Positive Care Link

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Inspection report

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Date of inspection visit: 19 July 2015
Date of publication: 25/08/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 19 June 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service where office staff may be out of the office providing care; we needed to be sure that someone would be in.

Positive Care Link is a domiciliary care agency that provides personal care to older people, people with mental health issues, people with ongoing health needs and those with physical disabilities. There were 15 people receiving personal care from the service at the time of our inspection.

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

We found that people were not protected from the risk of potential harm because staff could not identify different types of abuse and the manager was not aware to whom she needed to report allegations of abuse. Robust risk assessments were not in place to guide staff about how

Summary of findings

to manage risks to people. People were at risk of not living the way they chose because the manager had not embedded the principles of the Mental Capacity Act 2005 into the service.

Medicines were not well managed because staff were not given detailed guidance about how to administer them or what to do if something went wrong.

The provider could not be assured that staff were fit for work because criminal record checks were not obtained in a timely manner and staff were not supported by a robust induction programme.

People were supported to get enough to eat and drink and people had access to healthcare professionals.

Staff were compassionate and caring towards people using the service and did not rush care tasks. They took the time to talk to people and obtain consent for day-to-day tasks.

More could have been done to communicate with people who were not able to tell people about their preferences.

Communication methods and life histories were not included in care plans to tell care staff how to support the individual. People were not fully involved in their care planning although we found that the service responded to people's preferences to deliver care at different times.

People felt they could give feedback about the service, however the formal method of recording concerns was not fit for monitoring purposes. Audits and spot checks were in place to gather people's views but these did not always drive forward improvements in service delivery.

We have made one recommendation in relation to monitoring complaints.

We found six breaches of regulations relating to staffing, medicine management, safe care and treatment, safeguarding service users from abuse, person-centred care and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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?

The service was not safe. Staff could not identify different forms of abuse and were unaware of their reporting responsibilities. Risks to people's health and wellbeing were not managed appropriately.

Medicines were not managed safely.

The provider did not have a robust recruitment procedure.

The provider adequately managed the control and prevention of infection.

Inadequate

Is the service effective?

Aspects of the service were not effective. The provider had not embedded the Mental Capacity Act 2005 into the delivery of the service.

Staff did not receive an adequate induction programme.

People were supported to get enough to eat and drink and access healthcare services.

Requires improvement

Is the service caring?

The service was caring. Staff had developed caring relationships with people using the service and promoted their dignity and independence.

Good

Is the service responsive?

The service was not always responsive to people's needs. The care provided was not always tailored to the individual and there was a lack of guidance for staff about people's likes and dislikes.

The provider obtained feedback about the service but did not always manage complaints effectively.

The provider responded to people's requests.

Requires improvement

Is the service well-led?

The service was not well led in part. Monitoring systems were not always effective and did not drive forward improvements in service delivery.

Staff were able to feedback about the service during team meetings and supervision sessions.

Requires improvement

Positive Care Link

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.

The inspection took place on 19 June 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service where office staff may be out of the office providing care; we needed to be sure that someone would be in.

The inspection was conducted by an inspector and an expert by experience who had experience of using domiciliary care agency services. Before the inspection we reviewed the information we held about the service, statutory notifications received and the Provider Information Return. 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.

During the inspection we spoke with the registered manager, two care coordinators and an administrator. We looked at four people's care records, four staff files, as well as records

relating to the management of the service. After the inspection we spoke with two people who used the service, three relatives and three care staff.

Inadequate

Is the service safe?

Our findings

People told us that they were "Definitely" safe and "Happy and satisfied" with the service. A relative informed us that they, "Trust them. I can leave them to it…because I know [my family member] is safe with them."

Despite these positive comments, people were not always protected from the risk of unsafe and inappropriate care because the provider did not have systems to mitigate the risk of harm and potential abuse. Although there had not been any recent allegations of abuse, we could not be assured that staff would identify and report all safeguarding concerns in order to protect people from abuse. Some staff told us they had not received safeguarding training and were not aware of what constitutes abuse. Although the registered manager was aware she needed to inform "social services" of safeguarding concerns she was unaware of her reporting duties as stipulated in 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse'. The relevant policies and procedures did not reference this guidance nor did they include contact details of local authority safeguarding teams or the Care Quality Commission (CQC). Not all staff were aware that, if the need arose, they could blow the whistle on poor practice by reporting it to the relevant local authority and the CQC.

The issues above relate to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people who used the service were not appropriately assessed and managed to protect them from harm.

Risk assessments used by staff to manage potential risks were not fit for purpose because they did not provide guidance for staff about what steps to take to prevent the risk of harm. In addition, the provider did not effectively review the risks people faced in line with their policy.

For example, one person was identified as being at risk from falls however there was no guidance about how to support this person to minimise this from occurring. One person had a mental health condition. There was not enough information on the potential triggers that their mental health may be deteriorating and there was no associated risk assessment or care plan in place to support this person.

In another example, a risk assessment had not been updated after a person began to use a wheelchair.

In one instance care staff administered medicines when a family member was not available to do so. This was not detailed in the care plan and there was no corresponding risk assessment nor was this practice monitored by office staff. This meant the person was at risk of unsafe care though the family member reported there had been no problems to date.

The issues above relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not kept safe as the provider's recruitment procedure was not robust. We found that criminal record checks or robust interviews had not been completed for all staff. There was not a system to review existing criminal record checks in line with risk levels in order to update them if necessary. For example, one staff member's criminal check had not been renewed since 2009 and therefore the provider could not be assured that the staff member remained suitable to work with the people using the service.

A person said there were "no problems" with medicines and a family member felt this support went well and they were very grateful it had been available.

Despite these positive comments, medicines were not managed safely. Staff did not have access to clear guidance about safe management of medicines. For example, medicine names and how to prompt or administer them were not in care plans.

Medicines and their side effects were not recorded at the office. Office staff were unaware of the medicines being taken by people or their side effects meaning they could not provide prompt or accurate advice when care staff phoned the office if and when there was a problem as they were told to do.

The provider did not have protocols to guide staff about how to support people with medicines that were to be administered when needed rather than on a set schedule. Staff gave contradictory accounts about when and why this medicine was to be used.

The registered manager told us that care staff's competency was assessed by care coordinators but that this was not safe practice, "It's too medical for us and the

Inadequate

Is the service safe?

carers. The nurse is more appropriate. We can't train the carers. We assess their competency by going to the project officer but the project officer doesn't even know." These assessments were not recorded so we could not verify they had taken place or if they were fit for purpose. The provider had not implemented a plan of action to increase staff knowledge.

The issues above relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff explained how they administered medicines and made a record on the medicines administration record (MAR) appropriately. The care coordinator visited homes to check the medicine stock and the MARs, however, these were not systematically brought back to the office so we could not review them.

It was unclear whether there were enough staff deployed at the service to meet people's needs because the office did not have the appropriate systems to monitor visits, however, three relatives informed us that staff arrived promptly for calls and stayed the allotted time.

The control and prevention of infections was managed appropriately. Relatives confirmed that care staff wore gloves and aprons during personal care tasks. A supply of equipment was kept at the office for staff use.

Requires improvement

Is the service effective?

Our findings

Two people using the service and two relatives we spoke with thought that staff had the right skills to support them. A relative told us, "[The staff member] certainly seems to understand how to help [them] with standing, moving."

Despite this positive comment, we found the provider was inconsistent in ensuring staff had adequate knowledge to meet people's needs. The staff files we reviewed demonstrated that staff had regular access to support, supervision and appraisals to discuss their work. However, there was not an effective induction procedure for new staff, such as a period of shadowing more experienced staff or probation reviews. Training provided was not always fit for purpose. For example, safeguarding, Mental Capacity Act 2005, Deprivation of Liberty Safeguards and medicine administration training had not been effective in equipping staff with the skills and knowledge to carry out their roles.

The issues above relate to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were sometimes at risk of not being supported to live their lives in the way they chose. Care staff had an understanding of the basic principles of the Mental Capacity Act 2005 (MCA) and sought consent to care tasks. They did not force people to do or not do things. A person told us, "They've never stopped me doing anything". However, there was no evidence of mental capacity assessments having been carried out where there may have been reason to do so. The policy was not fit for purpose. The registered manager was unaware of her responsibilities under the MCA and associated legislation and guidance for example about making decisions in a person's best interests.

People were supported to eat and drink enough. The majority of people were assisted by relatives with their meals. Support from care staff was clearly detailed in care plans and they explained how they involved people in decisions about what they wanted to eat. Staff frequently prepared meals and provided fluids such as water and milk.

People's health needs were generally met by their relatives. There was evidence in people's care records and the communication book that the provider worked collaboratively with healthcare professionals such as district nurses and GPs. Relatives informed us that care staff fed back to them if they had concerns about someone's hygiene or health needs in order for the person to receive care from healthcare professionals in a timely manner.

Good

Is the service caring?

Our findings

Staff developed caring relationships with people using the service. People told us, "[The staff member] is great, more like one of the family really" and "[The staff member] ticks all my boxes, [they are] polite respectful, intelligent, and the best dressed carer around."

The provider ensured consistency in care by ensuring the same care staff worked with the person where possible. A person told us, "Wonderful! [The staff member] is really good. I have the same one all the time so we are used to each other." Relatives told us, "Yes we had the same carer from the beginning up until recent. Now there is another [staff member] coming, [they have] been coming to us for about two years sometime, when the other lady was away and things, now [they come] regular and we are pleased with [them]." Another said, "Yes, they try to keep the same ones coming, [my relative] likes to get to know people."

Staff reported that they were able to spend time talking with people and getting to know them, "We have a laugh and a joke." People told us that they were encouraged by staff to undertake activities that they could do for themselves to promote their independence, "[The staff member] always asks what I want if there is an option, and encourages me to go out, suggests things."

Staff respected people's privacy and dignity. Relatives told us, "Very pleasant and helpful, very respectful" and "They are pleasant to him, chatting and that but always respectful. They are careful about his dignity and make sure they dress him and things like that in the bedroom or bathroom so he has privacy."

Staff told us they took measures to ensure that personal care tasks were done in private and with as much sensitivity as possible. Staff did not rush through tasks such as bathing and worked up to an extra half an hour in the mornings to ensure that people were supported in a dignified manner. This was noted on the call logs we reviewed.

People told us they were involved in day to day care decisions. People told us, "Oh yes, I'm the boss" and "[The staff member] always asks what I want if there is an option." Staff explained that they offered people choices about things such as what they wanted to wear and different food. A relative told us that staff had developed a way to communicate with their family member who was not able to fully verbalise their views.

Requires improvement

Is the service responsive?

Our findings

Care plans were developed following an assessment of needs carried out by the local authority. People's care and support needs were not always written in care plans to ensure staff had appropriate information available to meet people's needs. For example, in one care plan it was noted that a person had a visual impairment. There was no guidance for staff about how to care for this person taking account of their visual impairment and how this may affect them. Information about people's preferences and life histories was missing in all but one of the care plans reviewed.

People were not fully involved in planning their own care. Care coordinators were responsible for reviewing care plans on a monthly basis but there was no evidence that people who used the service had been routinely invited to participate in reviewing these documents. Involvement in care planning can help some people to feel more in control of their care arrangements and it can also help staff to understand an individual's priorities.

The issues above relate to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Service delivery was changed to respond to people's requests. For example, a person told us that the provider had worked with them and social services to provide visit times that were more suited to their needs. More recently, care staff had fed back to the provider that morning visits were overrunning due to the amount of care that was required to meet people's needs. The provider was consulting with other parties about this and it had been discussed during a recent staff meeting.

The provider gave opportunities for people to feedback about the service. We noted that surveys and home visits were conducted on a regular basis by the care coordinators. People indicated that they felt able to raise concerns. A relative told us, "Oh for sure I could say, there would be no problem to phone the office and have a word with someone." The complaints system at the office was not effective for monitoring purposes as they were recorded in different places such as in the safeguarding folder or in people's files. Investigations into the issue were not always recorded to identify root causes and ensure that people's concerns were resolved.

We recommend that the service obtain support and guidance from reputable sources about implementing an effective complaints monitoring system.

Requires improvement

Is the service well-led?

Our findings

The service was not organised in a way that always promoted safe care through effective quality monitoring because the monitoring and audit systems in place were not fit for purpose. Staff performance was monitored by the care coordinators visiting people's homes while care staff were present. People told us, "They do monitor, from time to time, the carers and how things are."

One person's relative reported that staff did not stay for the allotted time or attend all scheduled calls. The provider had an electronic system to monitor the time and length of appointments, however, when we asked to see the data for four people we were told that the electronic system had not been implemented for them and no other monitoring system was used in its place. We were shown data for one other person. We reviewed the entries and found that staff were routinely over half an hour late to certain calls or no data was recorded at all meaning that they may have been missed. No investigation of these late or missed calls had been undertaken by office staff to ensure that the provider was meeting people's individual needs.

Service wide monitoring took place each year and surveys of people using the service were conducted on a regular basis. Audits such as medicines audits were carried out but were kept at people's homes so we could not check them at the time of the inspection.

However, these audits did not identify all the issues we found, such as concerns with risk assessments and care plans and there were no areas that had been identified for improvement by the management team. Accidents and incidents were not always recorded by staff in line with the provider's policy meaning they could not form a basis for service review.

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

The management of the service consisted of two full time care coordinators, an operations manager and the registered manager. People told us they would tell staff of any concerns and raise issues with the care coordinators if they needed to. They felt confident that their concerns would be listened to. A person told us, "[The care coordinator] knows I would tell [them]! When it first started and things were not good, [they] sent people we didn't like I told [them] I wanted people I like who are good at it or I will go to another service. Now [they are] like hot cakes; if I say something [they sort] it."

Internal communication systems for staff to contribute their views about the service or to provide mutual support were available. These consisted of full team meetings and office staff team meetings. Staff also reported that they spoke regularly to the care coordinators by telephone and had support and supervision sessions. However, on one occasion staff felt that their concerns to do with training had not been remedied and morale had been lowered because they were not paid for travel time or for extra work they were doing, particularly during morning shifts.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 provider did not ensure the proper and safe management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not assess all risks to the safety of service users and did not do all that was reasonably practicable to mitigate all risks. Regulation 12(2)(a) and (b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not established or operated effectively to assess, monitor and improve the quality and safety of the services provided nor did they assess and mitigate the risks relating the safety and welfare of service users. Regulation 17(2)(a) and (b)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care did not reflect people's preferences and the provider did not collaborate with people to assess their needs and preferences and did not support them to participate in making decisions relating to their care to the maximum extent possible.

This section is primarily information for the provider

Action we have told the provider to take

	Regulation 9 (3) (a)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not effectively established and operated systems and processes to prevent abuse of service users. Regulation 13 (2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured staff received appropriate training to carry out their duties. Regulation 18(2)(a)