Care Line Homecare Limited

Careline Homecare (South Tyneside)

Inspection report

Unit 3
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Ratings

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

Overall summary

The inspection took place on 14 and 24 August 2015. This was an announced inspection. This was the service's first inspection since Careline Homecare South Tyneside registered with the Care Quality Commission.

Careline Homecare South Tyneside is a large domiciliary care service, which provides support with shopping, domestic tasks and personal care to people living in their own homes.

The service did not have a registered manager. However, the person managing the service had applied to register. A registered manager is a person who has registered with

Summary of findings

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 the provider had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider did not maintain accurate records to support the safe administration of medicines. We found gaps and inaccuracies in people's medicines administration records (MARs). The registered provider also did not have systems in place to identify issues with medicines records effectively and in a timely manner. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe with the staff delivering their care. They said they received good care from trained and competent staff. One person commented, "They [staff] know what to do." Another person said staff, "Definitely know what they are doing. You can tell they are well trained in how to care properly." Other comments included: "Staff have been very good to the both of us. I cannot fault them. Lovely lasses all of them", and, "The staff are worth their weight in gold. They visit me and [my relative] four times a day. They are lovely lasses and don't half look after us. We have found them all to be very respectful and always willing to help us."

Most people we spoke with said staff were either often or occasionally late. One person commented, "Staff are not always on time and it happens every week. Mind you their appointments do not allow any time for travelling. They may have to be at another appointment the time they finish with me but it is impossible. Because of this they leave 10 minutes early so they can get to their other appointment, as they may need to help other staff on other appointments." Another person told us, "Staff have been late the odd time. For instance once a fortnight but I expect that because they have so many calls to attend and no time in between appointments." Staff rotas confirmed care staff were not allocated travelling time between calls.

Staff confirmed people were asked for permission before receiving care. They said they would always respect a person's right to refuse. Staff understood the requirements of the Mental Capacity Act 2005 (MCA). They had access to information about how to help people with making decisions.

People received support from caring staff who treated them with dignity and respect. One person said, "Mind you saying that I am more than happy with the staff who look after me. They are very polite and respectful."

People had their nutritional needs assessed when they started receiving a service. This included identifying any eating and drinking preferences they had. Staff supported people to have enough to eat and drink, through making meals for people or leaving snacks. Where people were identified as at risk of poor nutrition action had been taken to keep them safe. People had access to a range of health professionals depending on their particular needs.

Staff understood safeguarding adults and the registered provider's whistle blowing procedure. They told us they currently had no concerns but any concerns they had would be taken seriously. Staff said they were well supported in their role. The registered provider carried out recruitment checks before new staff started caring for people.

Staff described how they aimed to promote people's independence so that they retained the skills they currently had. People were given information about how to access advocacy services.

People had their needs assessed shortly after they started using the service. Care plans identified goals for people to aim towards and the support required to achieve their goals. Care records showed care plans had been reviewed to take account of people's wishes and their changing needs.

People knew how to complain if they were unhappy. They said they would contact the office if they were unhappy. However, people we spoke with were happy with care they were receiving. People had the opportunity to feedback their views about the support they received through an annual survey. Feedback from the most recent survey was mostly positive. Feedback in relation to consistency of staff was less positive.

The registered provider had systems in place to assess the quality of the care people received. This included

Summary of findings

unannounced spot checks on care practice and regular telephone reviews with people using the service. Action plans had been developed following audits to improve the care people received in the future.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. Medicines records did not support the safe administration of medicines.

Staff were not allocated travelling time between calls which meant they were sometimes late or did not stay for the allocated time.

Staff had a good understanding of safeguarding and the registered provider's whistle blowing procedure. Staff knew how to report any concerns they had.

The registered provider carried out recruitment checks before new staff started working with vulnerable adults.

Is the service effective?

Good

The service was effective. People told us the care staff were competent and knew what to do.

Staff told us they were well supported and had regular supervision. Staff were provided with the training they needed.

Staff had a good understanding of the Mental Capacity Act 2005. Care records contained strategies to help staff support people with decision making.

People were supported to have enough to eat and drink. They had regular access to health care professionals when required.

Is the service caring?

Good

The service was caring. People told us they received good care from kind staff. They also said care staff treated them with dignity and respect.

Staff understood the importance of maintaining people's independence. People were given information about how to access advocacy services.

Is the service responsive?

Good

The service was responsive. People had their needs assessed shortly after they started using the service.

Most care plans were personalised with goals identified for people to aim towards. Care plans had been reviewed to take account of people's wishes and their changing needs.

People knew how to complain if they were unhappy. People said they were happy with care they were receiving.

People had the opportunity to feedback their views through an annual survey. Action plans had been developed in response to people's feedback about consistency of staff.

Summary of findings

Is the service well-led?

The service was not always well led. The service did not have a registered manager. Staff described the person currently managing the service as approachable and supportive.

Medicines audits were not always effective or completed in a timely manner.

The registered provider had systems in place to assess the quality of the care people received, including unannounced spot checks on care practice and regular telephone reviews with people using the service.

Requires improvement

Careline Homecare (South Tyneside)

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 14 and 25 August 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. The inspection was carried out by an adult social care inspector.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, the local Healthwatch and the clinical commissioning group (CCG). We did not receive any information of concern from these organisations.

We spoke with 17 people who used the service. We also spoke with six members of care staff. We looked at a range of care records which included the care records for nine people who used the service, medication records for six people and recruitment records for four staff.

Requires improvement

Is the service safe?

Our findings

Medicines records we viewed did not support the safe management of medicines. This was because medicines were not administered in line with the provider's 'Support with medication Policy' dated July 2015. The medication policy stated, 'All support provided with medicines by a care worker must be entered on the MAR. Care workers must complete the record on each occasion and itemise each medication taken including: date; time; dosage; any exception codes; initials.' We found staff were not always following the guidance as described in the company policy.

We viewed the medicines administration records (MAR) for six people using the service. We found some of these medicines records were inaccurate and incomplete. For example, we found gaps on the MAR for all six people. This was because care staff had either not signed to confirm some medicines had been administered, or had not added a non-administration code where they hadn't been given. At the time of our inspection these issues had not been identified and investigated. Although the registered provider audited MARs, these were not done in a timely manner. For example, some of the gaps in signatures we identified were from May 2015. Where audits had been carried out these were not always effective in identifying concerns with MARs. For instance, we found gaps in the MAR for one person who had been prescribed a specific cream. The relevant medication audit stated, 'not recorded when unable to apply cream.' However, daily notes for the person confirmed that creams had been applied. In some situations care staff were recording the administration of creams on a form used for a different purpose rather than the MAR. This meant the current systems in place for the administration of medicines did not ensure people received their medicines safely.

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

People said they felt safe and they trusted the staff providing their care. One person commented, "100% safe." Another person said, "All of the staff who have visited have been reliable and I trust them. They are good staff." Another person told us, "All of the staff who I have seen I would regard as being very reliable and trust worthy. They are here to help you for which I am grateful." Another person said, "The person [staff member] who we get is very good and is as honest as the day's long."

Staff we spoke with understood the importance of safeguarding adults. They had all completed safeguarding training and knew how to raise concerns if they needed to. The registered provider had systems in place to log and investigate safeguarding concerns. We viewed the safeguarding log and found that eight concerns had been logged. These had been referred to the local authority in line with the registered provider's safeguarding procedure. Staff told us they were aware of the registered provider's whistle blowing procedure. All of the staff we spoke said they hadn't needed to use the procedure. One staff member said, "I have never needed to use it." Another staff member said, "I haven't needed to use it so far." Staff said concerns would be taken seriously and dealt with. One staff member said, "I think they would be dealt with. [Manager's name] deals with things like that good." Another staff member said they felt concerns would be, "Dealt with appropriately. The manager is really good." We saw when we entered the registered provider's offices that information about whistle blowing was displayed prominently on a notice board.

People were assessed, when they first started receiving care to help protect them from potential risks. For example, people were assessed for the risk of falling, skin damage, poor nutrition and mobility. Where risks had been identified staff had identified control measures to help keep people safe. However, we saw that some risk assessments were not always fully completed or contained very basic information about how to keep people safe. For example, one person was identified as at risk when 'standing for periods.' Staff had identified the control measures for the risk as, 'cannot stand for long periods, sits down a lot' rather than what was in place to keep the person safe when standing.

Deployment of staff was not always effective to ensure people received their care in a timely manner. We saw from viewing staff rotas that calls were planned back to back. Therefore, there was no travelling time built into the rota for the care worker to travel between calls. Although people said staff were usually reliable, 10 out of 17 people we spoke with said staff were either occasionally or regularly late for their call. People told us this was because staff were not allowed travelling time between calls. They also said some staff did not have cars to travel between appointments. One person said, "Staff are not always on time and it happens every week. Mind you their appointments do not allow any time for travelling. They

may have to be at another appointment the time they finish with me but it is impossible. Because of this they leave 10 minutes early so they can get to their other appointment, as they may need to help other staff on other appointments." Another person told us, "Staff have been late the odd time. For instance once a fortnight but I expect that because they have so many calls to attend and no time in between appointments."

We also saw from viewing rotas that staff did not always stay for the allocated time of the call. For example, we saw on one occasion the care workers had only stayed for two minutes on a 30 minute call. On another occasion they had only stayed for seven minutes. The manager said that they believed this was the person's choice and this should be recorded in their daily logs. We asked the registered provider to send us the daily logs for these calls. We saw from viewing the logs that the care staff were not always consistent with their recording in the log. For instance, staff sometimes specifically recorded that the person declined any further assistance. However, on other occasions this was not made clear.

People told us they don't always receive prior notice that the care worker was going to be late. One person said, "They tell me when they arrive why they are late, but it would be nice if they could ring me to let me know they are running late. I wouldn't mind that." Another person commented, "I receive four visits a day and some staff do ring and let you know they will be late by 10-15 minutes, but this does not happen all the time." Another person commented, "Staff are late at least once a week and only tell you why they are late when they arrive. I don't like hanging on for a visit and would wish to be told beforehand if they are running late."

All of the staff we spoke with raised the lack of travelling time as a concern. They said people sometimes felt rushed but were understanding. One staff member said, "The only downfall is travelling time. People feel rushed. People know what it's like." Another staff member said the lack of travelling time, "Takes away time from people." Another staff member said, "[People] are getting the care they need, but not the time they need." Another staff member commented, "They [registered provider] have you so rushed. We need time on the rotas, it is not possible to get from one to another."

The provider had recruitment and selection procedures to check new staff were suitable to care for vulnerable adults. We viewed the recruitment records for five staff. We found the provider had requested and received references, including one from their most recent employment. A disclosure and barring service (DBS) check had been carried out before confirming any staff appointments. Where required risk assessments had also been completed. These checks were carried out to ensure people did not have any criminal convictions that may prevent them from working with vulnerable people.

Good

Is the service effective?

Our findings

People told us they were cared for by skilled and knowledgeable staff. One person commented, “They [staff] know what to do.” Another person said staff, “Definitely know what they are doing. You can tell they are well trained in how to care properly.”

Training records we viewed confirmed staff had completed the training they needed to help them fulfil their caring role. This included nutrition, moving and assisting, infection control, medication and food hygiene. Staff had also completed specific training to support people with particular health conditions, such as diabetes and continence care. One staff member said, “We get training quite a lot.”

Staff said they were well supported to carry out their role. One staff member said, “I can talk to them [management] and they do help. We get supervision quite a lot.” Another staff member said, “I have just had my appraisal.” Records we viewed showed staff had regular supervision and appraisal.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their ‘best interests.’ During the initial assessment staff assessed whether people had any difficulty with making decisions. Where people lacked capacity to make decisions care records identified how staff should support people to ensure decisions were made in their best interests. Staff we spoke with were able to tell us when MCA applied to a person receiving a care service. One staff member commented they had completed, “Training last week.”

We found people’s communication needs had been assessed so that staff could support people to make decisions about their care. This included details of the most effective strategies to support each person. For example, one person needed to be given time to think before responding. Another person needed care workers to speak clearly whilst giving good eye contact. Another person used a memory board to help with remembering and making choices.

Staff said they always asked people for permission before delivering care. They also said they would respect the person’s decision and their right to refuse. One staff member said they would always, “Ask them [person using the service]. They went on to say that if the person refused they would, “Encourage them. If they declined I have to respect their wishes.” Another staff member said, “I would explain I was here to help”, and, “We have to respect the person’s right.” Staff said they would report any refusals to the office.

People were supported to help ensure they had enough to eat and drink. We found that a nutritional assessment had been completed shortly after people starting using the service. This identified whether a person was at risk of poor nutrition. The assessment also provided guidance for staff about people’s preferences and whether they needed assistance with eating and drinking. Staff told us they supported people with eating and drinking through making meals for them and leaving snacks out during the day. Where one person had been assessed as being at risk of poor nutrition, a referral had been made to a dietitian for additional support and advice. A speech and language therapist had assessed another person as they had difficulty with swallowing.

People had access to other health care professionals when required. This included GP’s and community nurses. For example, care records we viewed for one person showed regular contact with the district nurse.

Good

Is the service caring?

Our findings

People told us they received care from kind, caring and considerate staff. One person said, "Staff have been very good to the both of us. I cannot fault them. Lovely lasses all of them." Another person said, "They visit me twice a day and I look forward to seeing them. They have all been lovely to me and [my relative]." Another person commented, "The staff are worth their weight in gold. They visit me and [my relative] four times a day. They are lovely lasses and don't half look after us. We have found them all to be very respectful and always willing to help us."

People said staff treated them with dignity and respect. One person said, "Mind you saying that I am more than happy with the staff who look after me. They are very polite and respectful." Another person commented they looked forward to their visit from the care staff. They said, "I love the visits. We chat, have a good laugh." From our discussions with staff it was evident they clearly understood the importance of treating people with dignity and respect. They gave us examples of how they delivered care in a dignified and respectful way. This included offering plenty of reassurance to the person, keeping people covered up whilst delivering personal care, respecting people's decisions and explaining what was happening at all times.

People we spoke with confirmed they were in control of their own care. They emphasised how they were enabled to make their own decisions. One person said, "I make the decisions." Another person said, "[Staff] always ask is there anything they can do for us." One staff member said they. "Always ask what they [people using the service] would like."

Staff told us they promoted people's independence as much as possible so that they didn't lose the skills they had. They said if people were able to do things for themselves they would assist them to complete tasks rather than do things for them. One staff member said, "If people can do things, I encourage them to do the things they are still capable of doing." Another staff member said, "If I know people are capable of doing things, I keep encouraging them."

People told us about the positive relationships they had developed with the staff providing their care. One person said, "[Staff member's name] is fantastic and we treat her as one of the family. All our family know of [staff member] and they all say how lovely she is." Another person told us, "They come twice a week to shower me and the three lasses who I see are lovely. They are all little treasures; I do not know where I would be without them." Another person commented, "Mind you my permanent carer, I would trust her with my life. She is excellent and I really like her. She is really good and I look forward in seeing her when she visits."

Care records provided staff with information about strategies to support people's mental wellbeing. For example, triggers to look out for and strategies for staff to deploy when people were experiencing low mood. Suggested strategies included offering re-assurance, distraction and making time to sit and chat about topics of interest to the person.

Each person using the service was given a copy of the service user guide, 'Your Care Service.' We viewed the guide and found it contained information about the role and purpose of an advocate. The guide also included details for people about to get more information and how to contact an advocate.

Good

Is the service responsive?

Our findings

Shortly after starting to receive a service from the registered provider, staff gathered information about people's preferences. This included people's likes and dislikes and preferred dates and times for their calls. For example, one person preferred a full body wash rather than a shower. They also stated they preferred juice but also wanted to be offered the choice of a hot drink. We saw a brief 'Life History' called 'Me and my life' had been completed for each person. This gave details of important people and events in each person's life. We found people's needs had been assessed shortly after they started to receive the service. This meant staff had access to information to help them better understand the needs of the people they supported.

This information, including the initial assessment, was used to develop people's care plans. People we spoke with were aware of their care plans. One person told us they had a, "Book which they [staff] write in." Most care plans we viewed were person-centred with sufficient information recorded to help staff understand how people wanted their care delivered. However, this was not always consistent. For example, one care plan we viewed contained lots of details about people's preferences for each call to help staff provide consistent care. However, another care plan for a person with complex needs was more task focused with little personalised information recorded. The manager said they would use a good example of a care plan we viewed as a 'model care plan' to improve the overall quality of care planning.

Care plans identified specific goals for people to aim towards, including details of the support needed to achieve the goal. For instance, the goal for one person was 'To have a tidy home and clean bedding. This was to be achieved through care staff providing support on a particular day each week to ensure these tasks were completed.' The registered provider assessed during service reviews whether the goals had been achieved. For example, the registered provider had determined that the goal for one person had not been achieved. This was because staff had not completed tasks in line with the person's expectations. We saw that action was taken to raise awareness with staff to ensure this improved in future. Care plans were reviewed at least annually and whenever a person's needs changed. 'Care amendment forms' had been completed when care plans needed to be changed, such as following requests from people using the service or care reviews. For example, one person wanted their morning call at an earlier time. Another person had requested care staff help them with additional tasks. This showed the registered provider was keen to respond to people's views and their changing needs.

People did not raise any concerns with us about the care they received. One person said their care was, "Very good, I have no concerns." Another person said they were, "Really satisfied." People said they knew how to complain. One person said if they had any concerns they, "Would ring up Careline." Another person said they had occasionally needed to ring up Careline. They said they had, "Always been helpful and polite."

People had the opportunity to give their views about their care service through an annual survey. We viewed the findings from the most recent survey from May 2015. We found that 85 out of 237 people had replied and given mostly positive feedback about the care they received. For example, 100% of people had stated staff either 'always' or 'usually' uphold their dignity, 100% said staff 'always' or 'usually' treat them with courtesy and respect and 86% of people said they were 'very satisfied' or 'satisfied' with the overall service. However, there were some areas such as staffing where responses were less positive. For instance, 36% of people said there were 'too many' different care workers and 35% said they were only 'sometimes' told if their care worker was running late. We saw that an action plan had been developed following the survey to address these areas.

Requires improvement

Is the service well-led?

Our findings

The service did not have a registered manager. The person in day to day management of the service had recently applied to the Care Quality Commission to become the registered manager. This application is currently being considered. Staff we spoke with described the manager as approachable. One staff member said, "I can ring up and go and see them [the manager]." Another staff member commented, "If I have any problems I speak with the manager." Staff told us they had opportunities to give their views through attending team meetings. However, staff we spoke with said they had raised the issue of travelling time with management but nothing changes. We discussed this issue with the manager who told us they would review the situation regarding travelling time.

The systems used to monitor quality of the administration of medicines were ineffective and did support the safe management of medicines. This was due to the provider not having effective and timely checks in place to monitor the quality of medicines records and ensure action was taken to deal with concerns identified. We saw evidence that some ad hoc unannounced MAR spot checks were done. The records we viewed showed these had identified concerns with inconsistent and incomplete MARs. Action taken following the spot check included speaking with the relevant care worker. However, the systems currently in place were insufficient to promote continuous sustained improvement in medicines records. The manager took action during our inspection to develop a more in-depth medicines audit. However, we were unable to fully assess the long term effectiveness of the audit as it had not yet been implemented.

The registered provider carried out other unannounced spot checks to assess the quality of care worker's practice. These checks looked at areas of care practice, such as whether the care worker was on time, stayed for the allocated time, communication between care workers and people and treating people with dignity. We viewed records from previous spot-checks. We found there had been no concerns identified or actions required. Regular telephone service quality checks had been carried out with people. We saw from previous records that people were usually happy with their care and support.

The registered provider monitored the number of missed visits. We viewed records from January 2015 which showed there had been 21 missed visits recorded. Nine of these missed calls involved missed medicines. We found the record wasn't always completed fully. For example, the outcome of the investigation was usually not documented. We saw the registered provider had taken action to try and reduce the number of missed calls. For example, additional supervision for staff and in some cases disciplinary procedures had been started.

Information gathered from a range of sources was used to develop the service and used as a learning opportunity for staff. For example, we were provided with material from the quality team to be used locally to improve the care people received. This included good practice guidance about effective record keeping, nutrition and medicines. Events such as incidents and accidents were placed onto an online reporting system. The system incorporated checks to ensure appropriate action was taken in response to an incident. For example, regional managers were alerted to incidents. Incidents were then escalated to a 'Quality Governance Group' and the Board for further scrutiny. We found that action plans had been developed to improve the quality of care delivered. Actions identified included additional medicines training for staff, raising staff awareness and additional quality checks.

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 People who use services and others were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems operated by the registered provider did not support the safe management of medicines. Regulation 12 (2) (g).