GT Care (Wakefield) Ltd

Clark Hall

Inspection report

Unit 2
Aberford Road
Wakefield
West Yorkshire
WF1 4AL

Date of inspection visit:
27 December 2018

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07 May 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Clark Hall is registered to provide personal care for people in their own homes. When we inspected the service there were 12 people who were supported by the service, four of whom were supported with personal care. The inspection took place on 27 December 2018 and was announced. This was the first inspection of the service because the provider had previously told us there were no people supported with personal care.

There was a registered manager in post. However, the service was not well run and the registered manager did not demonstrate a clear understanding of the regulations. When we arrived at the service we found the premises empty and the registered manager told us the service had moved to a new address. The Care Quality Commission had not been notified of this. We found there were breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to regulation 12 Safe care and treatment, regulation 16 Receiving and acting on complaints, regulation 17 Good governance and regulation 18 Staffing.

There was little evidence of any robust oversight of the quality of the provision and no evidence of systems and processes in place to ensure people received appropriate care and support.

The provider was unable to provide sufficient evidence of how people were kept safe from harm. Staff understood their safeguarding responsibilities but there were limited procedures and guidance in place for staff to know or manage risks. CQC had not received statutory notifications in relation to safeguarding matters. Risk assessments were not comprehensively in place. Systems for supporting people with medicines were not clear.

The provider was unable to evidence people were supported to have maximum control and choice over their lives and staff supported them in the least restrictive way possible. Policies and systems were in place, although staff were not all aware of these. The assessment process did not provide sufficient evidence people had choice and involvement in their care and support.

There was limited evidence staff were appropriately supported. There was some evidence of staff supervision meetings but no clear system in place to ensure this was carried out robustly and with any consistency. Staff training had been completed but there was a lack of evidence of specific training where staff supported people with specific needs, such as autism. There was no evidence how the skill of staff was considered when providing care to individuals.

Staff demonstrated kind and caring attitudes towards the people they supported and their families. Staff showed awareness of people's rights and told us how they respected people's privacy and dignity.

Care records were not fully available at inspection because there was no documentation held at the registered location. The one care record made available to us contained information which was easy to

locate. However, there was not enough information in this for staff to support the person safely or effectively and information in their daily records was not up to date. Relatives and staff we spoke with expressed concerns at the lack of care documentation for individuals whose records we were unable to see. The provider sent some further examples of documents from people's care and support plans but these did not evidence sufficient information.

Complaints were not recorded appropriately or responded to. Some relatives we spoke with were not confident complaints would be managed well.

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.

You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to individuals were not always assessed or communicated to staff.

There was no robust recording or analysis of accidents and incidents.

Systems for supporting people with medicines were not always clear.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had undertaken some training, but there was no evidence this was to support people with complex needs or learning disabilities.

Staff did not always feel there was effective support for them in their role. There was no evidence the skills mix of the staff team was considered in support of people's care.

Staff understood the legislation around the mental capacity act but there was limited evidence people were supported to have maximum choice and control of their lives.

Is the service caring?

Requires Improvement

The service was not always caring.

There was a lack of regard for people's confidential information.

Staff demonstrated a kind and caring attitude to the people they worked with.

Staff understood how to respect and promote people's rights, their privacy and their dignity.

Is the service responsive?

Inadequate

The service was not responsive.

There was little evidence as to how the service responded to people's individual needs.

Care documentation was not all in place, up to date or available in people's homes and staff lacked knowledge of the content of people's care plans.

There was no record of complaints made or the registered provider's response to these.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had moved to operate from new premises and had not informed CQC of the changes prior to doing so.

The registered manager lacked awareness of their responsibility to make statutory notifications to CQC regarding specific incidents.

The service was not well run and there was a lack of robust oversight of the quality of the provision.

Clark Hall

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 checked 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 was carried out by one adult social care inspector on 27 December 2018 and was announced. We gave the service short notice of the inspection site visit because we needed to be sure someone would be available for us, to review records and speak with staff.

We reviewed information we held about the service, such as notifications, information from the local authority and the contracting team. There were 12 people using the service, four of whom were receiving personal care.

We looked at care documentation for one person as no others were made available on site. The provider sent further samples of care documentation which were considered following the inspection. We reviewed three staff files and some records relating to how the service was run. We spoke with the registered manager at the time of the visit. Following the inspection visit we spoke with nine members of staff over the telephone. We spoke with one person who used the service, one social worker and four relatives by telephone after the inspection visit.

Inadequate

Is the service safe?

Our findings

One person we spoke with told us they did not always feel safe because the staff did not reliably come on time. The registered manager told us staff were reliable in their support for people, but there were no systems in place to evidence this. Relatives we spoke with gave mixed views about whether the service was safe. Some relatives told us their family members felt safe when cared for by staff. Other relatives told us staff did not always understand the individual or complex risks to their family members. Staff we spoke with said they were not always aware of risks associated with people's care because care records were not always available in people's homes for them to refer to and information was not always communicated well.

There was some evidence in the one person's care record we reviewed, of assessment of risks to the individual. The registered manager was able to tell us how risks were mitigated but this was not always documented. For example, we saw information in the person's care record which showed they had a history of medicine overdose, yet there was no information in the care plan to show whether a continued risk had been considered or how it was being mitigated. The registered manager told us staff knew the person well and said there would be a medication care plan in the file, but was unable to find this. For other people whose care records were not available to us, we spoke with their relatives and staff about risks associated with their care. Some relatives told us their family members had particular risks and complex needs which were not documented in their home for staff to refer to. They told us they were concerned staff lacked knowledge and ability to meet their family members' needs safely. One relative said they were happy with the care of their family member and felt staff managed this in safe and informed ways.

The registered manager spoke of safeguarding referrals which had been made in respect of the person whose file we looked at. However, CQC had not received statutory notifications in relation to these. There was no other information available to us to evidence whether safeguarding referrals had been made where necessary. Further information was sent to us following the inspection which showed safeguarding referrals for the provider's services. Further information was sent to us following the inspection which showed safeguarding referrals for all of the provider's services.

We saw the safeguarding policy and procedure which gave clear information to staff about how they should identify and act on any concerns including the whistleblowing procedure to report poor practice should they find this. Staff we spoke with knew how to identify and report any concerns.

Accidents and incidents were not robustly recorded or monitored to identify any trends or patterns. The registered manager told us they looked at people's daily notes on a monthly basis to identify whether there was any cause for concern, yet there was no evidence this system was in place. The daily notes we saw had no entries for the previous eight weeks and there was no evidence of any scrutiny for information of concern. The registered manager sent us a blank accident form by email after our visit, but there was no further information sent regarding the number of accidents or incidents, any analysis of these or any indication of lessons learned.

The registered manager told us people were supported with medicines and this was through staff prompting and supervising them. The registered manager told us medicines were recorded when staff supported people, although they said this support was often carried out by people's relatives. We saw no documentation to show how people were supported in individual ways with their medicine. The provider sent some medication support plans following the inspection, but there were no individual PRN protocols or medicine administration records (MARs). Relatives we spoke with told us staff supported their family members with medicines, but said this was not always recorded. Where people needed medicines 'as required' (PRN) such as for agitation or pain, there was no information about how staff should support each person and the steps they would take to ensure the person's needs were met. Staff we spoke with gave conflicting accounts of whether they recorded medicines they supported people with. One member of staff told us they knew only through an informal conversation with a colleague, one person required medicine for use in an emergency, should they have a seizure. They said there was no written information in the person's home about this.

We saw evidence in the staff files we reviewed of observations of staff practice and competency in supporting people with medicines. Some staff we spoke with confirmed they had checks of their competence. However, some staff told us they were not always aware of people's individual needs and what medication they needed. For example, one member of staff told us it was only through conversation with a colleague they became aware of one person's significant medication need for which staff required specialist training, but there was no supporting information for staff to understand the risks.

This evidence demonstrates a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Staff we spoke with were aware of when it was important to use personal protective equipment and understood how to minimise the risk of infection.

At the inspection visit we were unable to review staffing levels because there were no staff rotas on site and it was not clear how many people were being provided with personal care. Following our visit we asked the registered manager to send us some rotas by email so we could see how people were supported. The registered manager emailed this to us with further information about staff deployed to support people. The registered manager told us they did not have a system for checking whether staff turned up to support people or how long they stayed at each visit. There was no information available for us to see what the dependency needs were of other people supported by the service, to know how vulnerable they were in the event staff did not arrive on time. Following the inspection, the provider sent us one example of a person's pen picture which showed their family would support in the event staff did not arrive.

Some relatives told us staff deployment was based around the needs of the service and the staff available, rather than the needs of individuals. Some relatives told us the service was not reliable; they asked the provider for staff rotas in advance so they could be sure of who was coming to support their family members, but these were not provided.

This evidence demonstrates a breach of Regulation 18(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We saw staff recruitment files brought to the location. We found these contained references and DBS checks to show staff had been recruited robustly. Staff we spoke with said there were enough of them to provide support to the people in the service.

Requires Improvement

Is the service effective?

Our findings

We saw information in the person's file, of an assessment of their needs. The registered manager told us staff were consistent in attendance to the person and they made sure they had the right skills and abilities to support the person properly, although there was no evidence to show how the skills mix of staff was considered. However, there was no information available to us regarding other people supported with personal care.

Some relatives said they felt staff were able to support their family members with sufficient skills to meet their individual needs. One relative said, "I feel confident the staff understand where [my family member] is coming from". However, we spoke with some relatives who told us there were not consistent staff and the staff who attended lacked the skills and expertise needed to care for their family members, particularly where there were complex care needs. They said assessment and review of their family member's needs was poor and staff lacked awareness of how to provide person centred care in matters such as recognising pain or triggers for particular behaviour.

We spoke with one person who received support and they told us different care staff came to support them and there was little continuity. The provider told us different care staff were deployed due to this person requesting changes to staff who supported them. Staff we spoke with said they were not always consistently deployed to individual people and did not know far in advance who they would be supporting.

Staff files contained induction and training information and the registered manager emailed us a training document which showed the subjects staff had completed training in. The registered manager told us there were no people who had any need for staff to support with moving and handling, although staff had up to date training in this. Staff told us they completed mandatory training and some staff felt this was effective and suitable to support them in their role. However, some staff felt there was a lack of skills and confidence amongst the team when supporting people with behaviour which challenged.

Some staff who supported people with autism said they had not had sufficient training to be able to meet people's needs properly. Where staff told us they had received such training, they were not secure in their knowledge of how to support people. We spoke with relatives of people with autism and they told us staff lacked the skills to understand their family members' individual needs. The training list we were sent contained very limited information about the training staff had undertaken in particular areas, such as learning disabilities or supporting people with autistic spectrum disorders.

There was evidence in the staff files we were given of regular supervision meetings in the form of performance and progress reviews. When we spoke with staff some told us they had regular supervision and could approach the management team for advice and support. However, a number of staff told us they did not regularly see the management team and there were no competency checks of their work. Following the inspection the provider sent us examples of some staff competency checks. Some staff we spoke with could not recall having had any supervision meetings. There were no team meeting minutes for us to review. Some staff we spoke with told us they did not attend team meetings and they were not aware of any having been

arranged recently.

The provider was a breach of Regulation 18(2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Following the inspection the provider sent us information to show the registered manager had an open door policy for staff to be able to raise any matters. Newsletters were made available to staff.

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. Staff told us they always asked for people's consent when providing care for them, or worked with the person's relatives where appropriate. Staff we spoke with had an appropriate understanding of people's rights and the legislation around people's mental capacity. There was some limited information in the person's care file we saw of mental capacity considered in relation to some decisions.

The registered manager told us people were not supported with eating and drinking, only personal care and social activities.

There was evidence in the person's file we reviewed that other professionals such as their GP and social worker were involved. The registered manager told us they worked closely with the social worker to ensure communication was effective in support of the person's care. One person we spoke with told us there was effective communication between the service and their social worker.

Requires Improvement

Is the service caring?

Our findings

Some relatives we spoke with said staff who came to support their family member were very kind and caring. One relative said, "Nothing is too much trouble, I don't have any concerns about the way staff speak with [my family member]". Another relative said, "Staff are trying their best with what they've got. They have a caring enough attitude", another relative said, "On the whole they are really good, very caring. The way [staff] are comes from a genuine place" and another relative said "I can't rate the care staff highly enough." One person we spoke with told us, "Staff are alright, they are kind."

Our discussions with staff showed they understood people's rights. Staff were inclusive in their approach to meeting individual needs and acknowledged people's rights and preferences. Staff we spoke with said they were aware of how to promote people's privacy and dignity and gave examples of this. Relatives we spoke with said staff were respectful at all times when working in their home. One relative told us staff included them in discussions about how best to communicate with their family member and support their independence. However, some relatives told us staff lacked skills in communication with their family members, particularly where they were unable to easily express their needs.

The care record we looked at contained individual information about the person and the diversity of their needs. Following the inspection the provider sent us some examples of pictorial timetables and mood cards which they said were used in people's care and support plans.

The service lacked regard for confidentiality of people's personal information. When we arrived to inspect the service we saw documents containing some personal information in a skip outside. We have referred to the Information Commissioners Office (ICO). We gave these to the registered manager who then made a further check of the skip and told us there was no more discarded sensitive information. It was not possible for us to check whether care records were securely maintained or accessed by staff and people who needed to see them, because these had been removed from the registered office due to the provider changing address. Following the inspection the provider sent assurances about how documentation was securely transferred to new premises and stored.

Inadequate

Is the service responsive?

Our findings

We were only able to review one person's care record because this was the only one made available to us during the inspection. We found information was clearly set out with details of how staff should support aspects of the person's care, although where we identified a risk there was no supporting documentation for staff. There were communication sheets in the person's care record, but these were only dated up to 1 November 2018. The registered manager told us these would be at the person's house, but there was no evidence how often these were reviewed or whether they were up date.

Following the inspection the provider sent in further documentation and examples of people's care and support plans. This information was not complete or comprehensive enough to demonstrate how care was responsive to people's needs.

Some staff we spoke with said they tried to make sure they read the care plan for the person they were supporting. Staff said care plans were not always in people's homes and if they needed information they thought this would be held at the office. Some staff told us care plans were not always completed, up to date, or accessible to them. For example, some staff said they would see a person's name on the rota, but they may not have met the person and there was no information, such as care plans or risk assessments to guide staff how to provide appropriate support. Some relatives said they were not aware of a care plan and some said they had not seen any care records in their home. Some relatives said where care information was recorded this did not always accurately reflect their family member's needs or was maintained up to date. One relative told us, "The care plan took weeks and weeks and was not a shared piece of work taking into account what we know about our [family member]. We did not feel this care plan was realistic to what our [family member] needed." In contrast, one relative told us their family member's care plan was based around their needs and there was a communication book, kept up to date for them to see.

Some relatives told us there was a lack of partnership with others to ensure people's needs were met if they transferred from another care provider. Some relatives we spoke with told us the care provided was not always person centred and they did not feel the service put people's needs first. Some relatives told us they had a reliable team of staff supporting their family members, but other relatives said staff were inconsistently deployed and this was unsettling for their family members, particularly where routine and structure for individuals was crucial to their well being. One person we spoke with who received support told us different care staff came to support them and there was little continuity. They said, "They send me carers I don't like. When I tell them not to, they still send them. They don't listen to what I want. Once, they missed me out and no one came." Staff we spoke with said they were not always consistently deployed to individual people and did not know far in advance who they would be supporting.

Some relatives told us they did not feel involved as partners in their family member's care and they did not think communication was good. Relatives said they were not invited to express their views about the service or have input into their family member's care at routine reviews. Some relatives told us there was an assumption made by the management team about their family member's needs, without fully considering or listening to what the relatives had to say. Where people's needs were very complex, some relatives said

assessment and review of their family member's needs was poor and staff lacked awareness of how to provide person centred care in matters such as recognising pain or triggers for particular behaviour. In contrast, some relatives said they had established working relationships with staff to create a two way communication process in order to meet their family member's needs and they felt this was working well.

There was no complaints information available for us to look at and the registered manager told us this was at the other premises. They sent us some copies of emails from one person's social worker which alluded to a complaint, but there was no evidence sent to us of the provider's response or how the complaint had been resolved. We saw one complaint log emailed to us with a response made to the complainant. Some relatives we spoke with said they were aware of how to complain and confident their concerns would be acted upon. One relative said, "Any issues we have had have been dealt with" and another relative said, "I feel I can contact them any time of day or night and I am never made to feel I'm wasting their time. As soon as I've made them aware of any issues they've dealt with it." However, in contrast, some relatives said they were not at all confident any concerns raised were dealt with or taken seriously and they did not feel comfortable discussing matters with the management team. One person we spoke with told us, "I tell them if I'm not happy. But they don't do anything."

The provider was in breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Complaints.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post. They told us they spent their time between two of the provider's services. The service was not operating from the registered location at the time of the inspection because the provider was in the process of moving to new premises. However, until we announced the inspection the commission had not been informed of this move. The provider told us they had not understood the regulations in relation to moving premises. We are exploring this outside of the inspection process.

We arrived at the location and found this to be an empty premises with no evidence of the service being run from here. We saw a skip outside with various discarded items including office furniture and some documentation.

The registered manager brought some documentation for us to look at which related to one of the people who received personal care from the service. When we announced the inspection by telephone the registered provider told us there was only one person who received personal care. At the inspection we discussed this further with the registered manager, they still told us there was only one person who received personal care. However, when we questioned this further we were told more people received personal care. We asked for further care documentation to be sent to us should there be other people receiving personal care, but this was not sent.

Records were incomplete. We saw the documentation brought to us to review, but there was no comprehensive documentation relating to all people's care or how the service was run because it had been removed to the proposed new location. We requested the registered manager sent us some information by email relating to complaints, staff rotas, list of people supported and any other care documentation they felt demonstrated how people's needs were met. They told us all documentation had been emptied from this location due to needing to maintain confidentiality. They acknowledged sensitive information should not have been in the skip. The registered manager was unable to demonstrate any mechanism for checking the content of care documentation regularly to monitor the quality of the care provided.

We found contrasting views from relatives about how the service was run. Some relatives told us they thought the service was run well and there was an approachable staff and management team. One relative said, "I know they have other people they support but I always feel they are only there for [my family member] they give their full support." However, other relatives expressed significant concern about poor management of the service and a lack of quality where the service said they specialised, such as learning disabilities. Some relatives we spoke with said they felt they themselves were driving the quality of care for their family members, through instigating discussions with staff and giving critical information and guidance.

The registered manager told us surveys were sent out to people and relatives to obtain their views. There were no records of these. We asked the registered manager to send these by email following our visit, they sent us a blank survey form but no details of the information gathered.

Staff we spoke with told us communication with the management team was not always effective and where they raised issues they did not always see results. For example, staff said when they had discussed concerns about the late availability of the rotas nothing had been done about this. Staff consistently told us their rotas were made available with only two days notice and sometimes less than that. Staff said this meant they had little time to plan their own time and achieve a work life balance. Only one member of staff we spoke was aware there was an inspection taking place, but the majority of staff said they had not been informed.

Staff we spoke with said the on-call system was reliable if they needed to contact the management team. Some staff said they felt supported to do their work, but other staff told us there was little support. Some staff said they had not often seen the registered provider or the registered manager whilst they carried out their work. Some staff told us there was a lack of information available to them which meant they did not always feel they provided safe and well managed care.

We saw policies and procedures were in place and the registered manager told us these related to all of the provider's services. These were up to date and had been reviewed in December 2018. Not all staff we spoke with said they knew about the policies and procedures for the service.

There was no evidence from the information we looked at, of any robust oversight of people's care. For example, the care plan we reviewed had no evidence of management review. There were no robust audits of the quality of the service and the registered manager did not demonstrate how the service was monitored to ensure people received appropriate care and support. The registered manager showed us a medicines audit but we saw this was dated August 2018 and there was no evidence of any further audit since then in the person's file. Following the inspection the provider sent us more recent medicine audits, although this did not provide sufficient evidence of robust oversight. There was no information to show how matters which should have been reported to CQC had been done and the registered manager lacked understanding of their responsibilities in this regard.

This evidence demonstrates a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. This also evidences a breach of the Care Quality Commission (Registration) Regulations 2009 Regulation 18, Notification of other incidents.

The registered manager agreed systems and processes for assessing the quality of the provision could be made more robust and said they were in the process of refining roles and responsibilities.

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 Risks to people were not always assessed or communicated to staff. Accidents and incidents were not assessed or monitored.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no record of complaints or the registered provider's response to these.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was no evidence staff had training in specific areas to support people's individual needs, such as learning disabilities.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no evidence of robust systems and processes in place to assess and monitor the quality of the provision. There was no evidence of secure storage of records.

The enforcement action we took:

We issued a warning notice to the registered provider and the registered manager.