Abbey Health & Social Care Group Limited

Abbey (Grimsby)

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

Overall summary

Abbey (Grimsby) is registered to provide personal care. They primarily support people who want to retain their independence and continue living in their own home. They provide services to all age ranges and at the time of the inspection were providing services to approximately 263 people, many of whom were living with dementia.

This inspection was unannounced and took place over two days. The previous inspection of the service took place on 21 August 2013 and was found to be non-compliant with one of the regulations inspected. The service was re-inspected on 28 January 2014 when it was found to have made the necessary improvements.

The service did not have 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. The registered manager had left the service in December 2014 after which the deputy manager took over the running of the service from 01 January 2015. As yet, no application had been received by CQC to register the deputy manager.

Summary of findings

Medicines were not always handled safely. Most medicines were supplied in a monitored dosage system. This was used correctly to support the safe administration of medicines in the home. However, we found the medicine administration records were not always completed to support and evidence the correct administration of medicines.

Whilst staff had been trained in the safe administration of medicines, we found this training did not contain enough detail on how to record that medicines had been given.

Staff told us that there were enough staff to fulfil the rota. The 263 people who used the service were cared for by 146 care workers. We were told the staffing levels were based on people's dependency and this was monitored and adjusted depending on the needs of people.

The registered provider had policies and procedures in place to protect vulnerable people from harm or abuse. Staff had received training in safeguarding vulnerable adults from abuse.

Each person had a set of risk assessments which identified hazards people may face and provided guidance to staff to manage any risk of harm. However, a significant amount of these were out of date and a reviewing process was underway.

Staff were supported through a programme of staff training, supervision and appraisal. This ensured staff were supported to deliver care safely to people.

Training records showed the majority of staff had received recent training in the principles of the Mental Capacity Act 2005. Our observations showed staff took steps to gain people's verbal consent prior to care and treatment.

The service supported some people to eat and drink. Care plans contained a detailed assessment of people's dietary needs and gave information about people's appetites and preferences. Each assessment included information about specific cultural or religious requirements.

Staff told us they took time to understand the needs of people who were not able to communicate as well as others, particularly those with dementia. However, some staff were unable to describe how specific people's language and facial expressions could be an indication of how they were feeling or whether they were in pain or discomfort.

People who used the service told us they were invited to express their views about the service they received at 'Service User Forums' which the registered provider held every three to four months.

Before our inspection visits we had been made aware of concerns that some people's care plans and risk assessments had not been reviewed for over a year. Records showed the deputy manager had put in place a new style care plan and had implemented a structured approach to the review of care plans and risk assessments, all of which were planned to be re-written by the end of February 2015.

The new style care plans we reviewed were written around the individual needs and wishes of people who used the service. Care plans contained detailed information on people's health needs and about their preferences and personal history.

People who used the service told us they knew how to complain. We saw information on how to make a complaint was contained in the 'Service User Guide' within people's homes.

Staff told us the leadership and management of the service had improved in the last few months. There were systems in place to effectively monitor the quality of the service although there had been no recent surveys of relatives, external health professionals or people who used the service.

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 and required improvement in the way it trained staff on the administration of medicines and the way in which staff recorded when medicines had been administered.

Staff were recruited safely and understood how to identify and report any abuse. People told us there were enough staff to meet their needs and this had improved over the last few months.

People said they felt safe. Risks to people and others were managed effectively although some risk assessments were out of date and did not reflect the current levels of risk people may face.

Is the service effective?

Good

The service was effective. Staff had been well trained and were supported through supervision and appraisal of their work.

People who used the service told us they felt the staff had the skills they needed to care for them effectively.

As far as possible people were involved in decisions about their care. Staff understood the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was mostly caring but required some improvement in the staffs' knowledge of how people's language and facial expressions could be an indication of how they were feeling or whether they were in pain or discomfort.

Staff respected people's privacy. Staff spoke with people in a calm, sensitive manner which demonstrated compassion and respect.

New style care plans provided staff with good information about how people who used the service wished to be treated. However, the older style care plans did not always give sufficient information in this area.

Is the service responsive?

Requires Improvement

The service was mostly responsive but required improvement in the provision of up to date care plans written around people's individual needs.

People knew about the complaints policy and felt confident any issues would be dealt with by the deputy manager.

Is the service well-led?

Requires Improvement

The service was mostly well-led but required some improvement as no surveys had been sent to people who used the service, their relatives or external professionals.

Summary of findings

Accidents and incidents were monitored and trends were analysed to minimise the risks and any reoccurrence of incidents.	

Abbey (Grimsby)

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 registered 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 26 January and 10 February 2015. The registered provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in the office.

The inspection was carried out by one adult social care inspector and telephone interviews were conducted by an expert-by-experience. 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 local Clinical Commissioning Group's (CCG) safeguarding and contracts teams were contacted before the inspection, to ask them for their views on the service and whether they had investigated any concerns. They told us about the current concerns they had, specifically about visits to people's homes being missed and the review of care plans being overdue.

We spoke with 14 people who used the service, four care workers, the deputy manager, one care co-ordinator and four relatives. We visited four people who used the service in their own homes after first gaining their permission.

Six people's care records were reviewed to track their care. Management records were also looked at, these included: staff files, policies, procedures, audits, accident and incident reports, specialist referrals, complaints, training records, staff rotas and monitoring charts kept in folders in people's homes.

Requires Improvement

Is the service safe?

Our findings

People who used the service and their relatives told us they felt the service was safe. Comments included, "I feel he's very safe", "We have lots of equipment to help move him", "I feel very comfortable with the carers, I have never been worried", "I like all the carers and I'm not worried about anyone, I trust them all" and "I feel very safe with them (care workers)." One person told us they received an afternoon safety check. They felt that because of their condition and its variable nature, a check was vital for their wellbeing. They told us the check had never been missed during the five years they had used the service.

Medicines were not always handled safely. Most medicines were supplied in a monitored dosage system. This was used correctly to support the safe administration of medicines in the home. However, we found that the medicine administration records were not always completed to support and evidence the correct administration of medication. We saw gaps in the record keeping for two people that meant we could not tell whether their medicines including tablets, inhalers and eye drops had been given correctly. The deputy manager showed us the monthly audits of the MARs which identified many gaps in recording, particularly in relation to 'when required' medicines rather than essential medicines. The deputy manager was able to demonstrate the actions taken when such omissions occurred, the re-training of staff for example.

We visited four people who used the service in their own homes. They told us the staff were knowledgeable about their medicines and prompted them to take them as prescribed. The MARs kept in people's own homes had been maintained accurately. However, in one person's home we found open bottles of liquid medicine did not have a date of opening recorded on them in line with relevant guidance.

Safe systems were in place for assessing and recording people's medicines needs before they began to use the service. This information was used to inform people's care plans to help ensure the right support was provided with their medicines. Medicines were administered by care workers who had received assessed medicines training. However, we found this training did not contain detail about how to record onto the MARs and the codes which should be used. We brought this to the deputy manager's attention who responded by arranging for the training material to be re-written by the second day of our inspection. People who used the service told us they were prompted to take medicines in accordance with the times specifies on their prescriptions.

We reviewed the policies in place for infection prevention and control (IPC). We saw staff were given guidance about the appropriate personal protective equipment (PPE) to wear, disposable gloves for example. The members of staff we spoke with were able to describe when to wear PPE and how to dispose of it safely in order to prevent cross infection between visits.

Each person had a set of risk assessments which identified hazards people may face and provided guidance to staff to manage any risk of harm. Before our inspection the local Clinical Commissioning Group (CCG) had told us care plans and risk assessments had not been reviewed monthly to ensure they were current and relevant to the needs of the person. The deputy manager told us that since they took over the running of the service at the beginning of January 2015 they had set each senior carer monthly targets for the review of care plans and risk assessments. Records showed the reviews of 109 care plans were outstanding in January. This had reduced to 78 at the time of our first inspection visit and 65 by the second. The deputy manager told us the service was on target to have all reviews completed by the end of February 2015. This meant some care plans did not reflect any changes in people's needs that may have occurred over the last year.

We reviewed the registered provider's policies and procedures designed to recruit appropriate staff. We checked staff files and confirmed that at least two references had been received for each new member of staff. Checks had been made with the disclosure and barring service (DBS) to confirm the person had not been registered as being unsuitable to work with vulnerable adults. There were clear disciplinary procedures in place to use should a staff member's conduct or performance fall below the registered providers' accepted levels.

Staff we spoke with told us there were enough staff to fulfil the rota. The 263 people who used the service were cared for by 146 care workers. The deputy manager and four care co-coordinators were supernumerary. The deputy manager told us the staffing levels were based on people's dependency and this was monitored through the use of a recognised dependency tool. Wherever possible we saw

Requires Improvement

Is the service safe?

the care co-ordinators tried to allocate a core team of staff to each person in order to promote continuity of care. People who used the service told us this had improved considerably from the previous six months when they had no certainty as to whether any care workers who were familiar to them would arrive.

We reviewed the staff rotas and saw there was a specific computerised system to allocate calls and identify any calls not allocated the correct number of care staff. We saw the care co-ordinators responsible for the staff allocation telephoned each care worker after a call to confirm they had attended and two care workers were present if required. We were told this system had reduced the number of missed or late calls significantly. On the second day of our inspection visit we confirmed only one call had been late that week and none missed.

Staff told us there was an out of hours on call system and a manager or care co-ordinator would always be available if assistance or advice was needed outside office hours. Rotas showed two senior members of staff were on duty in the office at weekends together with a care co-ordinator to support the care staff and deal with any issues. We were told three relief support staff were also available should there by any shortages in staff.

Records showed staff had received safeguarding adults training and had regular updates. The members of staff we spoke with were able to describe the types of abuse to look out for and the system for reporting any concerns. All the staff we spoke with said they felt confident the management would deal with any such reports quickly. The deputy manager showed us records of referrals made to the local authority safeguarding team and we saw they had worked with them to investigate concerns and address any shortcomings.

Good

Is the service effective?

Our findings

People who used the service and their relatives told us they felt the staff were knowledgeable. Comments included, "They are aware of her needs and encourage her to be as independent as possible", "They always ask me of its alright to do my personal care", "They know a lot of things and they are good at helping me to move around" and "I think the staff are well trained, I have never had cause to doubt it."

Staff files confirmed that staff were supported through a programme of staff training, supervision and appraisal. These ensured staff were supported to deliver care to people safely. One member of staff told us, "I get a supervision session about once every two months. We talk about any concerns about people and our workloads." Core training for all staff included: administration of medicines; moving and handling; fire safety; infection prevention and control; diabetes; dementia care; safeguarding vulnerable adults; epilepsy care; Mental Capacity Act 2005; pressure care; and food hygiene. Records showed 25% of the care staff had achieved a recognised qualification in care whilst 24% were working towards one.

Staff told us they had undertaken the registered provider's induction programme at the start of their employment and they were required to shadow more experienced staff before a senior member of staff assessed them to be competent to work on their own. They told us their induction covered whistleblowing and safeguarding. Staff confirmed they had received training in moving and handling before they were permitted to assist people using a hoist or other mobility aids. This showed people were protected from the risk of receiving care from untrained staff.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure the rights of people who may need support to make decisions are protected. Training records showed the majority of staff had received recent training in the principles of MCA. People who used the service told us and our observations showed staff took steps to gain people's verbal consent prior to care and treatment.

Our discussions with the deputy manager showed that they had a good understanding of the Mental Capacity Act 2005. The care staff we spoke with also had a good understanding of this act and issues relating to consent. All confirmed they had received training on mental capacity within the last two years. This meant there were suitable arrangements in place to obtain, and act in accordance with the consent of people using the service.

We noted the service supported some people to eat and drink. Care plans contained a detailed assessment of people's dietary needs and gave information about their appetites and preferences. Each assessment included information about specific cultural or religious requirements. The deputy manager told us the service worked with external healthcare professionals from the Speech and Language Therapy (SALT) team and dieticians and would record people's food and fluid intake on specific monitoring charts. In addition staff told us anyone who experienced difficulty in swallowing or had sustained weight loss were placed on the monitoring charts and appropriate referrals were made to specialist services through people's GP.

We visited one person in their home who required a liquidised diet as recommended by SALT. We observed the care worker preparing the meal but rather than liquidising the whole meal together, they prepared each component of the meal separately so its presentation was more acceptable.

Records showed three people received their meals through a percutaneous endoscopic gastrostomy (PEG) tube. We confirmed all staff providing care to these people had received appropriate training on how to facilitate this.

People who used the service had access to healthcare professionals such as dentists, chiropodists, opticians, and told us their care workers helped them to organise appointments and transport to them.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us, "I get good regular care from someone who knows and understands me", "What I ask for I get. They treat me with respect; I've got nothing to say against them", "Whilst I have had difficulties in the past with missed calls and things, the carers have always been good and caring" and "The carers are very kind and compassionate." All the people we spoke with said they felt the care workers had enough time to complete tasks and usually stayed for the allotted time.

Members of staff told us they took time to understand the needs of people who were not able to communicate as well as others, particularly those with dementia. However, three of the four staff we spoke with were unable to describe how specific people's language and facial expressions could be an indication of how they were feeling or whether they were in pain or discomfort. In addition, some staff were unable to demonstrate they knew specific people well and were largely unaware of their life histories or social interests.

We observed staff respected people's privacy, always knocking on their doors, waiting to be asked to enter unless it had been specifically agreed that they could let themselves in to people's homes. We observed staff speaking with people in a calm, sensitive manner which demonstrated compassion and respect. They looked directly into people's faces when asking questions and talking to them. Staff told us they received training in dignity and were assessed on their strengths and weaknesses in this area at the regular 'spot checks' carried out by senior staff.

We observed staff spoke to people who had limited communication and understanding with patience. People were given time to respond to questions. We saw care plans for people with limited communication clearly set out the ways of communicating with them.

Some people who used the service told us they had used the night rover service which consisted of two vehicles each staffed by two care workers. This service was used by people who required positional changes, medicines as well as those who wished to go to bed later than their allocated time or the call had been missed as a result of the person going out with their families for example. It was also used to provide support to people who were discharged from A&E during the night. The deputy manager told us this service was provided between 8pm and 8am.

The new style care plans we reviewed provided staff with good information about how people who used the service wished to be treated. However, the older style care plans did not always give sufficient information in this area. The deputy manager told us that once all the care plans had been reviewed and re-written by the end of February 2015, all would contain a good level of information. The six care plans we reviewed also contained the person's or their representative's written consent to each section of their care plan, including personal care, administration of medicines, moving and handling tasks, and referrals to a GP. All of the people we spoke with told us they knew they had a care plan and had been involved in its development and review.

People who used the service told us they were invited to express their views about the service they received at 'Service User Forums' which the registered provider held every three to four months. They told us transport was provided to these events and refreshments were made available to them. The notes from these meetings showed people were encouraged to talk about both positive and negative experiences of the service. Following the meetings we saw action plans had been created to address any shortcomings. In addition, people who used the service were telephoned at regular intervals to check the care they received and the staff were acceptable.

Information was made available to people about the use of advocates although at the time of our inspection no one was using the services of an advocate.

We reviewed the service's equality and diversity policy which included information for staff about different faiths and cultures and the potential implications for care and dietary requirements.

Requires Improvement

Is the service responsive?

Our findings

People who used the service and their relatives told us, "The carer sits and talks to xxx about football, tells him jokes or plays dominoes with him", "The carers chat about things that xxx remembers, like the old town" and "They give the care that xxx needs, it's very personal to him and they know that."

Prior to our inspection visits concerns had been raised with the local CCG that some people's care plans and risk assessments had not been reviewed for over a year. Records showed the reviews of 109 care plans were outstanding in January 2015 when the deputy manager took over the running of the service. This had reduced to 78 at the time of our first inspection visit and 65 by the second. The deputy manager told us the service was on target to have all reviews completed by the end of February 2015.

The new style care plans we reviewed were written around the individual needs and wishes of people who used the service. Care plans contained detailed information on people's health needs and about their preferences and personal history. Each care file included individual care plans for: personal hygiene, end of life planning, continence, mobility, communication, infection control, pressure care, and nutrition. The older style care plans did not contain the same level of information. The deputy manager told us that once all the care plans had been reviewed and re-written by the end of February 2015, all would be written around the specific needs of the individual. However, we noted the template for the new dementia care plan had been designed for the use in a residential care setting rather than in the community although we were told one for the community setting was in development.

A care co-ordinator told us a handover meeting took place each morning when the out of hours on call team's shift came to an end. Records showed any issues, accidents and incidents were discussed so the senior care team were aware of any changes in people's needs. We saw each care co-ordinator signed the handover sheets to confirm they had understood any new requirements.

People who used the service told us they knew how to complain. We saw information on how to make a complaint was contained in the 'Service User Guide' within people's homes. Staff told us this was made available in alternative formats if required. Several of the people we spoke with said they had made complaints in the past. The complaints file showed people's comments and complaints were investigated and responded to appropriately. There was evidence that actions had been taken as a result of complaints and the person who made the complaint had been responded to within the timescales set out in the registered provider's complaints policy. This showed the complaints system at the service was effective.

We saw one person had complained about the time of their visits. The service responded by re-arranging their visits in accordance with their wishes. Another series of complaints were around the use of different care workers on each visit and that teams of two carer workers were not always sent when people needed to be assisted in moving with a hoist. We saw the senior staff had made every effort to address these issues and use core teams of staff to deliver care to people and utilise the electronic rota system to ensure and monitor two staff members were sent when required.

Requires Improvement

Is the service well-led?

Our findings

Members of staff told us, “We’ve had some real problems over the last six months but now xxx has taken over the management side of things, it’s getting a lot better quite quickly”, “The new manager is really good at involving us with things, we seem to know what we’re doing now”, “I know we’ve still got a way to go but the improvement in the service is there already” and “The manager is really open and honest with us, she’s quite firm but knows exactly what needs doing to improve the care for the clients.” Most of the people who used the service we spoke with were positive about the management of the service. They told us that if they rang the office with concerns then problems were sorted out quickly. People’s comments included, “I had problems in the past but now it’s come right” and “Everything is going to plan now.”

We saw there were monthly records of accidents, incidents, injuries and safeguarding referrals and, where appropriate, investigations had taken place and trends had been identified. We saw any issues were discussed at staff meetings and learning from incidents took place. We confirmed the registered provider had sent appropriate notifications to CQC in accordance with registration requirements.

We found there were systems in place to monitor the quality of the service. We reviewed monthly audits for medicines management, pressure care, infection prevention and control, and care plans. We saw action plans had been created to address any shortcomings. The deputy manager showed us the audit schedule which we confirmed appropriate audits had been planned throughout the year. However, the medicines audit had failed to identify the recording issues identified at our inspection. It also failed to identify that a lack of detailed training may have contributed to these issues.

We saw that when people who used the service had received late and missed calls or when they had received different care workers at each visit, a red alert label had been attached to their physical and electronic record. The senior staff then created a time specific action plan to address the issues. The deputy manager told us this allowed them to monitor improvements to the service and ensure that the rota and allocation systems worked effectively.

We reviewed the record of spot checks carried out on care workers by senior staff. Each senior care worker was required to complete 10 spot checks each week. This meant each staff member would receive a spot check at least once every three months. Newly appointed staff received a weekly check for four weeks. However, records showed that during the week of our first inspection visit only 21 had been carried out when the target was 40. We noted the spot checks included observations of people’s care, adherence to the uniform policy, completion of MARs, use of PPE, and the promotion of dignity and independence. We saw that when care workers had fallen below the standard expected by the registered provider, formal supervision meetings or disciplinary action had taken place.

Records showed staff meetings took place infrequently; some members of staff told us they would like to see these being held more frequently and used to discuss best practice and learning. The deputy manager told us they were aware of the need to increase the frequency of staff meetings and this would be addressed in the near future.

The deputy manager told us that although surveys were sent last year to people who used the service and external health professionals in order to assess the quality of the service, they were unable to locate the evaluations due to a change in management. The deputy manager told us further surveys would take place this year and a subsequent evaluation would add to the information gained from the telephone ‘courtesy calls’ which took place each month and the 'service user forums'. This meant that whilst the service had taken some actions to effectively monitor the quality of the care provided it could not, at the time of our inspection, readily identify and analyse patterns, trends, and improvements.