Castle Care Teesdale Limited

Castle Care Tessdale Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 8 and 16 February 2017 at the registered location office and we subsequently carried out interviews with staff and spoke with people via telephone on 3 and 6 March 2017. We also visited people in their own homes on 21 February 2017. Castle Care provides personal care to people living in their own homes in and around the Barnard Castle area. There were currently 72 people using the service.

At the last inspection on 16 and 19 September 2016 we rated the service as "Requires Improvement." The service has not been compliant with regulations since our inspection in 23 and 28 July 2015. We had issued a warning notice to Castle Care Teesdale Limited on 13 October 2016 where the service was required to be compliant with regulations by 31 January 2017.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We checked to see if people were given their medicines in a safe manner and found there were gaps in the Medicine Administration Records (MAR). We saw that not all people had a list of medicines in their dosette

boxes so staff knew what they were supporting people to take. Not all staff had training in the safe administration of medicines. This put people at risk of not receiving their medicines safely.

Risk assessments were not in place to ensure people were kept safe. People who required restrictive equipment such as bedrails did not have specific risk assessments in place. This meant staff did not always have the guidance in place to help them mitigate the risks to people using the service. We saw one person had a serious incident with a bedrail that was not followed up or reported to the relevant authorities by the registered provider.

There was not a systematic method of recording incidents. We found incidents had not been reviewed in sufficient detail to ensure people who used the service were kept safe. CQC requires registered services as a part of their registration to notify the Commission when there are incidents of a safeguarding nature, people receive injuries or there is a death of someone using the service. We found no notifications had been made to CQC since the service registered with us in 2010.

The registered provider did not carry out comprehensive pre-employment checks to ensure staff were safe to work with vulnerable people.

Staff were not supported to carry out their role through regular supervision and appraisal. We found staff were caring for people without having had training to meet people's needs. For example we found no staff had received training in diabetes or catheterisation. Some staff members had not received training in mandatory areas such as safe handling and administration of medicines, food hygiene, safeguarding and health and safety. Induction training could not also be fully verified for new staff which meant people were at risk of receiving care from staff who were not trained.

We saw the service had now sought the written consent of people using the service.

Assessments were not always carried out with people prior to them receiving the service. We found two people without assessments and care plans in place. This meant that people were at risk of receiving unsafe care.

We found people with specific needs such as diabetes or were at risk of choking did not always have care plans in place to ensure staff were given guidance on how to care for people. This meant people could be at risk of receiving unsafe care.

There was a lack of established quality audits carried out at the service by the registered manager and director. The service had implemented some spot audits to visit people at home and observe staff but this had not commenced until January 2017. There were still no mechanisms for reviewing medicine administration records which meant gaps we found had not been picked up and addressed.

Management systems such as policies and procedures were not shared with staff, and although staff told us they felt supported by the registered provider and registered manager, there were not systems in place to share service updates via staff meetings as these did not take place.

We did see that the registered manager had begun to carry out care plan reviews. These had not taken place systematically previously.

Care plans were not person centred and did not reflect the views and preferences of people who used the service. We found care plans were a list of tasks to be carried out by care staff.

The service did not have an established complaints process in place and we saw complaints had not been dealt with according to the registered provider's own policy on receiving and responding to complaints.

Feedback from people who used the service at Castle Care was positive about the care and support they received from staff.

During our inspection we found a number of continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Details of any enforcement action taken by CQC will be detailed once appeals and representation processes have been completed

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Medicine records showed unexplained gaps and a list of medicines in dosette boxes was not always available. This meant people were at risk of not receiving their medicines safely.

Incidents and accidents were not actioned and reviewed to keep people safe.

Staff were not all trained in areas to keep people safe such as handling medicines and health and safety.

Risk assessments were not in place for people which described restrictive equipment such as bedrails.

Is the service effective?

Inadequate

The service not effective.

Staff were caring for people with diagnosed conditions without having the necessary training in place.

Staff had not been provided with support through regular supervision and appraisal.

Where people's service included support with eating and drinking this was not adequately detailed in their care plan in relation to specific dietary needs.

There was not always enough information relating to capacity and decision making in people's care plans.

Is the service caring?

Requires Improvement

The service was not always caring.

Feedback from people who used the service told us that staff were caring.

We saw staff upheld people's dignity and respect.

Staff we spoke with knew people's preferences and needs well although this was not reflected in their plans of care.

Is the service responsive?

Inadequate

The service was not responsive.

Some people did not have an assessment or a care plan in place.

Care plans were not person centred.

The registered provider did not follow its own complaints procedure which meant complaints were not responded to, investigated or reported on.

Is the service well-led?

Inadequate

The service was not well led.

Audits were not in place to address the deficits in the quality of the service we found during our inspection.

Feedback from people was still not addressed in a way that showed the service took action where it needed to.

The service had not made any notifications to CQC since 2010. This meant the service was not meeting their registration requirements.

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Detailed findings

Background to this inspection

This inspection took place on 8 and 16 February 2017 at the registered location office and we subsequently carried out interviews with staff and spoke with people via telephone on 3 and 6 March 2017. We also visited people in their own homes on 21 February 2017. Castle Care provides personal care to people living in their own homes in and around the Barnard Castle area.

At the last inspection on 16 and 19 September 2016 we rated the service as "Requires Improvement." The service has not been compliant with regulations since our inspection in 23 and 28 July 2015. We had issued a warning notice to Castle Care Teesdale Limited on 13 October 2016 where the service was required to be complaint with regulations by 31 January 2017.

The inspection team consisted of two Adult Social Care inspectors.

During the inspection we met with three people who used the service and carried out observations of people in their interactions with staff. We read eight people's files in detail and other records associated with the management of the service. We spoke to six care staff and the registered manager, assistant manager and director of the service. We also spoke with four relatives of people who used the service via telephone interview.

The service had submitted a pre inspection information return to us in January 2017 which we used to inform our inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example we looked at the inspection history, notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. There had been no notifications received from Castle Care Teesdale.

We also contacted professionals involved in caring for people who used the service including local authority commissioners.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe using the service. Everyone we spoke with replied they felt safe with the care staff from Castle Care. However two people told us they had missed calls from Castle Care, and although one person said Castle Care had apologised for this, we found other occasions from people's care records where staff had missed a visit. We were aware through a safeguarding concern that one person who used the Castle Care service had come to harm due to a missed call in December 2016. There were not robust procedures in place for the service to prevent, recognise and respond where missed calls may occur.

Not all staff had been trained in safeguarding adults procedures. During the course of the inspection, we saw the registered manager and assistant manager had applied to attend safeguarding training with the local authority.

Staff we spoke with when we asked them about their understanding of safeguarding told us, "Common sense, keep client and work colleagues safe," and "If something is not right you have to tell someone." All staff members told us they were not familiar with the policies and procedures in relation to safeguarding. This meant people may be at risk as staff may be unaware of how recognise and respond to safeguarding concerns.

We checked to see if people were receiving their medicines in a safe manner.

We saw where the service was responsible for collecting people's medicines from the pharmacy, there were no checks to show the content of the dosette boxes were correct. This may mean staff could administer medicines that were not checked against what was prescribed.

We looked at people's Medication Administration Records (MAR) and found there unexplained gaps in several care records we viewed. This meant people were at risk of not receiving their prescribed medicines. There was no evidence to show care staff had followed the medicines policy of the registered provider to inform the manager of the missed dose.

We saw that staff who had not been trained in the safe handling of medicines had been signing medicine administration sheets which showed they were administering medicines without training. One staff member told us, "I prompt people to take their medicines at the right time from dosette boxes. I have had no training in medicines with Castle Care." There were no specific medicines competency assessments carried out with staff.

People had also been prescribed topical medicines; these are medicines applied to the skin. We saw there were body maps in place to show were the topical medicines should be applied although these were not complete in all medicine records that we viewed. This demonstrated that systems were not in place to ensure the safe administration of medicines.

We saw that people who had restrictive equipment in place such as bedrails did not have appropriate

assessments in place. This meant people could be at high risk of injury by care staff not having the appropriate assessment and guidance in place. We saw from an incident record that one person had sustained an injury that required hospital treatment and there was no risk assessment in place specific to the bedrails. The registered provider had not followed up this incident to ensure the risk was minimised in future.

Accidents and incidents were not recorded appropriately. We found people using the service had been put at risk due to incidents and there was no analysis of the incidents in relation to the safety of these and other people. This meant the service was not doing all that was possible to mitigate risks to people.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found the registered provider was not carrying out the appropriate pre-employment checks on staff. We saw that although the service had got Disclosure and Barring Service (DBS) checks in place for all staff, some of these were from people's previous employers and were not transferable. The registered provider told us they were not aware that DBS checks were not transferable unless a specific fee was paid by the applicant and the registered provider told us they would seek new DBS checks for these staff. We saw that information required in respect of persons employed had not been sought by the registered provider. There were no interview records in the five staff files we viewed. Not all staff had two references and gaps in people's employment history had not been explored. This meant the service could not verify that people employed by them were of good character and had the skills and competencies required to carry out their role.

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

Inadequate

Is the service effective?

Our findings

Arrangements to ensure that staff members had appropriate training were inadequate. Training records showed that the provider did not have a programme of training which encompassed the needs of people being supported. This included how to support people with diabetes, catheter care, epilepsy and people who were at risk of choking. Induction training verification for staff was inadequate. Of the 32 staff members, 12 had completed a NVQ at Level 2 in health and social care. The training matrix for 2015 and 2016 showed some staff had received training in safeguarding, first aid, dementia, infection control, equality and diversity and mental capacity. 14 staff had not received any other training than their induction training (which could not be verified). There was no evidence any staff members had received training in the specific conditions stated above. One staff member told us, "I have been given booklets to complete but I never have time to do them." One staff member in response to us asking "Do you feel you have the right skills to care for people effectively?" stated "No."

We looked at training for the safe handling and administration of medicines. This had been a breach of Regulation 12 since July 2015. We saw that Castle Care had brought in a series of workbooks which it had asked staff to complete. We saw 11 staff had taken copies of the workbook and seven staff had returned them although they had not been marked or sent for external verification by their training provider. There were eight staff who were trained to NVQ Level 2 standard which included a unit on the safe handling of medicines. This left 13 staff who had no training in the safe administration and handling of medicines. Of these staff we saw in the four medicine administration records we viewed that seven staff members had administered medicines including creams, transdermal patches and eye drops with no training.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at induction training records for five staff. This comprised a checklist of introduction, home care role, service users and health and safety. We saw these were all partially completed. The dates, names, and signatures of inductee and supervisor were not consistent if completed at all. We spoke with one member of staff about their induction. They stated they "Went through the staff handbook in the office" and had gone out shadowing with experienced staff. Another staff told us, "I worked shadow shifts for a week." We asked the registered provider to show us the induction training pack that corresponded with the induction checklist. We were given a copy of the staff handbook and were told this was what the service used for induction. The staff handbook contained no guidance in relation to service users or health and safety and covered only employment issues such as terms and conditions of employment, rules, attendance at work, disciplinary rules and protection and safeguards.

We found staff did not receive appropriate support and supervision as is necessary to enable them to work in the service. We saw the registered provider had carried out one supervision session with 11 out of 32 staff. Supervisions had not been in place from our inspection in July 2015 and subsequently at our inspection on 16 and 19 September 2016. We asked staff if they received regular supervision and we were told, "No never," "I have a supervision form to complete now but I can't remember the last time I had a supervision or

appraisal." Staff we spoke with did tell us they could contact the director for Castle Care or the registered manager at anytime for advice. Staff told us, "We have a 24 hour on call number and they will help you." The supervision policy dated October 2016 for Castle Care stated formal supervision will be undertaken as follows; "During the first week of employment, "shadowing" duties with the employee where necessary and thereafter formal supervision at 3-monthly intervals. Additional formal staff appraisals carried out on an annual basis."

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. No applications had been made to the Court of Protection. We saw the service had sought specific written consent from people or their next of kin to receive personal care from Castle Care. When we looked at the assessments and care plans relating to people's day to day care we found that they did not contain much information about capacity and decision making, and how this related to people's day to day care. For example, how the person could be supported and enabled to make decisions for themselves wherever possible.

We looked at the arrangements that were in place to ensure that people received the help they needed with eating and drinking. This service supports people in their own homes and only provides help with meal preparation and eating and drinking where this has been agreed as part of the person's individual care plan. The service reported in its pre inspection information submitted in January 2017 to CQC, that only one staff member had completed training in basic food handling and hygiene. We spoke with five staff who all confirmed they supported people with eating and drinking. We saw that some people had specific dietary needs such as diabetes. We looked at the care plan for one person with diabetes. There was no reference as to what an appropriate diet should be for someone with diabetes and there was no guidance on recognising any symptoms of issues in relation to diabetes. The care plan stated, "[Name] is to follow a diet suitable for his diabetes." The registered manager also confirmed to us that staff had not been trained in diabetes.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)

We looked at the arrangements that were in place to ensure that people were able to maintain their health, including access to specialist health and social care practitioners when needed. The staff we spoke with were generally aware of people's needs and able to describe what they would do if someone was unwell or needed medical support during a care visit. For example, contacting the doctor or ambulance service, and contacting the office for additional support if needed so that they could stay with the person until medical help arrived. Emergency first aid training was included in the list of training staff were expected to complete. However, according to the training records provided during the inspection, no staff had completed the workbook for basic emergency aid. One staff member told us, "I asked about renewing my first aid and they [management] said "Why would you need first aid?"

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

Requires Improvement

Is the service caring?

Our findings

We looked at the arrangements in place to ensure that the approach of staff was caring and appropriate to the needs of the people using the service. The people who used the service and relatives we spoke with all said that the staff were caring and treated people well. People spoke particularly fondly and positively about their regular, main carers, who they had formed positive relationships with.

On our home visits, we observed staff interacted with people in a friendly manner. People told us they felt comfortable with care staff. One person told us they thought the staff were, "Kind and nice girls." The registered provider told us they felt the staff in post were the right kind and were able to demonstrate they cared. Staff said they knew the people who used the service well especially as some of them had been supporting individuals for several years. However we found in the absence of appropriate care plans and risk assessments staff were not fully aware of people's health conditions and how they should care for people. For example, one member of staff we spoke with who supported someone with a long term catheter in situ told us they had not been trained in catheter care and could not confirm to us what to do if the catheter was blocked or how often the catheter bag was changed. There were no care plans in place for the person's catheter. This could compromise this person's well-being.

Some relatives told us they had been involved in assessing their relatives care needs although some fed back that they had not been involved in a recent review of care by Castle Care.

Everyone we visited as part of this inspection had information about the service included in the front of their care file, so that they could access it at any time and people told us they knew how to contact the office.

The staff we spoke with were able to describe how they helped to maintain people's privacy and dignity while carrying out care. For example, one staff member told us how they always made sure curtains and doors were shut and described how they asked if people wanted to do things themselves rather than just doing things for people.

The service had on display numerous thank you cards which contained comments on the kindness of the staff towards people.

Inadequate

Is the service responsive?

Our findings

During our inspection we looked at eight people's care plans in detail. We asked about people who were new to using Castle Care. We saw for one person who had commenced the service the previous day that there was no plan of care, or an assessment of the person's needs either from Castle Care or from the service commissioner. We discussed this with the director of Castle Care who confirmed they did not have any information on the person due to an assessment not being received from the service commissioner. The director confirmed they would not take on new packages of care unless they had received or carried out a written assessment of the person's needs. We also saw for another person who commenced with the service in 2016 that there was no assessment or care plan for staff undertaking personal care. This meant staff would be providing care and support to someone without knowing their needs.

We saw that the service had begun to undertake reviews of care; however, care plans were still task focussed and did not reflect people's needs or preferences in relation to how they wanted their support to be provided.

In one file we saw the care plan stated, "Assist with undressing, showering and personal care tasks," and "Assist with dressing into clothes and ensure a clean continence pad is worn," and "Prepare breakfast and drinks, assist with feeding." There was no indication of preferences or involvement of the service user concerned. For another service user. the new client information sheet was blank bar the name so there was no evidence of medication, mobility or medical history. The care plan comprised the following, "Care package in place to apply pain relief patch each morning. Remove existing patch and apply new pain relief patch to a different area as detailed in medication record. Please see Exelon medication record for area the patch it to be applied and record on medication sheet. Assist [Name] with any other tasks in the required time." There was no record of what the medication patch was or what it was prescribed for. This meant the service failed to carry out, collaboratively with the relevant person, an assessment of the person's needs and preferences; and the care and treatment was not designed to ensure the service user's needs were met.

Daily notes were in place for service users but we saw they were not routinely checked or reviewed. We asked for one person's notes which had just been brought back to the office from their home by a carer and we saw they went back to July 2015. There was not up to date information in this person's file. This meant that you did not keep contemporaneous records in relation to service users.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people and their relatives about their experience of making a complaint. We saw there were no complaints recorded since 2010. We were aware of three complaints submitted in December 2016 and January 2017. We asked the registered provider and registered manager about these complaints and they gave us an incident report which stated an "internal investigation was underway". There was no evidence of the complaints being acknowledged in writing within the two day timescale of the registered provider's Management of Complaints policy. There was no evidence of a "thorough investigation into the complaint"

or a full response provided to the complainant within a maximum of 28 working days as stated in the registered provider's policy. We also saw from service user questionnaires in December 2016 that two people had stated they had submitted a complaint to Castle Care historically, but we could find no evidence of these complaints. This meant that complaints were not recorded, investigated and acted upon by the registered provider.

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

Inadequate

Is the service well-led?

Our findings

We looked at spot audits carried out by the registered manger to determine if the staff were delivering a quality service. We saw these had only been introduced in January 2017, despite a warning notice from our visit in September 2016 stated these must be in place by 31 January 2017. These spot checks covered seven of the 31 staff team and six of the 56 people who used the service. Castle Care Teesdale Limited had a "Quality System self-assessment/ auditing policy dated October 2016. This stated a record form was used to plan an annual audit schedule under the key questions inspected by CQC, such as Safe, Effective, Caring, Responsive and Well-led. There was no evidence that this was in place. There was also a Quality Self-Assessment Manual divided into business management, continuous quality improvement, looking after the service user and health and safety management. There was no evidence of any of these quality systems being completed as per the registered provider's policy.

We saw evidence of gaps in medicine administration records, missed visits and a lack of response to complaints. This meant the systems in place to measure the service had failed to identify the deficits.

On our last visit to Castle Care, we saw questionnaires had been undertaken but there was no analysis of the feedback given or an action plan produced. On this visit we found that service user satisfaction questionnaires from people using the service had been undertaken in December 2016. These highlighted issues from people using the service such as one anonymous person highlighting carers "rarely" arrived on time, inaccurate recording of diary sheets, carers "rarely" wearing gloves for personal care. Another service user stated carers "rarely" wore a name badge and photo ID and when asked "Do you feel your views and wishes are taken into account when planning your care?" the service user replied "Never been discussed." None of these issues had been followed up by the registered provider or an action plan created.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered providers are required by law to submit notifications to us when there has been a death, safeguarding incident or serious injury to a person using the service. During our inspection we found a number of notifications had not been submitted to the Commission and the service had not submitted any notifications since it was registered in November 2010. This meant the service was failing to meet the registration requirements.

This was a breach of Health and Social Care Act 2008 Regulation 18 Registration Regulations 2009

We found staff updated people's records on a daily basis in their home but these were not routinely checked and we found one person's records were brought to the office from their home on the day of our inspection and their records went back to July 2015. This meant the service did not have an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user.

There had been no staff questionnaires completed. There had been no recorded staff meetings. We conducted interviews with staff members via telephone about policies and procedures We asked staff if they knew where these were and when they last looked at them. One staff member who had worked at Castle Care for 10 years stated, "Manuals are in the office, I got copies when I first started but I haven't looked at them for a long time." Another staff member who had worked at the service for a year stated, "In the office, I have never seen them" and "In the office, I haven't looked at them." Every policy we requested had a date of October 2016 on it and staff were clearly not aware of these new policies and there had been no staff meeting or communication to ask staff to bring themselves up to date with these policies.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post who took a hands-on role in the service delivering care to people. There was also an assistant manager who was office based and the registered provider who also had a regular presence in the office dealing with phone calls and issues in relation to the running of the service.

Staff we spoke with were positive about the responsiveness and support of the registered manager and registered provider when they needed advice or support. Staff members told us, "They are always there for you," and "They are on call 24/7, and that's really reassuring. You can go to them about anything."