Castle Care Teesdale 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 effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Castle Care Teesdale was last inspected on 23 and 28 July 2015 and we issued a number of requirement notices in relation to breaches of regulations relating to medicines, consent, care plan reviews, supervision and appraisal of staff and ensuring feedback from people about the service provided. The registered provider had sent us an action plan detailing how they would address the requirements identified. This had not been fully completed when we carried out our latest inspection.

The service is registered to provide personal care to people in their own homes. At the time of our inspection the provider gave us a list of 100 people who used their service, 60 of whom were in receipt of personal care.

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. At the time of our inspection there was a registered manager in post.

We found new medicine administration records had been implemented but we saw gaps in recording which had not been identified through a robust audit process which meant people may be at risk of not receiving their medicines in a safe way.

There was a recruitment procedure in place to protect people from care being delivered by unsuitable staff but the service had not ensured appropriate references were sought in the case of one recently recruited staff member.

The registered provider had in place clear guidance to staff regarding gifts and gratuities which helped prevent people from being placed at risk of financial abuse.

People's written consent had not been obtained by the provider to deliver care. During the course of our visit the assistant manager devised a new format to implement in people's care plans to record their consent.

The service had considered people's food and fluid intake and put in place specific plans to meet individual people's needs.

We found staff did not receive recorded support through supervision and appraisal meetings although staff told us they felt supported and could raise issues at any time with the service's management team.

People, their relatives and other professionals told us the service was caring.

The service supported people to attend local groups and day centres to help prevent social isolation.

The registered provider had in place a statement of confidentiality and staff we spoke to understood the statement.

The registered provider had in place arrangements to gather information about people before they visited to assess their needs before delivering care.

We found care plans had not been formally reviewed but feedback and discussion took place between staff and people to confirm care was still appropriate. This meant there was a risk that people's needs had changed but staff did not have up-to –date written information to guide their practice.

We found training records were not up to date but saw a new programme of training was scheduled with a new training provider. Staff told us they had received training in moving and handling, dementia, administering medicines and first aid.

Staff who were new to the service underwent an induction period although this was not always well recorded. This included staff shadowing other more experienced staff members to learn about people's needs and how they liked their care to be delivered.

The service had sought people's views on the quality of the service they received but needed to ensure this linked to an improvement / action plan so that the service could demonstrate it had followed up any suggestions, comments or feedback.

The service worked in partnership with key organisations to support care provision and to ensure people's healthcare needs were met.

During our inspection we found a number of 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 always safe.

Gaps in recording meant we could not be assured people received their medicines safely.

Employment references to ensure risks of unsuitable persons being employed to work with vulnerable people were not always sought.

Staff could tell us about safeguarding and knew how to respond and report concerns.

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Is the service effective?

Requires Improvement

The service was not always effective.

People's written consent had not been obtained by the provider to deliver care.

Staff inductions did take place but were not always recorded appropriately.

We found staff were not receiving appropriate support through supervision and appraisal.

Is the service caring?

Good

The service was caring.

People told us the service was caring.

Staff were able to give us examples of providing care with dignity and respect.

We saw people had an initial assessment of their needs in person by the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider had in place arrangements to gather information about people before they visited people to assess their needs.

The provider did not have in place arrangements to review people's care plans.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had in place links with other community organisations including day centres and luncheon clubs.

The provider had conducted quality surveys but we could not see a plan which showed how the service intended to make improvement or take action following feedback received.

The registered manager had undertaken spot checks within the service.

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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.

This inspection took place on 16 and 19 September 2016. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of one adult social care inspector.

Prior to the inspection visit we reviewed the information we had about the service. We reviewed the action plan from the previous inspection in July 2015 where the registered provider stated how they would meet the breaches in regulations we identified.

During the inspection we reviewed six people's care files and looked at four staff records. We contacted six people and their relatives by telephone and spoke to four care members of staff as well as the registered manager, a partner and assistant manager.

Requires Improvement

Is the service safe?

Our findings

We checked to see if people's medicines were safely administered. Since our last visit the registered provider had implemented a medication administration record (MAR). This should have identified which individual medicines or creams were to be administered by the staff team and whether these had been given or not . However, in the six care files we viewed we saw a number of omissions in the MAR that had not been addressed through a robust audit process.

We found accidents and incidents were not consistently recorded. For example, a person had fallen over and the staff member supporting them had fallen with them. This was recorded in the incident file but not recorded in the accident book. There was also no recorded review or follow up to the incident to check that any risk reduction measures had been taken.

We reviewed a range of staff records and saw that all staff underwent pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks. The provider asked prospective staff members to complete an application form which detailed their past work experience, their knowledge and skills they had to carry out the role. We saw that no interview records were held for staff and we discussed with the management team that they should have a record of prospective staff responses from interviews. We also saw in most files, the registered manager had requested two references and ensured proof of identity was provided by prospective employees prior to employment. We saw for one recently recruited staff member that there were no references in their file and they were already working on their own from the rotas we viewed. We asked the registered manager to ensure that they had appropriate references for each person employed.

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

The people who used the personal care services told us that they felt Castle Care staff delivered safe care. One person told us, "I feel very safe with all the staff who come."

During the inspection we spoke with four staff who provided personal care. The staff we spoke with were aware of the different types of abuse and what would constitute poor practice. The staff members we spoke with told us they had confidence in the registered manager responding appropriately to any concerns. A staff member told us, "I would immediately report to the manager and I have just raised a concern." Another staff member said, "I would offer reassurance to the person too and inform them that we would support them."

We saw the provider had in place arrangements to protect people from potential abuse perpetrated by staff. We found the provider had in place disciplinary procedures which outlined what action was to be taken if there were any concerns regarding staff members. The provider told us there were no on-going disciplinary issues concerning staff. The provider also had in place a staff handbook which outlined the expected behaviours and conduct of staff. There was a clear stance taken by the provider on gifts and gratuities to

prevent people from being placed at risk of financial abuse. The staff handbook also contained a whistle blowing procedure for staff who wished to report any concerns about colleagues.

We saw the provider had in everyone's care file a health and safety risk assessment which was carried out at the start of every period of care. The risk assessment required the assessor to consider if staff could move safely around the home and if there were any hazards including the potential for a fire to break out. Each person also had a mobility risk assessment.
Each person had listed emergency contact details, this included people's names, their relationship to the person and their contact details as well as including doctors and social workers. A 24 hour on call contact number was also given out to families should an urgent need arise. This meant people had access to staff members and other professionals in case of an emergency. The staff we spoke with told us in the event of a medical emergency an ambulance would be called and that staff would follow the emergency operator instructions until an ambulance arrived.

Requires Improvement

Is the service effective?

Our findings

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. The provider told us that no applications had been made by the service to the Court of Protection.

At our last inspection of the service on 23 and 28 July 2016 we looked in people's care records to see if they had given their written consent or there was a best interest's decision in place for people to receive personal care and found there were no signed records to this effect. At this latest inspection we found the provider had failed to obtain written consent from people to agree to their care. We discussed this with the registered manager and assistant manager who, during the course of our visit devised a new format to include recorded consent within people's care plan. The registered manager told us that they would implement straight away.

We checked to see if staff received supervision and appraisals. A supervision meeting occurs between a staff member and their manager to look at their performance, any concerns they may have and training. Staff told us they received support from their manager and only had to ring the office if they needed help. The registered manager and the provider told us they were not good at supervision and appraisals. They confirmed they held no formal staff supervision meetings or appraisal meetings. We saw the service had tried to set up appraisal meetings for two staff and the service was now carrying out 'spot checks' or observations on staff in the workplace. The registered manager also told us they saw staff every day as they delivered care with staff when people needed to staff to care for them. This meant effective records in relation to person's employed were not maintained.

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

People told us they had confidence in the staff's abilities to provide good care. They told us the staff from Castle Care were able to deliver the care and could readily carry out the tasks they had been requested from their assessment. People told us they were very happy with the arrangements, "They do a very good job," They are like friends and always there on time," and "They are absolutely great no qualms at all."

We saw staff recorded that they had prepared people's meals and paid attention to people's individual requests such as specific ways or places they liked their food and drink to be served. We asked staff about how they would respond to concerns over someone's nutrition. One staff member told us, "I'd report it to our manager straight away but I'd also speak to the family and ask them to monitor it too. We would request an extra five or ten minutes so we could really support someone and we could refer them to the dietician". This meant the service had considered people's food and fluid intake and put in place specific plans to meet individual people's needs.

Staff who were new to the service underwent an induction period. This included staff shadowing other more experienced staff members to learn about people's needs and how they liked their care to be delivered. We found staff had not always signed induction documentation to say they had completed their induction so we could not verify if staff had received this training. One person told us, "Sometimes new [staff] come out and shadow them and they get to know me and that's good training." This meant new staff were not left unsupported to meet the care needs of people they did not know. This also meant that people using the service could be assured a familiarity of care in that no new care worker would attend a call without first being introduced to them.

Staff told us they had received training in moving and handling, administering medicines and first aid. The provider had a training matrix in place which showed the training staff had completed but this was not up to date and future training was not recorded on it. We spoke with the management team who told us they had moved training provider and were just setting up a programme of mandatory training for all staff. We saw they were prioritising staff undertaking training in the safe handling of medicines and staff workbooks were to be supported by the external provider rather than being done in house as the service had done previously. On our next visit to the service we will want to see the mandatory training programme embedded and in place for all staff.

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

Good

Is the service caring?

Our findings

People we spoke with who received personal care said they were very happy with the care and support provided. We found a range of support could be offered, which could mean staff visited once a day or several times a day to assist with personal care tasks; or completed domestic tasks or companionship.

We reviewed the care records of eight people. The people we spoke with were readily able to discuss what type of support they received and how they had gone through with staff exactly what their needs were and how these were best supported as part of their assessment.

We found that each person had an assessment, which highlighted their needs. The assessment could be seen to have led to a care plan being developed. We found from our discussions with staff and individuals, met their needs although ongoing reviews of care plans had not taken place.

We looked at the arrangements in place to ensure that people were involved in decisions about their day to day lives and provided with appropriate information. The care records we viewed included information about Castle Care and the services they provided. Everyone we spoke with 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 everyone told us they knew how to contact the office.

The people we spoke with told us staff always treated them with dignity and respect. People found staff were attentive, showed compassion, were patient and had developed good working relationships with them. People told us; "I am thrilled, I get very well looked after," and "They make me feel comfortable."

The staff we spoke with explained how they maintained the privacy and dignity of the people that they care for and told us that this was a fundamental part of their role. One staff member told us, "You treat people like your own family, nothing is shameful and you make people feel comfortable. Sometimes if it is appropriate I might make a little joke at my own expense not the person's just to break the ice." Another staff member said, "You have to respect older people living in modern times and older men often find personal care difficult. I make sure they have their privacy and I ensure they are covered with towels. I treat people as I'd like to be treated myself." This showed staff were caring and respected people's dignity.

The registered manager regularly worked providing support to people and one person we spoke with told us, "I rang the office this morning to ask for some information and [name] the registered manager couldn't have been more helpful."

The registered manager and staff that we spoke with showed genuine concern for people's wellbeing. It was evident from discussion that all staff knew people very well, including their personal history preferences, likes and dislikes and had used this knowledge to form very strong therapeutic relationships. One person told us, "Castle Care to me are A1, the staff that see to me I could not fault." We found that staff worked in a variety of ways to ensure people received care and support that suited their needs.

Requires Improvement

Is the service responsive?

Our findings

At our last visit to Castle Care we found people's care plans had not been reviewed. Of the eight care plans we looked at on this visit, six had not been reviewed. We spoke with the management of the service who stated they knew this was lacking and due to family circumstances and staff shortages they had not addressed this fully. This meant you did not maintain securely 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 and of decisions taken in relation to the care and treatment provided.

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

People told us that Castle Care staff always turned up as planned and that if, on odd occasions, they had been delayed by a few minutes the staff rang them to say why this had happened. People told us it was very rare for staff not to turn up on time. People using the service told us that they were kept well informed of any changes to the appointments. One person told us, "There's no trouble if I need to cancel an appointment and my bill is always correct when I receive it."

Staff told us they encouraged and supported people to remain as independent as possible. One staff member told us, "I started with a new person five or six days ago and they are doing more and more. I told them I am here to promote their independence and they accepted that. I'm here to help and it's really working with them."

The registered provider outlined the assessment process and we confirmed from the review of care records that this mirrored what had been outlined to us. We found that people's needs were assessed upon referral to establish if the service were able to meet the person's needs. Information was provided about person's care and support needs by, either the person or their carer or family member. This enabled the registered manager to produce a care plan.

We found that care plans were person-centred. For example one stated, "[Name] likes to use an electric razor but does request a wet shave occasionally." This meant people's preferences were recorded.

Staff visited people at defined times during the day or week and we heard that should someone appear unwell when they visited staff take prompt action to deal with this concern. One experienced staff member told us; "I know how to respond in an emergency or if someone is just unwell and we teach this to new carers coming out with us."

Care staff told us they were generally allocated the same people, which meant they could build very good working relationships. One person said to us, "I have the same two or three carers and they are first class."

The registered manager explained that due to living in rural communities people can feel isolated. In order to respond to this need they had set up a day centre and staff who worked with people in their own homes

also worked with people in the day centre. Staff confirmed these working arrangements were in place. We saw some people who received personal care from the service also attended the day centre.

The people who used the service we spoke with told us they were given a copy of the complaints procedure when they first started to receive the service. We looked at the complaint procedure and saw it informed people how and who to make a complaint to and gave people timescales for action. We spoke with people who used the service who told us that if they were unhappy they would not hesitate in speaking with the management team. The service had not received any complaints since our last visit. The management team told us that if they received any concern or issue no matter how minor, they immediately contacted the person via telephone or a visit to discuss and address their issues. One staff member told us, "I would try and sort it out myself if it was something minor but I would let the managers know."

Requires Improvement

Is the service well-led?

Our findings

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. At the time of our inspection there was a registered manager in post. We saw the registered manager worked alongside staff in delivering care to people in their own homes.

There was not an audit programme in place to check the quality of the service or an action/ improvement plan that would have highlighted the issues found at our previous inspection of Castle Care. Whilst we saw some issues we found on our last visit had been improved such as the introduction of spot checks and a quality assurance survey, other areas such as care plan reviews and obtaining people's written consent to care had not been actioned.

Accidents and incidents were not routinely monitored and recording needed to be improved. For example, an occurrence where a person fell over onto a staff member who also fell was recorded in the incident book but not the accident file. Also saw on one day where one person did not receive their medicines at all that this was not recorded as an incident it was just in the person's daily notes and was not picked up or addressed.

The registered provider had questionnaires in place to ask people about the quality of the service. We looked at the results of the survey and found peoples' comments were largely positive. However where a comment or issue had been raised we could not verify whether this had been addressed by the service.

Leadership of the service had also failed to identify that some people's care plans had not been updated, that medication administration records were not accurately kept and staff background checks had not been completed. This meant that the provider could not demonstrate good governance systems in several key areas of the providers' activities.

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

Staff told us if they had any concerns they would go to the registered manager and told us they had received positive support in the past. We saw that staff meetings did not take place at the service and we can understand that this would be problematic on a regular basis due to the rural nature of the service's area. However one staff did comment to us that it would be, "nice to have a staff meeting every now and again."

We found the service worked with other professionals to support people's needs. These included occupational therapists, district nurses, care manager and community psychiatric nurses. This meant the service worked in partnership with key organisations to support care provision, service development and joined-up care.

The service had links in place with other community organisations including day centres and luncheon clubs. The registered manager described to us their networks and we found they knew the area well.

The registered provider told us records were stored in people's homes and brought back into the office when completed. We looked at people's records and found staff filled out a contemporaneous record before they left a person's home. The records reflected what was required by the person's care plan at each call. Information in the office was stored in lockable cabinets and was easily retrievable. We found information was maintained and used in accordance with the Data Protection Act.

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 18 HSCA RA Regulations 2014 Staffing We could not verify if staff received induction training and mandatory training was not up to date.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was not a robust assessment on the quality or safety of the service carried out and previous breaches of regulation had not been fully addressed.

The enforcement action we took:

Warning notice