Choice Local Care Ltd

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

Summary of findings

Overall summary

The inspection took place on the 21 and 22 September 2016 and was announced. The provider was given short notice of the visit. This was because we needed to be sure key staff would be available for us to speak with. At the last inspection in March 2014, the service was judged compliant with the regulations inspected.

Choice Local Care Limited is a domiciliary care agency registered to provide personal care. The agency is managed from Choice Local Care Limited head office at 27 Taplin Road. From this location all referrals, staffing and service provision is organised. It is the main point of contact for families/professionals that domiciliary care is provided to.

There is a registered manager which oversees services provided from the office. 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 were 12 people using the service. We spoke on the telephone with two people who used the service and four relatives. We also visited one person in their own home and spoke with them and their relative. We asked people about their experiences of using the agency. People we spoke with told us they were mostly happy with the service provided. Two relatives raised concerns that they thought staff needed more training and they said there seemed a big turnover of staff and they sometimes did not stay for the allocated time.

People's care needs had not been thoroughly assessed, prior to the package of care being implemented. Care records at the office did not always demonstrate people's consent to their care and treatment.

The provider did not have robust systems in place to ensure that people were safe. Care records were not sufficiently detailed to ensure staff could deliver care safely. Risk assessments did not provide guidance for staff on how to mitigate the risks when providing care and support to people who used the service.

Care records told us that staff were administering medication to people who used the service. However, records showed staff had not received training in the safe management of medicines. Care records did not always show the list of medication administered and medicine administration records [MAR] were not being used to record that medication had been given as prescribed. Staff had not had an assessment to ensure that they were competent in the management and administration of medicines.

Staff had not received the relevant training for the work they did. Not all staff had received regular supervision and appraisals. Spot checks were not regularly carried out to establish whether they had the required skills, and experience for the work they did.

People were positive about how their care was managed by the care staff. They were treated with kindness and compassion. People were treated with respect and their privacy and dignity was promoted.

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 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

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard vulnerable people from abuse.

The provider did not carry out adequate risk assessments to manage the risks from people's health conditions. This meant that some people were at risk of avoidable harm.

The recruitment of staff was not sufficiently robust.

People were supported to take their medication. However, the recording of medication required improvement to make it safer. Staff training in the safe management of medicines had not taken place.

Is the service effective?

Inadequate

The service was not effective

Staff records did not demonstrate that they had the training they needed to deliver care safely. We saw induction and shadowing of new staff was not fully completed. There was insufficient assessment of the competency of new staff to provide care effectively.

The provider was not assessing people's mental capacity to consent to their care and treatment and, where appropriate, could not demonstrate that they were working in line with people's best interests and protecting people's rights.

Is the service caring?

Requires Improvement

The service was not always caring

People told us they were mainly happy with the care and support they received to help them maintain their independence. However relatives told us that some staff did not always stay the allocated time.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care was not regularly reviewed. Care plans did not accurately reflect the care that people actually needed, meaning that staff did not have access to up to date information on people's needs. Visits were sometimes later than planned and relatives told us that they sometimes did not know who would be attending the visit.

There was a system in place to tell people how to make a complaint and how it would be managed. However the records did not reflect how problems were resolved.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager often worked in the community which meant they found it difficult to carry out their roles and responsibilities as required by the Commission.

There was no evidence that a system or process was being operated to effectively ensure the monitoring and improvement of the service.

Staff told us they felt supported but could not tell us about things like spot checks and supervision and appraisals.

Policies and procedures required improvements to make them more effective.

Choice Local Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 and 22 September 2016 and was announced. The provider was given short notice of the visit. This was because we needed to be sure key staff would be available for us to speak with. The inspection was carried out by an adult social care inspector. We spoke on the telephone with two people who used the service and four relatives. We also visited one person in their own home and spoke with them and their relative. This helped us to understand the views and experiences of people who used the service.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the registered manager. We also looked at the information sent to us by the registered manager on the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the office we spoke with the registered manager, a team leader and the care coordinator who also delivered personal care and assisted the registered manager in the running of the service. We also spoke with six care staff who worked with people who used the service in the community.

We looked at documentation relating to six people who used the service, five staff files and the management of the service. The registered manager told us the care plans were also stored in people's home. These were copies of the files held at the office.

Inadequate

Is the service safe?

Our findings

We looked at six care plans and found they were not sufficiently detailed to ensure staff could deliver safe care and treatment. Five of the six care plans described that people required assistance to take their medication. However the care plans did not detail what support was needed with this task. One care plan only said, "Give medication." There was no list of the medicines the person was taking and there was a blank medication administration record [MAR] Daily records confirmed that staff had 'given' medication. Another person's care plan said, "Support me with my medication." There was no MAR or list of medication that the person required assistance with. A further care plan had written on the top of the page. "Give diazepam if [family member] requests it." There was no risk assessment or protocol to assist staff to give this medication safely. From the daily records of one person it was clear that the person sometimes required paracetamol for pain relief. There was no protocol to guide staff when this PRN 'as required' medication should be administered.

We looked at the training records for ten staff. None of the records identified that staff had attended the safe management of medicines training. We spoke to the registered manager about this and they said this subject was covered at induction. They were unable to show us confirmation of this. We spoke to staff about this training and they all confirmed that they had received some training in this subject but could not confirm what the training involved.

One relative we spoke with told us that their [family member] required assistance with taking their medication and described the medication which was prescribed for a mental health condition. The relative told us that it was essential that staff understood the importance to their family member to have the medication as prescribed. They expressed concern that several staff had supported their family member and they were worried that staff may not understand their relative's needs. Another relative confirmed that their family member required assistance with eye drops. There was no guidance on how to apply the eye drops.

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

The care records we looked at did not have any risk assessments. There were no clear instructions for staff on how to support people to ensure that they were not at risk of harm or injury. We noted from two peoples care records that care staff needed to move the person using and hoist. There was no instruction for staff to follow when using the hoist. For example the care record did not state the type of sling to use or the loop combination [on the sling] that should be used.

We looked at the training records for ten staff and found seven staff had received moving and handling training. We asked the manager who had delivered the training. They confirmed they had delivered the training. We asked the registered manager if they had completed any training to ensure they could deliver appropriate training to staff. The confirmed that they did not hold any formal qualifications and had left their previous job as a nurse six years previously and had not maintained their nursing competencies. Records for three staff did not confirm that they had undertaken moving and handling training. One of these

staff was involved in supporting a person's care needs included being moved using a hoist. This member of staff should not use this equipment until they had received formal moving and handling training.

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

We spoke with staff about their understanding of protecting adults from abuse. They told us they had undertaken safeguarding training and would know what to do if they witnessed bad practice or other incidents that they felt should be reported. They said they would report anything straight away to one of the managers. The service had a safeguarding policy which showed a flow chart how staff should report any allegation of abuse. We checked notifications sent to us from the service. We noted there had been no incidents of abuse.

We found that the recruitment of staff was not sufficiently robust or thorough. We looked at five staff files. We were unable to evidence when staff commenced employment at the service. The registered manager told us that staff were not allowed to commence employment until a Disclosure and Barring Service (DBS) check had been received. However one staff members DBS check was dated 9 August 2016. It was clear from other records on the staff members file that they had worked at the service from March 2015. The registered manager told us that this was a new DBS check and the previous one had been destroyed. We were unable to confirm this. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults.

This was a breach of regulation 19 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service if they got their calls/visits when they were supposed to or within an acceptable time frame, and also if they had experienced missed calls. Some relatives told us there were occasions when the carer was late or was not available so this had affected their calls. One relative said, "Sometimes they [staff] have to travel on public transport which can result in delays. Another relative told us that they did not think there were enough staff to cover when staff were off work.

The service did not have any methods to monitor calls. The Registered manager told us that staff signed in when they arrived at calls and then signed the care records when they left. We saw some of the records were made on paper torn from a small book. Some of these were not signed by the person attending the call or have the detail of when they had left the call. This meant there was not an effective way of monitoring of calls.

Inadequate

Is the service effective?

Our findings

There was an absence of effective training for staff to ensure they were able to carry out their job role. We looked at the training records for ten staff. None of the records included training in the safe management of medicines. Staff we spoke with told us this was covered during their induction but we were not able to confirm this. There were no certificates on the staff files and other topics like safeguarding, mental capacity dementia and dignity and respect had been completed all in one day. We looked at the training and development policy for the service and it said that training schedules would be held twice weekly and that all training sessions would last between two and six hours. This meant it would not have been possible to deliver effective training covering four topics in one day. The training policy also stated 18 core subjects in care would be undertaken. This was not being delivered.

The registered manager told us all staff completed a comprehensive induction which included, care principles and service specific training such as dementia care. We found a new staff member who was working at the service had not been registered to undertake the 'Care Certificate'. Their employment record showed they had no previous experience in working in a care setting. The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

Staff were expected to work alongside more experienced staff until they were deemed to be competent. We saw some records which confirmed some staff had shadowed a more experienced member of staff.

Three training records showed staff had not undertaken any moving and handling training. The registered manager told us that he and the registered provider delivered training. However we were unable to confirm if they held appropriate qualifications to ensure the training was effective. This meant the provider could not assess if staff were competent to carry out their role and this placed people at risk of harm from inappropriate care.

We looked at the frequency of supervisions and found they were infrequent and lacked detail. For example one staff member had a supervision on 02/09/2014 the next recorded supervision held on file was 19/05/2015. Another staff member's file showed supervision had taken place on 17/04/2015 and an appraisal of work completed on 19/01/2016. The registered manager told us that spot checks were also used to assess staff's competencies. These were also infrequent. One staff members file had only one recorded spot check completed on 16/07/2016. Another staff member's file had only evidence of one spot check completed on 02/04/2014. The provider was failing to ensure that staff employed to care and support people in meeting their needs were qualified, skilled, competent and experienced. This exposed people to the risk of unsafe care.

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

People were supported to live their lives in the way that they chose. One relative we spoke with told us how

they had worked with health and social agencies to enable their family member to return home after a long spell in hospital. They described the care they received as good. However, they had made several representations to the provider to ensure the right staff supported their family member. Another relative said they had discussed how important it was for their family member to receive care consistently which meant they needed to have assurance that the same staff to support their family member. They said, "Some of the staff stand back and I have to ask them to do things. They seem to lack initiative and training. There have been a lot of changes of staff."

Some people we spoke with told us care workers were involved with food preparation while other people did not require any assistance. We found that where staff were involved in preparing and serving food people were happy with how this took place. A relative we spoke with said, "My [family member] has microwave meals and staff have time to heat it before they leave. Sometime they are a bit rushed and need to get to their next call so they don't have time to chat to my [family member]."

We spoke to the registered manager about gaining consent to care and treatment. He told us that staff had received training in the Mental Capacity Act 2005. However, he said that most people they supported had some capacity to say how they wanted their care delivered in their own homes. Where people received support who had limited capacity they were usually living with a spouse who shared caring responsibilities with the care workers and other relatives. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment.

We looked at the six care records and found three had not been signed to confirm they had been involved in establishing their care plan and given consent to their care and treatment. We spoke with two people who used the service and two relatives who confirmed they were aware of the content of the care plans.

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

Requires Improvement

Is the service caring?

Our findings

Although people felt that they were well cared for, the service was unable to demonstrate how they cared for people who lived with dementia and those with mental health needs. This meant that people were at risk of receiving inappropriate care and treatment.

We spoke with people who used the service and their relatives and they told us the care and support provided was consistently good. People we spoke with were generally happy with their care and they felt staff were respectful. One person said, "Staff are respectful and treat me as I want to be treated." A relative said, "Some staff are better than others. I think the newer staff need more support to understand my [family members] care needs." Another relative said, "Some staff stand back and need me to tell them what to do. My [family member] relates very well to [staff name] but when they are off work we don't always know who is coming."

Staff were able to describe in detail how they supported people who used the service. Staff gave examples of how they approached people and how they carried out their care so that they were respectful and maintained the person's dignity.

The registered manager told us that the staff team was relatively small with some staff walking to calls and a number who were available to drive to calls. This meant people received care from only a small number of staff. A relative we spoke with told us that they thought more staff were needed to cover for holidays and sickness. They told us that they had told the registered manager that certain staff were not suitable to attend to their family member. Another relative told us that some staff did not stay the allocated time. They said, "I would like all of the carers to stay the full time. If they have finished their duties they should sit and chat to my [family member], instead they sit and write their notes and leave without having a conversation with my [family member].

The registered manager carried out observations of staff working with people in their own homes. However these were infrequent and meant the monitoring of call times was not effective.

Requires Improvement

Is the service responsive?

Our findings

People did not have a person centred care plan in place. We looked at the care records of six people who used the service. Five care records did not have an assessment of needs carried out prior to them using the service. We saw evidence that they had been reviewed in July 2016. However the reviews were generic with only the odd word of difference. For example 'his needs' or 'her needs'. There was no evidence of any previous reviews taking place. This meant the care plan may not be up to date and could lead to inappropriate care being given.

There was no evidence that people's preferences, in relation to their choices about who supported them were taken into consideration. For example, male or female care worker to deliver their care. The record did state their preferred name which carers were to use. We saw two of the care plans had evidence that their relative had been involved in planning their family members care. However the remaining care plans did not include this information. The care plans did not demonstrate that people's views about their care needs had been taken into account to ensure that staff supported them appropriately in meeting their needs. This puts them at risk of inconsistent care or not receiving the care and support they need.

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

People were provided with information about the service; this is called a 'Service User Guide.' The guide informs people of their rights, what they can expect from the service and how to raise concerns. It was written in plain English and gave timescales for the service to respond to any concerns raised. We were told that no formal complaints had been received. The manager told us some minor issues were dealt with straight away. However, they were unable to show documentation to support how minor concerns were dealt with. This made is difficult to assess if lessons were learnt to prevent reoccurrence of similar issues.

People we spoke with did not raise any formal complaints or concerns about the care and support they received. Relatives we spoke with told us they had no concerns but would discuss with the staff or manager if they needed to raise any issues. One person we spoke with said, "I have found the service to be good so I have nothing to complain about." A relative told us that they had asked for the same carer wherever possible for their family member. They said the registered manager had listened to their concern and acted appropriately to ensure their request was dealt with to their satisfaction. Another relative said, "I asked that a certain member of staff be removed from visits to my [family member] because I didn't like her approach. The manager sorted this for me."

Staff told us if they received any concerns about the services they would share the information with their manager. They told us they had regular contact with their manager which was usually on the phone.

Inadequate

Is the service well-led?

Our findings

There was a registered manager at the service. They told us that they worked in the community and covered a number of calls. They told us due to staffing issues they had covered care calls. Two weeks ago they worked 50 hours to cover for staff that were absent from work. This meant they were unable to ensure the effective monitoring of the service.

People told us they could get in touch with the office and that staff were easy to get on with. A staff member we spoke with said they could contact the on-call manager when the office was closed at the weekend. Staff said weekends were often busy because some staff would not make themselves available.

We looked at the daily records and found some were not written on the official record which was numbered, making it easy to audit chronologically. The records had been torn from a note pad and were loose in a plastic sleeve. This meant that records could potentially be lost making it difficult to monitor how care was delivered.

The provider did not have an audit system in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who used the service or staff. For example, we saw records that people were moved using a hoist but there was no risk assessment to guide staff how to move the person safely.

The registered manager told us that staff meetings were held however, they were not very well attended. Rotas and communication with staff were sent via their own personal mobile. A staff member said they did not think this was an effective way of communication and it put additional cost on their phone bill which they did not receive any recompense for.

The registered manager could not demonstrate how they monitored and evaluated the service. There were no systems to show how they audited things like infection prevention and control or how they resolved minor concerns and call monitoring. Care plans did not always state the time of arrival or when they left the visit. Therefore there was no safe method of checking if staff were staying for the allocated time. We saw two of the care plans we looked at contained a MAR chart audit. One was completed on 5/09/2016. This only contained tick boxes confirming everything was compliant. The second audit dated 06/08/2016 stated that a Nomad system [monitored dosage] was used so staff did not need to list the medication or to use a medication administration record [MAR] to sign to say that they had administered the medication. The audit also showed staff were administering eye drops but were not recording to confirm they had been administered correctly. The action from this audit was to check again in eight weeks. This meant staff could continue to make the same errors for a long period of time without any further supervision.

The registered manager showed us some surveys that had been returned in August 2016 which asked people their views. Some comments indicated that people were not entirely happy with the service. Comments included, "Care workers attend late." "Carers are sometimes not in the correct uniform." Another respondent said, "Staff are professional and polite." There was no evidence available to confirm how the service would address the negative comments. This meant that the view of people who used the service

were not listened to and acted upon.

We looked at a number of policies and procedures including the medication policy. This was for another care agency not for Choice Local Care Ltd. It was not service specific and although written in 2013 the provider had signed to say it had been reviewed in July 2016. The fact that this was reviewed but had not realised it was not service specific meant the reviewing of policies was not effective.

Other policies such as infection control and recruitment and training and development had not been reviewed since July 2012. From looking at staff files around training it was clear that the provider was not following their own procedures. For example the policy said the moving and handling training should be delivered by a dedicated moving and handling trainer within the training and development team or purchased from an external body. The registered manager was delivering the training who did not hold a training qualification.

The above evidence has demonstrated failings which has exposed people and staff to the risk of harm, as there was no effective system operating to ensure that the registered provider was operating within expected standards of governance and having robust oversight of the service.

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