Ms Lorraine Telford

121 Care

Inspection report

Unit 1 Former Wyndham Street Surgery
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Tel: 01946815706

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Ratings

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

Overall summary

This was an announced inspection which took place on 14th October 2015. This was the first inspection since the service was registered on 17th September 2014.

121 Care deliver personal care support to people in their own homes. At the time of the inspection they were delivering care to approximately 60 people. They operate in the Copeland area of Cumbria.

The registered provider is also the registered manager. 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 discovered that two incidents which may have been safeguarding matters had not been reported to the local authority or to the Care Quality Commission.

This meant that the service was in breach of Regulation 13: Safeguarding service users from abuse and improper treatment, because the provider had failed to notify relevant agencies of potentially harmful incidents.

Summary of findings

The service had suitable numbers of staff to deliver the care hours however we recommended that the provider keeps the rostering of these staff under review to ensure that care delivery was logical and timely.

New staff were being recruited appropriately but some staff did not stay in the service for more than a few weeks. People in the service were unhappy about staff turnover. We asked the provider to look into her recruitment and retention processes.

We saw that there had been some problems in the way medicines were being managed. These matters had been dealt with by the provider to prevent a re-occurrence.

Suitable infection control systems were in place but we had evidence to show that some staff did not use disposable aprons. We asked the provider to deal with this to prevent cross infection.

Some staff were helping people to move using equipment and they had not received training. When we visited there was no one trained to assess staff competence in this or to develop moving and handling plans.

This is a breach of Regulation 12 (2) because some moving and handling was not being done correctly in the service.

We saw that supervision and staff development needed to be improved. Staff needed more support to improve their skills and knowledge.

This is a breach of Regulation18 (1) (2), because staff needed more support to develop in their role.

People told us that the staff team were kind and caring and supported them to receive dignified care.

We found that some packages of care were inadequately assessed and that care planning lacked detail. These care packages were for people with complex needs.

This is a breach of Regulation 9: Person-centred care, because assessment of need and planning for care delivery were incomplete or lacked detail.

We looked at complaints management and we found that although there was a suitable complaints process some complaints had not been handled appropriately.

This is a breach of Regulation 16, because two complaints had not been dealt with appropriately.

We found that there had been some problems with communication between the local hospital and the service. We asked the provider to improve this and to gain more information about assessed needs.

The service had a registered provider who managed the service. She was suitably qualified and experienced to run a domiciliary care agency.

The provider had failed to notify us of two incidents of concern.

This is a breach of the registration regulations and this matter is being dealt with outside the inspection process.

The service did not have a functioning quality monitoring system. Records did not always reflect the way the service was operating.

This is a breach of Regulation 17: Good Governance, because quality of the service had not been consistently monitored. Records management was not appropriate to support good governance.

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

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin

Summary of findings

the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 always safe.

Staff understood safeguarding but we had evidence to show that a safeguarding matter had not been reported appropriately.

Staffing levels were suitable but there had been some turnover of new staff.

There had been some issues with medicines management which the provider had worked on.

Requires improvement

Is the service effective?
The service was not always effective.

Although there was a training programme some staff had not received appropriate training in moving and handling.

Supervision was in place but had not been done as regularly as needed to ensure staff were working effectively and were being appropriately developed.

Inadequate

Is the service caring?
The service was caring.

People we spoke to all said that the staff team were caring and respectful.

Where possible people were encouraged to stay as independent as possible.

Staff worked with people at the end of life but some more formal training was needed.

Good

Is the service responsive?
The service was not always responsive.

Assessment and care planning for people with complex needs were not as detailed as they needed to be.

Complaints were not always dealt with appropriately.

Inadequate

Is the service well-led?
The service was not always well led.

The service had a suitably qualified and experienced provider manager.

Incidents of concern had not been reported to the Care Quality Commission.

The quality monitoring system was not operating well enough to identify problems with the delivery of care.

Records management in the service did not allow for easy access to information.

Inadequate

121 Care

Detailed findings

Background to this inspection

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

This inspection took place on 14th October 2015 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office.

The inspection was carried out by the lead adult social care inspector.

Before the inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law.

We also asked the local social work team and local health care providers for information about the service. We had contact with staff from health and the local authority who purchase care on behalf of people. We planned the inspection using this information.

At the time of the inspection the service provided care and support to approximately sixty people. We spoke to eight people who used the service by telephone. We also spoke with four relatives of some of these people. We had contact with a relative of a former service user before we visited the service.

We looked at ten care records when we visited the office. We only had sight of four sets of daily notes in the office but we had a copy of daily notes sent to us by a relative prior to the visit.

We looked at eight staff files and spoke to six members of staff. The files included information about the recruitment, induction and supervision of staff.

We looked at some questionnaires that had been returned to the service. We looked at some of the policies and procedures. We selected some rosters and checked these against time sheets. We also looked at the way travelling between service users was programmed.

Requires improvement

Is the service safe?

Our findings

We spoke to people who used the service. A number of people told us that they felt there was a high turnover of staff or that there were not enough staff. "The girls are often in a rush to get to the next person...I think they are overworked." Another person said: "The same girls are out all day and they look tired." People told us that they did feel safe with the staff and that they were "decent people."

We asked the provider and staff about their understanding of safeguarding. Staff had a good working knowledge of what was abusive. We had evidence to show that the staff had received recent training in understanding abuse.

The provider understood how to make notifications about safeguarding but had failed to notify us, or the local authority, of two incidents that might have been considered to be safeguarding

This meant that the service was in breach of Regulation 13: Safeguarding service users from abuse and improper treatment, because the provider had failed to notify relevant agencies of potentially harmful incidents.

The service was based in an office in Cleator Moor that had disabled access and suitable security in place. The provider had a simple emergency plan.

We looked at the rosters and time sheets, compared hours delivered and numbers of staff. We judged that at the time of our visit there were enough staff employed to deliver the care. We spoke to members of staff who told us that they thought there were enough staff. We noted that on some days staff did work very long hours. We judged that some of the programing did not give staff enough time between visits.

We spoke to the person who was responsible for programming the way the staff met all the packages of care. They showed us some changes to the rostering which were to be put in place. We saw that this dealt with some of the issues. One of the people we spoke to told us: "There has been a new rota done for my girls this week and I think it addresses some of the problems they had."

We recommend that the programming of visits is kept under review so that people continue to get appropriate care delivery in a timely manner.

We looked at some recent recruitment. We saw that two references were taken up and that all appropriate checks were made. We judged that the service protected people from harm because suitable background checks had been made. New staff did not have access to people who used services until all these checks were completed.

We saw that some new staff did not stay with the company for any length of time. In some cases this was only a matter of weeks. The provider said she was unsure why this was happening. A service user said: "I think there is something wrong with recruitment…they take on youngsters with no life experience who don't realise what the job entails…and they only stay for a few weeks." We spoke to the provider about checking on her recruitment and induction processes to ensure the that prospective employees fully understand the role.

This is a relatively new service and the provider said that they had not needed to discipline staff. We saw some recording in supervision where staff were under performing and we also saw some staff meetings where staff had been given clear guidance. The registered provider had access to human resources support if she needed to discipline any member of staff.

We had learned from the local authority that there had been three occasions when staff had not supported people appropriately with their medicines. We noted that since these incidents, which were dealt with as safeguarding matters, the provider had made changes to minimise future risks. There were specific staff rostered to administer medicines who had received training. The provider had spoken to pharmacists and to GP surgeries about peoples' medicines. She had also identified staff who were not following policies and procedures correctly. She had reviewed all of the medication management and asked for updates from social workers. Senior care staff had checked on medicines in some people's homes. There had been no further incidents of problems with medicines management.

Staff said that they had ready access to gloves and aprons. The team received basic training in infection control during induction and in mandatory training. A number of people we spoke to told us that staff did use gloves but did not always use disposable aprons. This was discussed with the provider who agreed to remind staff of the importance of using personal protective equipment to lessen the risk of cross infection.

Inadequate

Is the service effective?

Our findings

We asked people who used the service about how effective the service was. Some people were very satisfied with the service but we had more than one person who felt that moving and handling was not always done appropriately and that staff needed more in-depth training in all areas. "The new staff are lovely but they even say they haven't had the training." "I know they haven't had training as I had to tell some of the new ones." Some people did say: "The longer serving staff are very good." And "I am quite satisfied that the staff know what they are doing."

We looked at files and spoke to staff who provided care to people with complex needs. There were at least two staff who had not received moving and handling training. These staff were going out with another member of staff and undertaking this kind of support. People we spoke to were aware that staff had not received training. One person told us that they had seen an unsafe moving and handling in their home. We also learned from other people that sometimes both staff were unsure of how to deal with moving people.

The competence of staff in moving and handling people should be checked by a senior member of the team. We could find no records showing that this had been done. The service had two staff members who had previously completed a longer training course. These two members of staff had not had an update to this for approximately 3 years. This meant that these two people could not assess the competence of others, nor develop moving and handling plans because their training was out of date. During our inspection visit the provider arranged for an initial training session for staff who had not yet received moving and handling instruction.

This is a breach of regulation 12 (2), because untrained staff were dealing with moving and handling equipment and manoeuvres which might endanger them and the service users.

The service had a dedicated external trainer who delivered mandatory training. The training covered health and safety, first aid, handling medicines, dementia awareness, safeguarding and moving and handling. We looked at a number of staff files and saw that some staff who had been with the company since it started operating in 2014 had received all the training that the registered provider had assessed was needed. Training covered basic tasks for home care staff. There was no record of more specific training for the care of people with complex health care needs.

We looked at a number of staff files. No one in the service had received appraisal but the registered provider was making arrangements to do this as the service had been operating for a year. Members of the team had received one formal supervision session, some group supervision and some staff had one formal check of competency in care delivery. Staff confirmed what we saw in files but said the provider and the senior team were approachable.

We judged that some of the recording of supervision needed to be done in more depth. The records we saw did not explore competence, skills or knowledge. We looked at one record for a staff member who had encountered a difficulty. There were no supervision notes showing how the provider had supported this person other than a repeated training session.

This is a breach of Regulation 18(1) and (2), because not all team members were suitably supported to develop in their job role.

We saw that the was a daily log of communication received from service users, care workers, families, health care providers and social workers. Information was recorded and staff in the office were able to talk about issues. However we found that the way this information was stored might become problematic when the numbers of service users increased.

We spoke to the registered provider and staff team about their understanding of their responsibilities under the Mental Capacity Act 2005. The staff we spoke to understood the need to gain consent from individuals. The registered provider told us that she was careful about taking on any packages of care where there might be issues of behaviours that challenge or a need for restraint.

Some of the care packages involved simple food preparation. There had been no requests by health or adult social care to support people who had problems maintaining good nutrition. Staff said that most of the work they did meant that they heated up ready prepared meals.

We also asked staff about accessing health care support. We had received a complaint where a family felt that staff had not responded to a healthcare crisis appropriately.

Inadequate

Is the service effective?

Other people we spoke to told us that staff supported them appropriately with health care needs. Most of the staff team had attended a basic first aid course and the staff we spoke to told us that "if in doubt I would call the ambulance and I have done that once since I started this job." Some of the care packages were led by a district nurse and staff said they took guidance from them.

The office space was suitable for the work the service provided . The organisation had suitable telephone and IT systems in place. The registered provider and her deputy had an office space and there was training and meeting room in the building.

Good

Is the service caring?

Our findings

We measured this outcome by talking to people who were in receipt of services. People were happy with the approach of staff in the team. We were told that the staff were "fabulous", "wonderful, and "really good."

Relatives told us: "The staff are always cheerful and kind. [My relative] looks forward to them coming…they have a bit of a laugh and it is new faces…and a window to the outside." This person also said: "They give [my relative] time…and gives them privacy…which helps retain dignity." One person said: "[My relative] who has dementia usually has the same staff…they always make eye contact and remind them who they are which helps…" Another person said: "Very nice girls who help engage with all of us as family members…which makes things easier."

People we spoke to said they had no concerns around confidentiality and that the staff team respected their privacy and dignity. Our discussions gave us evidence to show that the staff team did involve people and their families with the care provision and were respectful of people's needs.

We also looked at some of the, as yet not analysed, questionnaires that the provider had sent out to people who used the service. These surveys showed that people did think that the staff approach was kind and caring. The respondents said that they were satisfied with the way the staff involved them in decision making in relation to their care and support needs.

We spoke to staff who were able to talk about how they supported people to maintain their privacy, dignity and independence. We spoke to staff about one person who was being encouraged and supported to be as independent as possible. This person's care plan reflected this and social workers told us they judged staff did this quite well.

We saw a number of thank you cards and letters from relatives of people who had used the service. These cards said that staff were kind and caring. Several of these were from families where the service had supported people at the end of life.

This service gave support to people who were at this stage in life. Some of these were part of a 'fast track" discharge project from the local hospital. We had evidence to show that the staff worked in a kind and caring way with people at this stage.

Inadequate

Is the service responsive?

Our findings

We asked people about their care plans and we were told: "There is a care plan but it doesn't give all the details…we have to explain to new staff." Some people with simple needs said: "The care plan is fine as far as I am concerned but I don't need a lot of help." A number of people said that the planning around moving and handling didn't give details of how to support the person.

We read care files for people who were given a range of support packages. We looked at the assessment and care planning for people who had very simple needs. The simple packages of care included basic food preparation and assistance with personal care. The plans we looked at had adequate assessments of need and the staff had correctly identified the tasks to be completed.

We looked at the more complex packages where people had moving and handling needs, full personal care needs and might be living with long term illnesses. We found that the assessment of need and risk assessments did not cover all aspects of the person's care and support. We judged that the registered provider had accepted some packages of care but had not received enough information to deliver these safely. For example one care plan did not identify the need to thicken liquids but staff told us they did this. Several care packages had inadequate care plans in place.

This is a in breach of Regulation 9 person centred care, because the assessment and planning for care and treatment was not person centred enough to meet individual needs.

The service had a complaints procedure that we were told was in every person's home. It was written in a simple, easy to follow format. The provider told us that there had been no formal complaints. We had received one complaint about the service and heard of another complaint made directly to the service. The provider told us that they had dealt with these issues but had not treated them as formal complaints despite the complainants telling us that they had made a formal complaint. We were unable to find detailed recording of meetings or in-depth records of complaint investigations. Another complaint that came to us had been investigated appropriately. Two complainants were not satisfied with the way their concerns were investigated or dealt with.

This is a breach of Regulation16: Receiving and acting on complaints, because some complaints had not been investigated thoroughly.

We looked at how the service worked with other providers. We saw in files and in the daily communication that there was on-going contact with health and social care agencies. The staff team were able to work in a multidisciplinary environment and the registered provider did not have a problem discussing issues with local GP's, social workers and other care providers. We did judge that the provider needed to work more closely with the local hospital when taking complex, 'fast track' discharges because they had not received sufficient information about a person's care needs. There was no written discharge information on any of the 'fast track' files and the agency's assessments lacked detail.

We recommend that further work is done so that there is improved communications with the local hospital before individuals are discharged to the care of the service.

Inadequate

Is the service well-led?

Our findings

People said they were satisfied with the service "for the most part". One person said: "The staff are lovely girls but the organisation leaves something to be desired." Several people said: "I can contact the office and if I need to I would speak to the provider." A number of people who use the service said that things had improved in the service. One person said: "There were quite a lot of problems to start with but we have sorted them out." Another person said: "Some of the early problems have got better because I have told them…" A number of people commented on the staff turnover, time given for travel and the management of the service.

The service had a registered provider manager who was suitable qualified and experienced in managing domiciliary care services. People we spoke to said that they were able to contact her directly and discuss any concerns. Most people found her approachable.

There were two matters of concern that we noted in records and the provider had failed to report these to the Care Quality Commission.

The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

The service did have some information about quality monitoring but did not have a bespoke system which would allow for good monitoring of the service provided. The provider said that she had appointed two people who would be monitoring quality in the future and who would also do some formal supervision. There had been no analysis of the first year of operation and no future planning available for this inspection.

People in the service told us that they had been visited by two senior carers who completed a survey with them. We saw copies of these surveys which had been recently done with approximately 80% of the people who used the services. There had been no analysis of these questionnaires. Several people said they felt restricted in what they said. One person said: "Lovely girls and I didn't like to say anything difficult directly to them. I would rather have had an anonymous questionnaire so I could have said what I wanted openly." The service had operated for over a year and this had been the first survey. We judged that the survey did not give a true picture of satisfaction levels.

We asked people if there had been any other visits from senior carers or from the provider. We had mixed responses. Some people said they had contact with seniors and with the provider. Some people said that a senior member of staff had observed staff delivering care. Other people said there had been no follow up visits and no checks on competency. There were no consistent checks on monitoring personal care delivery or manual handling for individuals.

We asked the provider about monitoring competency and her evidence was the recent records of the visits to complete the questionnaire. The staff had not visited every person. Information recorded was scant and did not show in detail how these senior staff had monitored quality.

Records in the service did not support safe delivery of care. We read care plans and asked for daily records. We were told that the only copy of the daily record was in individual's homes. We asked the provider how she monitored what staff recorded, how the care was being delivered and any issues arising. She said that she did this through the contact staff had by telephone. There were telephone records but these were not filed in each person's record.

Staff training records were in place but it was difficult to pinpoint who needed training updates. Staffing records were not always complete. Supervision notes did not give enough detail. One member of staff had found some aspects of the work very difficult. This was not recorded in the staff file.

This is a breach of Regulation 17: Good governance because quality monitoring and contemporaneous recording were not being maintained correctly.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **This meant that the service was in breach of Regulation 13: Safeguarding service users from abuse and improper treatment, because the provider had failed to notify relevant agencies of potentially harmful incidents.**

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **This is a breach of Regulation 18(1) and (2), because not all team members were suitably supported to develop in their job role.**

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **This is a in breach of Regulation 9 person centred care, because the assessment and planning for care and treatment was not person centred enough to meet individual needs.**

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **This is a breach of Regulation16: Receiving and acting on complaints, because some complaints had not been investigated thoroughly.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **This is a breach of regulation 12 (2), because untrained staff were dealing with moving and handling equipment and manoeuvres which might endanger them and the service users.**

The enforcement action we took:
We served the service with a warning notice in relation to Regulation 12 (2) because the provider had failed to ensure that persons providing care or treatment to service users had the qualifications, competence, skills or experience to do so safely.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **This is a breach of Regulation 17: Good governance because quality monitoring and contemporaneous recording were not being maintained correctly.**

The enforcement action we took:
We served the provider with a warning notice because systems or processes to assess, monitor and improve the quality and safety of services provided had not been established and operated effectively.