviewed every six months or when their needs changed. Each person's care file contained a person centred care support plan, which provided care staff with detailed information about the care people required at each visit.

The provider sought feedback from people or their families through the use of a quality assurance survey questionnaire. The results from the latest survey were predominately positive. The service had good arrangements in place to deal with complaints and people and relatives told us they knew how to complain. Accidents and incidents were monitored and remedial actions identified to reduce the risk of reoccurrence.

People who used the service thought the service was well run. However, we found that the values and ambitions of the provider were aspirational, there was a lack of leadership which had caused confusion and staff feeling undervalued. They expressed concerns over the lack of consistency and direction at a regional level and a sense of "feeling adrift". Since September 2012 there have been two changes of provider. Neither of these changes has led to a full re-branding of the service, which has led to a mixture different systems, paperwork and policies being used across the service.

We made a recommendation with regard to staff motivation and team building.

All of the policies were appropriate for the type of service, reviewed regularly, up to date with legislation and fully accessible to staff. All staff had easy access to the service's policies and procedures.

Summary of findings

Although the provider carried out a formal audit of the service on a quarterly basis, there was no structure approach to the auditing of records at a local level. This informal approach to auditing was not robust enough to identified the breaches and concerns we have identified.

We made a recommendation with regard to the provider's approach to quality assurance.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

The recruitment process was not robust and checks on staff did not ensure they were suitable to work with the people using the service. There were enough staff available to meet people's needs.

Medicines were appropriately stored. People received their medicines when they needed them. However, documentation relating to when medicines were administered was not always completed accurately.

Risk assessments were carried out and plans were in place to minimise people experiencing harm. Staff were able to demonstrate an understanding of what constituted abuse and the action they would take if they had any concerns.

Is the service effective?

Good

The service was effective.

People and their relatives felt that the service was effective

People's views and decisions were respected. Staff gained people's consent before providing care.

Staff had a good induction and received on going training and development to support them in their role.

Senior staff undertook a pre-assessment before the person started with the service to ensure they were able to meet their needs.

Is the service caring?

Good

The service was caring

Staff were kind, compassionate and treated people with dignity and respect. The service had a culture that promoted inclusion and independence.

Records showed that people or when appropriate, their relatives had been involved in decisions about their care.

Is the service responsive?

Good

The service was responsive

People told us the support they received was personalised and reviewed every six months or when their needs changed.

Staff responded appropriately to people's changing needs. Records associated with people's health care were updated to provide accurate information of people's needs.

Summary of findings

The provider had arrangements in place to deal with complaints. People and relatives consistently told us any issued raised were dealt with in good time.

Is the service well-led?

Requires improvement

The service was not always well led.

The values and ambitions of the provider were not being delivered in practice. Staff did not receive the leadership necessary to inspire them to deliver a high quality service.

There was an inconsistent approach to quality assurance. At a local level the auditing was completed on an informal basis and was not robust.

All of the policies were appropriate for the type of service. The Care Quality Commission was kept informed of significant events regarding people using the service, in line with the requirements of their registration.

Two Counties Community Care Limited - Isle of Wight

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.

The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available. The inspection was carried out by one inspector and an expert by experience over the 8 and 12 January 2015. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of looking after family members receiving domiciliary care services.

Before this inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send tell us about by law. We also gathered information about the service from the Isle of Wight Local Authority Adult Services team.

We spoke with 26 people who used the service or their relatives. We also spoke with seven members of the care staff, the regional director, the training manager and the financial administrator, who was acting as the manager. We looked at care plans and associated records for six people using the service, staff duty rota records, eight staff recruitment files, records of complaints, accidents and incidents, policies and procedures, and quality assurance records.

The last inspection took place 25 October 2013 and there were no concerns identified.

Requires improvement

Is the service safe?

Our findings

A safe and effective recruitment process was not in place to ensure that staff who were recruited were fit to work with people using the service. Disclosure and Barring Service (DBS) checks were completed on all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, three of the eight recruitment files did not have a full employment history for the members of staff. Therefore, the provider was not able to assure themselves that the staff they employed were of good character and suitable to carry out the role.

This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they felt safe. One person said, "It seems odd having these strangers in your home but I feel quite safe". Relatives told us they could relax because they knew their relatives were in safe hands. One relative said "Can't praise the staff enough; I am 100% happy with all aspects of my relative's care and can go on holiday with total confidence in leaving them". Most people had a regular team of care staff; some people had formed close attachments with the staff and looked forward to their visits whilst others said they enjoyed the variety of having different staff calling.

There were arrangements in place to support people with regard to their medicines management. The agency had a clear medicines policy, which had been signed by staff. However, the recording of when medicines were administered were not always completed correctly. We looked at six sets of archived medicines administration records (MAR) and found they were not always completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines are required to initial the MAR chart to confirm the person had received their medicine. One person's MAR chart contained a number of gaps in the recording of whether medicine was administered or not. This meant people may not have received the medicines they should have.

People's care files contained information regarding the medicines people were using and whether they were self-administered and included a risk assessment, a description of the medicine, its purpose and any side effects. However, these did not always provide clarity for care staff. For example, two people's records stated they needed support with administering their medicine. However, a separate entry states all medicines were administered by their respective relative.

We have recommended that the service considers the current the National Institute for Health and Care Excellence (NICE) guidance regarding managing medicines in care homes.

The provider had a current safeguarding policy, which was adapted from the provider's generic policy in line with local working practices. The policy, contained guidance for staff in respect of dealing with safeguarding concerns, had been signed by staff to confirm they had read and understood it. Staff and the acting manager had received safeguarding training and knew what they would do if concerns were raised or observed in line with their policy. The training manager was able to provide records confirming this training had taken place. Staff were also issued with a 'code of conduct for support workers', which contained safeguarding information including, confidentiality and accepting gratuities and gifts. Therefore, staff had the knowledge necessary to enable them to respond appropriately to concerns about people. There were also appropriate systems in place to safeguard people's money.

People's risk assessments and those relating to the person's environment were detailed and contained strategies to enable staff to minimise any risk. Notifications received showed the provider had alerted the local authority safeguarding team and other professionals when necessary. The training manager was informed of all safeguardings and incidents to allow them to identify any remedial training requirements.

There were enough qualified, skilled and experienced staff to meet people's needs. The acting manager told us staff allocation was based on each person's needs. These were assessed, in conjunction with their care manager, prior to acceptance by the service. Staff said they generally had time between calls but sometimes traffic was a problem. People told us, care staff were sometimes a little late but they still spent the required length of time with them.

There was an electronic duty management system, which detailed the staffing requirements for each day and provided a visual warning when there were shortfalls in

Requires improvement

Is the service safe?

service provision. These gaps were managed through the use of overtime and cover by office based staff. There was also an out of office 'on-call' system providing 24 hour cover if required. Therefore, there were management structures in place to ensure that staff were available to meet people's needs.

Good

Is the service effective?

Our findings

People using the service and their relatives told us they felt that the service was effective because people were well matched with care workers who had the appropriate skills to care for them well. One person said, "I help the carers when they are giving personal care and they ask my opinion and respect my decisions". A relative told us, "Even though it takes longer, carers encourage my spouse to do as much for themself as they can".

Where people required support with their nutrition and hydration, this was documented in their care file. People were provided with suitable and nutritious food and drink in line with their needs and choice, by staff who were aware of their personal dietary preferences.

People who have their meals prepared for them told us they were happy with the level of support provided. One person whose meals were prepared by a care worker said that staff always wore aprons and gloves when preparing their meals which they cooked using fresh ingredients.

Before commencing with the service, senior staff undertook a pre-assessment with the person to identify their individual needs , their personal preferences and any risks associated with providing their care. This included their medical history, an assessment of their ability to communicate and information about their mobility needs. The pre-assessment gave the provider the opportunity to ensure they had the staff with the appropriate skills and experience available to meet the person's needs and develop their care plans.

Staff received an effective induction into their role. This included the provider's essential training, such as moving and handling, mental capacity act, infection control and safeguarding vulnerable adults. The training was followed by a number of shifts shadowing an experienced staff member. The training manager confirmed the induction training they provided was based on the Skills for Care common induction standards. These are the standards people working in adult social care should achieve to demonstrate their understanding of how to provide high quality care and support.

Staff had also completed specific training to meet the needs of people they were supporting. This included dementia and Mental Capacity Act training, end of life care and catheter care. Discussions with staff showed they were aware of how to use the training they had received for the benefit of people. When necessary staff liaised with other healthcare professionals such as GPs, district nurses and chiropodists to ensure people received a consistent approach to their healthcare.

Staff were provided with training which included practical skills to ensure they were well prepared for their role. They had good systems to record the training that staff had completed and to identify when training needed to be updated. Each staff member had a file that recorded the training they had completed and certificates that they had been awarded.

Staff had regular supervisions. Supervisions are a process which offers support, assurances and learning to help staff development. Senior staff had conducted competency checks in people's homes to ensure staff were appropriately skilled to meet people's needs. Staff files contained records of workplace supervisions carried out by supervisors, which included whether the member of staff had followed the agreed person centre plan. Where issues were identified this was followed up with a personal action plan.

People's views and decisions were respected. Staff told us they always check with people before providing care. They were able to explain the action they would take if a person refused care. The daily records we looked at recorded when people had declined support and this was respected. When appropriate people's care files containing information about people's capacity to make decisions and whether a family member held a power of attorney. A power of attorney is issued by the court of protection and gives named people authority to make decisions on a person's behalf. Staff were knowledgeable about their responsibilities under the Mental Capacity Act 2005.

There were arrangements in place to deal with foreseeable emergencies. A contingency plan had been prepared to ensure care was still provided in the event of disruption to the service, such as in extreme weather conditions, or a flu outbreak amongst the staff team.

Good

Is the service caring?

Our findings

Caring and positive relationships were developed with people. People using the service and their relatives described the care staff who supported them as being: very caring; very kind; marvellous; understanding; helpful; competent; fantastic; lovely people; friendly; respectful and excellent. The comments by people included "They are so lovely to me, they treat me just as my daughter treats me", "Sometimes I have a problem understanding them [because of their poor English] but they try hard" and "Having been a carer myself I know what good care is and that is what I get; it is superb, fantastic, everything that I need is being done for me".

People also told us that they were always treated with dignity and respect, and their wishes regarding the gender of their care staff were respected. Several people said that they did not know what they would do without their care staff , who never rushed and never leave with anything left to be done, often asking if there was anything else they can do before they leave.

Where possible people had the same team of care staff looking after them. People could ask for any member of care staff, they did not feel 'fitted the bill' to be excluded from their rota. This was usually respected but they had to accept that this was not always possible.

We asked staff how they ensured that they knew the person they were supporting and what support they needed. All of them said the information was contained in the person's care plan, including their personal histories and their likes and dislikes. They were able to explain the action they took to ensure people's privacy and dignity was respected, knocking on people's doors and identifying themselves before entering. They ensured doors were closed and people were covered when they were delivering personal care. One member of staff said "I ensure that doors and curtains are closed. I explain what I am doing and offer them a choice".

People and their relatives had been involved in the planning and review of their care. The care plans also covered a number of areas of a person's support needs. For example, health and wellbeing, eating and drinking, likes and dislikes, bathing and dressing, mobility, communication, social contact and activities, and preferred or desired outcomes they wanted from the support. The records showed that people, or when it was necessary due to the person's lack of capacity to make some decisions, their relatives had been involved in decisions about planning their care. Each person's needs assessment and subsequent reviews had been signed by them or their relative if appropriate acknowledging the content and agreeing the level of support being provided.

Information regarding confidentiality, dignity and respect formed a key part of staff's induction training for all care staff. This training also included a practical exercise providing staff with an insight into people's sensory perception. For example, the wearing special glasses that replicate the vision experienced by a person with cataracts. An integral part of the service's quality assurance process were impromptu telephone reviews, which included a question on whether they felt respected.

Good

Is the service responsive?

Our findings

People told us the support they received was personalised and reviewed every six months or when their needs changed. They said the staff in the office were very pleasant and responded to problems, which were "very quickly" resolved. People were satisfied with the care and support they received. For example, during our inspection one person we spoke with became distressed, as they were confused over the invoicing arrangements for the support they received. We brought this to the manager's attention, who was aware of the person and arranged for a field worker to make a personal visit to explain and reassure the person face to face.

A rota was prepared one week in advance so people would always know who would be coming. However, some of the people we spoke with told us that if there was a change to this rota they were not always notified.

Each person's care file contained a person centred care support plan, which provided care staff with detailed information of the exact care people required at each visit. The staff were knowledgeable about the people they supported and the things that were important to them in their lives. Records were personalised and documented people's interests, histories, wishes and personal preferences.

People received care that had been assessed to meet their specific needs. Their care needs were reviewed regularly by a supervisor and changes agreed with the person. For example one person's original health care assessment required staff to support them with administering their medicines. Following a review, the person's confidence had improved and they were assessed at being able to administer their own medicines, with prompting by staff. Their care plan was amended to reflect this change. We looked at the person's daily record of care and saw staff were supporting this person in line with their care plan.

This approach enabled decisions about care and treatment to be made by staff at the appropriate level. In addition, the regular review visits by a supervisor provided an opportunity for people to raise any concerns they had.

The provider sought feedback from people or their families through the use of a quality assurance survey questionnaire. This was sent out to people every year seeking their views. We saw the results from the latest "service user satisfaction survey" which had been completed in 2014. The results of the survey, which were predominately positive, had been analysed and assessed against other services owned by the provider. In addition, the office carried out a series of telephone surveys on an ad hoc basis to obtain feedback from people using the service. Where issues were identified these were responded to immediately.

People and relatives knew how to complain. The service had arrangements in place to deal with complaints. Since our last inspection there had been two complaints. These had been investigated appropriately and the complainant updated with the result. People, their relatives and staff told us that although they had not needed to complain they felt any complaints would be taken seriously and investigated thoroughly. For example, one person told us they had complained about care staff who had caused damage to some property. The manager responded and took appropriate action to resolve the complaint. The training manager was made aware of all complaints and concerns to allow lessons learnt to be incorporated into future training.

Accidents and incidents were recorded and remedial actions identified. For example, the service had recent experience of a series of incidents relating to medicine errors. This was identified by the management team, who carried out an analysis of the problem. This resulted in a bespoke medicines training workshop being provided to all staff. Therefore, when an incident occurred the provider identified the risk and took action to reduce the likelihood of the incident reoccurring.

Requires improvement

Is the service well-led?

Our findings

People who used the service thought the service was well led. They were happy with the care and service provided and said they never had reason to complain. Two people recalled completing a questionnaire regarding the service provided and all said they had frequent checks from the 'supervisors' to ask if everything was alright. Relatives' comments included "This is the best service available and I am thoroughly satisfied with it" and "Very good service, would recommend it".

However, our findings were that there was a lack of clear direction and leadership, particularly at a regional level. The service has been without a registered manager since October 2013. We had previously raised this with the provider who has detailed the action that had been taking to recruit someone to this post. At the time of our inspection the financial administrator was acting as the manager for the service.

The values and ambitions of the provider were aspirational and were not being delivered in practice. Since September 2012 the service experienced two changes of provider. This has led to a mixture different systems, paperwork and policies being used across the service. Staff felt undervalued and did not feel led well. They expressed concerns over the lack of consistency at a regional level and did not feel part of the organisation. One senior member of staff said "We just seem to go round in circles. I do feel adrift, it is a very strange place to be in. There is a lack of direction". Other comments from staff included "It is frustrating", "The structure just isn't right" and "It is confusing, with the paperwork". Therefore, there was a lack of strategic direction and leadership was not visible at all levels necessary to inspire staff and maintain a quality service.

We recommend that the provider research and consider opportunities in respect of motivation and team building to support staff through the change process.

All of the policies were appropriate for the type of service, reviewed regularly, up to date with legislation and fully accessible to staff. All staff had easy access to the service's policies and procedures. There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected.

The provider had a Quality and Performance Team, which carried out a formal audit of the service on a quarterly basis, with the last audit taking place in June 2014. Where issues were identified an action plan was established to monitor what action had been taken with regard to the areas for improvement which had been identified. However, at a local level there was no oversight of the manager's responsibilities nor a structured approach to the auditing of records. The informal auditing process was not robust enough to identify the breaches and concerns we have identified or drive improvements.

Information from accidents, incidents and complaints was used to improve quality across the service through remedial action and additional training. There was an effective structure in place to obtain feedback from service users and their families. Where concerns were identified these were responded to and remedial action taken. The manager was aware of the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service, in line with the requirements of their registration. They told us that support was available to her from the registered provider and the regional manager visited the service regularly to provide support in the absence of a registered manager.

We recommend that the provider research and consider adopting the latest best practice in respect of a robust approach to quality assurance processes.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person had not taken proper steps to ensure there was an effective recruitment process in place to ensure that staff who were recruited were fit to work with people using the service.