Heather Day Care Ltd

Heather Day Care

Inspection report

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Date of inspection visit:
04 October 2017

Date of publication:
10 November 2017

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

Summary of findings

Overall summary

This was an announced inspection that took place on 4 October 2017. This was the first inspection after the service registered with the Care Quality Commission in September 2016.

The service had a registered manager in place, who was also the registered provider. 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 was supported by a domiciliary care manager and a recently appointed administration manager.

Heather Day Care is registered to provide personal care to people in their own homes. At the time of the inspection the service was providing personal care support for four people. Heather Day Care also provides a day care service for older people and an educational service for people with a learning disability. These parts of the service do not provide any regulated activity and were not part of this inspection. One staff member who supported people in the domiciliary care service also worked in the day care service.

The one person and relatives we spoke with were complimentary about the support provided by Heather Day Care. They said that they felt safe being supported and found the staff were always on time and did not miss any calls. They said the staff were kind and caring.

We found that staff had not received any formal training from the service. All staff had completed a recognised course in health and social care and had undertaken training with previous employers. However this had not been refreshed since joining Heather Day Care. The service had agreed a series of distance learning courses to be undertaken by staff; however these would take a long time for the staff to complete them.

We were told that the service did not support people who required staff to administer their medicines on their behalf. However staff described how they supported two people who had used the service the service to 'pop' out of the tablets from their blister packs and assisted them to do this. This meant staff were administering people's medicines, but had not had the relevant training. Furthermore, we found safe documentation such as Medication Administration Records (MARs) had not been used to ensure medicines were accurately recorded.

Care plans were person centred and included details of the agreed support required at each visit. Risks had been identified and guidelines put in place in order to mitigate the risks. Care plans included information about people's likes, dislikes and hobbies. Staff knew people and their needs well and were able to describe to us the support each person required.

Care plans and risk assessments were reviewed every six months or earlier if people's needs changed.

Consent forms were used for people to agree to the care and support to be provided; however these had not always been signed. Where people had involvement from the local authority social services department they assessed the person's capacity to agree to their care and support.

We saw people's relatives were involved in developing and reviewing the care plans. Relatives are not able to sign consent on behalf of their loved one unless they have the legal authority to do so. We have made a recommendation to record the relevant people's agreement to the care and support being provided in people's best interests.

A system was in place to recruit suitable staff to be employed supporting vulnerable people.

Staff said they felt well supported by the domiciliary care manager and registered manager and they were approachable. Formal supervisions had been introduced in September 2017 and were due to be held every three months. The staff spoke with and met their mangers informally at the service's office on a regular basis.

A system was in place for recording and responding to complaints and accidents. We noted that due to the small nature of the service none had been received.

Staff supported people to ensure they had food and drinks available if agreed as part of the care plan. Staff explained how they would contact the person's family if they thought the person they were supporting was unwell. This meant people were supported with the nutrition and health needs.

At this inspection we found breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the management of medicines, staff training and good governance. You can see what action we have told the provider to take at the back of the full version of this 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.

Staff had administered people's medicines without the appropriate medicines training. Records of medicines administered had not been kept.

Relevant risks had been identified and guidelines were in place for the staff to mitigate these risks.

A system was in place to recruit suitable staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not completed training appropriate to their role.

Consent forms were used for people to sign that they agreed with the support to be provided. Where people did not have capacity to consent we have recommended that best practice guidelines are used to ensure a mental capacity and best interest assessment is undertaken.

Staff felt well supported by their managers. Formal supervisions had been introduced.

Is the service caring?

Good

The service was caring.

People and their relatives told us the staff were kind and caring.

People's care plans contained information about people's likes, dislikes and hobbies so the staff were able to form meaningful relationships with the people they supported.

Is the service responsive?

Good

The service was responsive.

Care plans were written in a person centred way with the

involvement of people and their relatives.

Care plans were reviewed and updated every six months.

A clear statement of the tasks to be completed at each support visit had been introduced.

Is the service well-led?

Requires Improvement

The service was not always well led.

Suitable staff training and staff administering medicines on people's behalf had not been acted upon by the registered manager or domiciliary care manager.

The service was monitored through speaking with people, their relatives and staff. No formal quality assurance audits were in place.

Staff and relatives told us the domiciliary care manager and registered manager were approachable.

Heather Day Care

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 4 October 2017. We gave the service 48 hours' notice of the inspection as Heather Day Care is a small domiciliary care service and we needed to ensure the registered manager was available to speak with us. The inspection was carried out by one inspector.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). The PIR 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. We reviewed other information that we held about the service including notifications made by the service. A notification is information about important events which the service is required to send us by law. We contacted the local authority commissioning and safeguarding teams. No concerns were raised with us about Heather Day Care.

During the inspection we observed interactions between staff and people who used the service. We spoke with one person who used the service, two relatives, the registered manager, the domiciliary care manager, the administration manager and two care staff. We looked at records relating to the service, including four care records, two staff recruitment files and daily record notes.

Requires Improvement

Is the service safe?

Our findings

The person we spoke with said they felt safe being supported by Heather Day Care staff. They told us, "We go out; I feel safe, oh yes." Relatives we spoke with were also positive about the support their loved ones received. One said, "[Name] is getting on well with their support" and another told us, "[Name] likes the staff and says she feels safe with them."

The staff members we spoke with were able to explain the potential signs of abuse or neglect and the procedures for reporting any concerns. They were confident the register manager would act on any concerns that were raised.

We saw that relevant risks for each person had been identified and guidelines completed for staff in how to mitigate these risks. These included, where appropriate, bathing, moving and handling, fire safety and the use of household chemicals. An environmental risk assessment for the property the staff were visiting was also completed which considered access to the person's home, parking, lighting and any trip hazards in the home.

This meant that potential risks were identified and mitigated for each person the service supported.

We saw medicine assessments were used to determine the support each person required with their medicines. The registered manager, domiciliary care manager and staff told us they only prompted people to take their own medicines and did not administer them on their behalf. This meant that medicine administration records were not required. However when talking to two staff members they described how for one person the service supported until two weeks prior to our inspection and another who they supported on one occasion for respite care, they directed the person to the tablets that the person needed to 'pop' out of the blister pack and assisted them to do this. This meant the staff were directing the person to identify which medicines they needed to take. Legally this constitutes administering the medicines on the person's behalf. One staff member said, "I used to pop the tablets out of the blister pack into a tub and give them to [name]." Records were not kept for which medicines had been administered. We noted that one of the above people had been assessed as being able to self-medicate. The assessment looked at whether the person understood what the medicines were for, what the effect of not taking was and what they were able to do for themselves. However the assessment had not identified what the staff actually had to do when supporting the person with their medicines.

We asked what training the staff had received for the administration of medicines. Both staff members told us they had completed medicines training in a previous job, but they had not undertaken any training with Heather Day Care to ensure that their knowledge was current.

The lack of awareness of what constituted the administration of medicines, no records of medicines administered and no staff training in medicines administration was a breach of Regulation 12(1) with reference to 2 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that accidents were recorded and reviewed by the registered manager or domiciliary care manager. There were few such incidents recorded due to the small nature of the service which meant the registered manager and the domiciliary care manager had an overview of all of the accident reports. None of the accident reports we saw involved people being supported by the domiciliary care service.

We looked at the recruitment process used by the service. We looked at two staff recruitment files and saw that they contained a completed application form which included a full employment history. If there had been any gaps in employment the application form asked for details for this period. Appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. Each file contained interview notes, two references and proof of identity. This meant that a system was in place to recruit suitable staff.

The rotas showed that staff were allocated for each planned support visit. Where staff were off, for example on annual leave, cover was organised. For example the domiciliary care manager would cover the visits or one staff member who worked in the day care service. Both of these staff members knew the people being supported and their needs. The rotas showed that travel time was allocated between visits. People told us that the staff arrived on time and stayed for the full length of their call time. This meant there were sufficient staff to support people with their assessed and agreed health and social care needs.

We saw that staff used personal protective equipment (PPE), such as vinyl gloves, when required.

Requires Improvement

Is the service effective?

Our findings

We asked about the training the staff had completed. We were shown a new nutrition and hydration distance learning booklet that the staff had recently started. The timescales for completion of the workbook was December 2017. Following this the service had established a list of distance learning courses the staff would complete, including health and safety, dignity in care, dementia awareness and safeguarding vulnerable adults. The registered manager and domiciliary care manager told us that the staff had not had any other formal training at Heather Day Care.

Staff told us, confirmed by certificates in the staff member's personnel files, that both staff had completed a nationally recognised qualification in Health and Social Care, one at level two and the other to level three. They also said that they had completed training in their previous roles; however one person had worked at Heather Day Care for three years.

This meant that the staff had not refreshed the relevant training for their role. This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the registered manager informed us that training had been arranged for staff in medicines administration, health and safety, safeguarding vulnerable adults and manual handling. We will check that this has been completed at our next inspection.

Staff told us that they had shadowed existing staff when they first joined Heather Day Care. This enabled them to get to know the people who used the service and their needs before supporting them on their own. Staff told us they were able to read the care plans and received a verbal handover of people's needs when they were going to support a new person. They were then introduced to the person by the domiciliary care manager so that they had chance to get to meet the person before undertaking their first support visit.

Staff said that they felt well supported by the registered manager and domiciliary care manager. A system of formal supervisions was being introduced by the administration manager, and the first supervisions had been completed in September 2017. There was a plan in place to complete supervisions every three months. The domiciliary care staff regularly visited the services offices and one also worked at the day care service, co-located with the office, as well as the domiciliary care service. They said that the registered manager and domiciliary care service manager were approachable and they could speak with them whenever they wanted to.

We saw that staff meetings were held for staff across the day service and domiciliary service. These had been held every six months, although the administration manager said that they were now planning to have team meetings every two months. Staff said these were open meetings where they could raise any ideas or concerns they wanted to. This meant that whilst there had not been formal supervisions until September 2017, the care staff were supported in their roles by the managers of the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in community settings are through the court of protection.

In people's care files we saw that a consent form was used to record that people agreed with the support to be provided by Heather Day. One person had signed this form as they had capacity to do so. Information was gathered during the initial assessment about people's mental health and if they had any memory issues. However we did not see a formal assessment of people's capacity to make decisions within the files.

Where people had involvement from the local authority social services department they assessed the person's capacity to agree to their care and support. One file contained information provided by the local authority requesting a service for the person. This noted that the person probably had capacity, although they had not signed the consent form for their support.

A consent form in a further file referred to the person's relative. Relatives are unable to sign consent on behalf of their loved one unless they have the legal authority to do so through a Power of Attorney. We saw that people's relatives were involved in agreeing and reviewing the care plans. It is important that people's relatives are involved in agreeing their loved ones support, but they can't legally sign their consent to the care and support. We also noted that where people had legal representatives, such as a solicitor, they had been involved in agreeing the support to be provided and the costs involved.

We recommend that best practice guidelines are followed to record relevant people's agreement for all decisions taken in people's best interest if they are unable to consent to their care and support. Any person who is assessed as not being able to consent to their care should be referred to the local authority for a formal capacity assessment.

We saw that staff supported people to make day to day choices. One person pointed to items on a list that he wanted the staff to buy on their behalf as they were not able to tell the staff what they wanted verbally.

Where there was an assessed need we saw staff supported people by preparing their meals and ensuring that they had drinks available at the end of the visits. Currently staff did not support people to attend medical appointments. Staff gave us examples of when they had contacted the person's family or GP if they thought the person was unwell.

This meant the staff supported people with their nutrition and health needs.

Good

Is the service caring?

Our findings

The person who used the service told us they looked forward to the staff visiting and they found the care staff were kind and caring. They said, "They (the staff) are very nice girls. It's always [name] or [name] and I enjoy them coming." One relative told us, "[Name] is happy with all the support."

The interactions we observed between staff and people who used the service were positive and respectful.

We saw that people's care plans contained information about people's likes, dislikes and any hobbies they enjoyed. This meant that staff had the appropriate information to build relationships with the people they supported. The care plans also contained information about people's cultural and religious needs. This meant the staff were able to provide the appropriate support where required to meet people's cultural needs.

Staff knew people's needs well and were able to describe the agreed support for each person on each visit. Staff explained how they supported people with dignity and respect. One told us, "I treat people how I'd like to be treated."

We saw comprehensive notes were made by staff for each visit. These were kept in a care file in the person's home. We were also shown notes left by relatives providing the staff with any updated information they may need , for example if the person had not been well. This meant relatives and staff were able to ensure any relevant information was shared when required.

The care plans had a section to record people's end of life wishes if applicable. At the time of our inspection the service was not supporting anyone who was at the end of their life.

People's confidential information was securely stored in locked filing cabinets at the offices.

Good

Is the service responsive?

Our findings

The provider had comprehensive documents in place for assessing people's needs and recording what support they needed and wanted. These had been purchased from a recognised company specialising in compliance management for care organisations. This meant the care planning documents would be reviewed and updated in line with current best practice by the external company.

The care files we looked at included an assessment of people's needs. It specifically asked for the views of the person and their relatives, if appropriate, about the support they wanted. The assessments we saw showed that people and their relatives were involved in agreeing the care plans and the support to be provided by Heather Day Care. One relative said, "They came out to see us at first and explained what they offered."

The care plans were written in a person centred way and included details of people's support needs, for example communication, personal care, social, eating and drinking. The plans included details of what the person was able to do themselves. Where applicable the plans noted the ongoing support provided by the person's family. This meant the staff would know what tasks they were to complete and what the person or their family would do.

In one file we saw a concise record of the tasks to be completed by staff on each visit. We also saw similar documents that were to be added to other people's files. This would mean that the staff had clear guidance of what support was required at each visit.

The files showed that the care plans were reviewed every six months with the person and their relatives. This meant that any changes in the person's needs or the tasks they wanted staff to support them with could be agreed and incorporated into the scheduled visits. One relative said, "Initially they only visited a couple of times a week, but they go every day now and we will look to increase the support again as [person's name] needs change."

The domiciliary care manager confirmed if any changes in people's need were identified in between reviews then the service would contact the person and their relatives to discuss any changes in the support required.

Where agreed we saw that staff supported people to go out, for example to the local shops. This showed the service would support people with activities or to access their local community where this had been identified in the care plans. One person told us, "I've been out this morning, just to get some fresh air."

We saw the service had a complaints policy in place, detailing how the service would respond to any complaints received. At the time of our inspection we saw that no complaints had been made.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). A domiciliary care manager was responsible for the day to day management of the service, completing the initial assessments and reviews.

The staff we spoke with said the domiciliary care manager and registered manager were approachable and supportive. They had regular contact with the domiciliary care manager and registered manager when they visited the office. One staff member also worked in the day service run by the provider, which was based at the offices. Formal supervisions had been introduced and were planned to be held every three months.

The domiciliary care manager monitored the service by talking with the staff and visiting the people who used the service. They covered for the staff when they were on annual leave and used these visits to ask people about the support they received and if they were happy with the service. Six monthly reviews were used to obtain feedback from the people who used the service and their relatives. No formal quality audits were used at the service. This meant that the domiciliary care manager had an overview of the service and people's needs, although formal audits to record this were not used due to the small nature of the service.

Relatives told us that the managers were approachable and were responsive to any requests for a change in the support required.

The service was aware that additional staff training was required, however the distance learning that had been arranged would take many months for the staff to complete; for example the first distance learning course for nutrition and hydration was scheduled to take three months for the staff to complete the workbooks. The registered manager told us they would look for short day courses to cover key areas of training that needed to be completed, for example safeguarding vulnerable adults and health and safety. The registered manager did not have a complete overview of the training staff had done in their previous roles and when this had been completed.

The registered manager and domiciliary care manager had not been aware that the support previously provided for two people to administer medicines required recording on medicine administration records and therefore the staff required appropriate medicines training. We were told by the registered manager that medicines training would be arranged before any further people were offered support with their medicines.

The registered provider had not ensured staff received training in a timely manner to meet people's needs and ensure people were assessed correctly in relation to their medicines support.

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

We saw from the minutes that formal management meetings had started in September 2017 and were

planned to be held every month. These discussed all areas of the service, for example any new referrals and staffing.

The provider had a full set of policies and procedures in place to guide members of staff.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the (CQC). Due to the nature of the service only supporting four people at the time of our inspection, no notifications had been required in the last 12 months. We discussed what incidents would need to be reported to the CQC with the registered manager.

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 12 HSCA RA Regulations 2014 Safe care and treatment The lack of awareness of what constituted the administration of medicines, no records of medicines administered and no staff training in medicines administration. Regulation 12(1) with reference to 2 (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured staff received training in a timely manner to meet people's needs and ensure people were assessed correctly in relation to their medicines support. Regulation 17 (1)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not completed the relevant training for their role. Regulation 18(2) (a)