Care Quality Commission

Victorletticia Care Limited

# CRW Leeds

## Inspection report

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08 November 2018
20 November 2018
22 November 2018
23 November 2018
28 November 2018

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## Ratings

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

# Summary of findings

## Overall summary

We carried out an announced inspection of CRW Leeds. We carried out an announced inspection of CRW Leeds between 8 and 28 November 2018. CRW Leeds is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older people, younger adults, people with a physical disability or sensory impairment. At the time of our inspection the service was providing support to 10 people.

This was our first inspection of this service.

There was a registered manager in post. A registered manager is person who has registered with the CQC 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.

People told us they received safe care. Staff told us they had been recruited safely although documentation to support this was not always present. Staff were aware of how to safeguard adults at risk although risk assessments had not been completed to direct staff. There was not always safe processes in place for the management and administration of medicines.

Audits and checks of the service were not completed regularly. We found the checks completed were ineffective in ensuring that appropriate levels of quality and safety were maintained at the service.

Care records documenting people's needs and preference were absent. Risk assessments documenting and directing staff how to minimise the risk when supporting people were absent.

People receiving support and their relatives told us staff visited them mostly on time and stayed as long as they should. They liked the staff who supported them and told us they were usually supported by staff they knew. Although agency workers covered most of the shifts, it was usually the same agency workers that visited people.

Staff received an induction and appropriate training. However, we found some gaps in training for some staff. People receiving support and their relatives felt that staff were competent and had the knowledge and skills to meet their needs.

People mostly received appropriate support with eating, drinking and their healthcare needs. Referrals were made to community health and social care professionals to ensure that people's needs were met.

People told us staff respected their right to privacy and dignity. They told us staff took their time when providing support and encouraged them to be independent.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way; the policies and systems at the service supported this practice. Where people lacked the capacity to make decisions about their care, the service had taken appropriate action in line with the Mental Capacity Act 2005.

We saw evidence that people usually received care that reflected their needs, risks and preferences. People told us their care needs had been discussed with them in the past although staff were not always aware of changes in people's needs. Initial assessments had not been completed with people prior to support being offered.

People being supported and their relatives told us they were happy with how the service was being managed. They found the registered manager and staff approachable and helpful.

Staff felt well supported and fairly treated by the registered manager and the provider.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulation 12, Safe care and treatment and Regulation 17, Good governance.  You can see the action we told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Risk assessments were not in place.

Medicines were not managed safely.

Staff told us they were recruited in a safe way, although documentation was not always present to assess this.

Staff knew the importance of infection control.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had not always completed their training.

Information was not accessible to people who used the service.

People had not always had their needs assessed.

Staff had knowledge of the Mental Capacity Act (2005).

### Is the service caring?

**Good**

The service was caring.

People told us they felt well cared for and had their needs met.

People confirmed they were treated with respect and dignity.

People told us they had their independence promoted.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care records were not in place.

End of life care was not planned for.

Complaints were documented and acted on.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The provider had not identified failures in the service.

It was not always easy for us to acquire information from the service.

People were consulted about their views of the service.

At the time of inspection the service had a registered manager in place. The registered manager has since de-registered.

Care Quality Commission

# CRW Leeds

## 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 was 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 comprehensive inspection took place between 8 and 28 November 2018.

Inspection site visit activity started on 8 and ended on 28 November. It included visits to people in their homes on 20 and 22 November 2018 and phone calls to staff on 28 November 2018. We visited the office location on 8 and 23 November 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection was announced. We gave the service 24 hours' notice of the inspection, so that the registered manager could contact people being supported and ask if they would be willing to provide us with feedback about their support.

The inspection was carried out by three adult social care inspectors.

Before the inspection we reviewed information we held about the service including notifications we had received from the service. A notification is information about important events which the service is required to send us by law. As part of the inspection we contacted health and social care professionals who were involved with the service for their comments, including community nurses and a social worker. We also contacted the local authority contracts team.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we visited four people in their own homes who received support from the service and three relatives. We spoke with three support workers, the registered manager and the managing director.

The registered manager has since left the service. We reviewed the care records of two people who received support from the service. We looked at service records for three staff including staff recruitment, supervision and training records, policies and procedures, complaints and compliments records and audits of the service delivered and its quality and safety.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe. However, some people said different staff turned up at different times and communication was sometimes a problem. Other people and their relatives were happy with the care received.

People being supported and their relatives told us staff usually arrived on time and stayed as long as they should. One person commented, "I have no problems with that." Another told us, "They're usually on time."

Most shifts were completed by agency staff. The registered manager told us it was the same agency and staff they used. According to the rota, most staff were working 14 days in a row for long days. We spoke with the provider and registered manager about this and they said they would review the number of shifts staff worked continuously. Staff being overworked increases the risk of them being tired and making mistakes.

We looked at staffing rotas and found multiple conflicts and errors. We were given three different rotas of the same time period, all with duplication's and multiple errors. For example, we saw staff allocated to support two different people at the same time and staff's names had been written in the wrong column. We also found numerous shifts where no staff had been allocated. We mentioned this to the registered manager and provider who apologised for the mistakes and told us they would make corrections. This meant people were at increased risk of not receiving support in line with their care package as staff rotas were confused and it was not clear who was allocated to support people in receipt of care.

Staff told us they had been recruited in a safe way. However, we reviewed three staff recruitment files and found that documentation to support the recruitment process was missing. Records were not available for some staff to show they had applied for their jobs, or had been interviewed. Background checks had been completed and references sought on all staff employed at the time of inspection. We mentioned this to the registered manager and provider who agreed records of applications and interviews should have been kept. This was a failure to keep accurate recordings.

Records showed that staff had not always completed safeguarding training. However, staff we spoke with understood how to protect adults at risk of abuse and said they had received training. A safeguarding policy was available which included the different types of abuse and staff responsibilities. The contact details for the local authority's safeguarding team were also available. This showed us the provider had failed to maintain accurate safeguarding records.

These concerns are a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

No safeguarding alerts had been raised about the service in the previous 12 months and we found no evidence to say any should have been made. The registered manager informed us that if any safeguarding concerns were raised in the future, lessons learned would be shared with all staff. The service had a whistle blowing (reporting poor practice) policy in place. Staff were aware of the policy and told us they would use

it, for example if they had concerns about the conduct of another member of staff.

Staff were protected from the risks associated with environments. We found generic environmental risk assessments were in place to support staff covering lone working and verbal abuse etc. However, people were at risk of harm because identified risks were not recorded. Risk assessments provide information for staff about the nature and level of each risk and how best to support the person to reduce the risk. After the first day of inspection, we asked the registered manager and provider to produce full risk assessments for two people so we could see what they wanted to achieve when assessing risk to people. On the second day of inspection in the office, we were shown a 'risk assessment log' sheet identifying areas of risk with summarised information. These assessments did not direct staff on how to support a person and reduce risks to people. During visits with people in their own homes we found one person smoked and the fire service had supplied this person with a fire blanket to protect them from burns. This person told us staff were supposed to support with wearing the fire blanket however, they said staff did not always do this in a morning. According to the records no one smoked in the house. Another person needed to sit up to take their medicines as they were at risk of choking. The provider had failed to record this to ensure staff could support the person to remain safe.

People did not receive their medicines safely as prescribed. All staff had completed medicines training to administer medicines. However, safe and effective processes were not followed. Care records did not include appropriate guidance for staff to follow and Medicines Administration Records (MARs) for four people were not in place. One family member said they now assisted with medicines as staff were late on arrival sometimes. Another relative told us staff applied creams for a person, but no body map indicating where it should be applied or a record to say it had been applied was present. One relative told us a time critical medicine was not always administered on time, causing pain and discomfort to the person.

Staff failed to accurately record the administration of people's medicines. One person told us their MAR had been implemented a few days prior to our visit. We checked and found the records had not been completed in line with guidance. The registered manager told us they would review these practices. The provider told us they would create care records for two people for their medicines. On our second day of inspection, we viewed the new care records for medicines and found they still lacked person specific direction for staff to follow.

There was no business continuity plan in place. A business continuity plan guides staff in the event that the service experiences disruption due to flooding, adverse weather conditions, loss of amenities such as gas, electricity or water, or a shortage of staff.

These concerns are a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that accidents and incidents involving people had taken place in the previous 12 months. We reviewed the accidents and incidents documented and found appropriate documents listing minor accidents and incidents had been recorded. For example, service user shouting at staff to get out. This incident was documented and shared with the social worker so positive outcomes could be found.

People were protected from the risks associated with poor infection control. The staff we spoke with confirmed they had completed infection control training and told us they used appropriate infection control equipment, including gloves and aprons, when they supported people. Most people told us staff used appropriate equipment when supporting them.

Requires Improvement

# Is the service effective?

## Our findings

We found records relating to staff supervision were duplicated by the registered manager and provider. Supervision records for two staff were identical and signed by each staff and the registered manager. We asked the registered manager and provider about this and they told us they completed group supervisions across two dates because the issues were the same. They acknowledged they needed to be individualised and they were copied and pasted at present.

Records showed that an assessment of people's needs had not always been completed before the service began supporting them. We asked to see assessments of people's needs and these could not always be given to us. The registered manager and provider told us these had not always been completed. They went on to give us an example of one person who had a disease but staff were unaware of this when they started supporting them.

After we asked the registered manager for new care plans and risk assessments we found they contained very limited information about people's nutrition and hydration needs. The staff we spoke with were aware of people's preferences and special dietary requirements. However, we were concerned that new staff supported people without complete and accurate care records, people would be at risk of harm.

People's care files did not always included information about their medical history, medicines and any allergies. We saw some evidence people were referred to health care professionals when required. This helped ensure people's healthcare needs were met. One staff member told us, "We would tell the manager if we thought there was a problem." People told us medical attention was sought when needed. However ongoing monitoring sheets had not always been completed in full. For example, we saw a pressure sore recording tool that was not dated or reviewed despite the person being at high risk of pressure sores. This meant people could be at increased risk as monitoring sheets to identify issues had not always been completed.

These shortfalls in recording are a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

People and relatives were happy with the support provided by the service and felt staff had the skills to meet their needs. Comments included, "I have no complaints overall" and "They [staff] do what we need them to do."

Staff told us they received an induction when they joined the service and this was partially confirmed when we viewed training records. However, some people's training records indicated some training was missing. The registered manager and provider told us these staff had completed the course previously, but this was not recorded properly.

We looked at whether the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must

make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The service did not have an Accessible Information Standard policy and procedure in place. The absence of records in people's homes showed that the service was not meeting the Standard. People and their relatives did feel overall well communicated with. The registered manager told us they would create this policy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Any applications to deprive someone of their liberty in a community setting must be made through the Court of Protection.

An MCA policy was in place which included information about the principles of the MCA, capacity assessments and best interest's decisions. Where people lacked the capacity to make decisions about their care, their relatives had been involved in line with the MCA. Staff sought people's consent before providing care and gave examples of how they provided additional information when necessary to help people make decisions.

Good

# Is the service caring?

## Our findings

People and relatives told us they liked the staff who supported them. Comments included, "The staff have a very good work ethic; they know what they are doing. I am treated with dignity and respect, if they have any spare time they use it" and "Most of them are very good."

People gave mixed feedback about communication from the service. Some people told us it was good and others said they had requested changes which had not happened. People and their families also told us staff had asked them about their needs. Staff told us that communication at the service was effective. One staff member commented, "If there are any changes, we ring the office who inform all the staff who visit that person."

We saw evidence that records containing personal information were managed in line with data protection legislation. People's care documentation and staff files were stored securely at the service's office and were only accessible to authorised staff.

People and relatives told us they were encouraged to be as independent as possible. The staff we spoke with described how they supported people in a way which kept them safe but encouraged them to be independent. One staff member commented, "We ask them if they can do things for themselves, like washing when in the shower."

People told us that staff treated them with dignity and respected their right to privacy. Comments included, "They help me with showering and dressing. They're always discreet." One relative commented, "They protect their dignity." Staff gave examples of how they respected people's right to privacy and dignity, such as being discreet when they were supporting people with personal care, offering people choices, using people's preferred name and seeking their consent before providing support.

We saw evidence that people's right to confidentiality was protected. The service had a data protection policy which provided clear information about their responsibilities. People's personal information was stored securely and the staff we spoke with understood the importance of keeping people's information confidential.

At the time of inspection all people had close family members or themselves who could advocate on their behalf. As such the service did not have formal advocacy advice information to pass on. The registered manager advised they would include information about local advocacy services to the care files in people's homes, to ensure they had access to this information.

Requires Improvement

# Is the service responsive?

## Our findings

On the first day of inspection, due to the lack of care records for people, we asked the registered manager and provider to focus on two people's care records so we could see the level of care records they intended to use. On the second day of inspection, we reviewed the two care records and found contradictory statements relating to people's medicines. We also found a lack of detail and numerous typo's and grammatical errors.

Another person's medical history indicated they had epilepsy and were paraplegic, however this was not mentioned in their care records. They could also not feel pain which had led to pressure sores. There was no information about this person's lack of pain awareness documented in their care records. We reported this to the registered manager who agreed it should be in the care plan so that staff had relevant and up to date information to refer to.

These shortfalls in records were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received care that reflected their individual needs and preferences. One person commented, "I know they do their best." However, some people did not have records of care in place.

People being supported and their relatives told us staff offered them choices verbally. One person commented, "They all have a chat when they are here. They listen to what we say." Staff told us they encouraged people to make decisions when they could. One staff member commented, "[Person's name] likes to choose her own clothes."

We looked at how the provider ensured that people were protected from discrimination. The service had an equality and diversity policy which advised that the service would challenge any discrimination against people supported or staff. One relative told us, "There has never been any discrimination from staff; they are always respectful and polite." Some staff had completed equality and diversity training. One staff member gave an example of how they had supported a person in a way which ensured their religious and cultural needs were respected.

The service used paper and electronic documents to support people and staff. We noted that most information, including staff rotas, care documentation (on the second day of inspection) and policies and procedures were stored on paper copies in a locked office. The registered manager told us any concerns or changes in people's needs or risks were communicated to staff by text or email and all staff were contactable by mobile phone. However, people and their relatives told us staff were not always up to date about people's changing needs.

A complaints policy was in place which included timescales for a response and the contact details for the Local Government Ombudsman. We reviewed the record of complaints and noted that four had been received in the previous 12 months. We found evidence that they had been managed in line with the policy

and an apology offered when the service was found to be at fault. We saw evidence that lessons learned had been shared with staff to avoid similar issues in the future. People had recorded on customer satisfaction surveys that they knew how to complain.

We looked at how the service supported people at the end of their life. An end of life care policy and procedure was in place.  This provided guidance to staff and emphasised the importance of people having choices and experiencing as comfortable and pain free a death as possible. However, in the absence of care records, people's personal end of life preferences had not been documented.

Requires Improvement

# Is the service well-led?

## Our findings

At the time of our inspection the service had a registered manager in post who was responsible for the day to day operation of the service. Since the inspection took place the registered manager has left the service.

The provider did not have robust quality assurance systems in place. We looked at the checks of quality and safety completed at the service. We found the service monitored late calls, completed spot checks on staff practice and medication audits. We noted that checks of care documentation were created during our inspection as the service did not have its own care records in place prior to inspection. There was no care records audit completed as there were no care records or personalised risk assessments in place to audit. The new care plan audits created on 15 November 2018 did not specify what had been checked in the first audits carried out. For example, the section for communication, medication and mobility all said 'no changes'. This meant the registered manager and provider were unable to monitor the quality of the service and identify shortfalls. The registered manager told us in the future they aimed to have completed audits every three months but at the beginning they will do more to drive improvements. Recruitment records were not always present to evidence a safe process when recruiting new staff.

During the inspection we asked for documentation to view. This documentation did not always come to us or come in a timely manner. For example, we asked for a copy of the staff rota. We were eventually given three different copies on two different types of paperwork, all filled with errors. We also asked the provider and registered manager for information about staff. We were told all staff were located close to where people lived. We found one member of staff lived far away. This showed us the provider and registered manager were not always clear on the running of the service.

Care records and personalised risk assessments had not been completed for people who used the service at the start of the inspection. We asked the registered manager and provider to create these documents for two people. During the second day visiting the office, records still lacked important information about how to support people in a safe way.

These concerns are a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

People and relatives, we spoke with were happy with the way the service was being managed and felt that the registered manager and staff were approachable. Comments included, "I find the office staff helpful" and "When I had a problem they sorted it."

The registered manager told us that satisfaction questionnaires were issued yearly to gain feedback from people and their relatives about the care provided. We reviewed the outcome of questionnaires issued in September 2018. We noted that most people who responded were satisfied with the service. There were frequent comments mentioned around staff arriving late. This matched information we gathered from speaking with people. The people we spoke with confirmed that their views were sought about the service they received. The registered manager told us that people's views about their care were also sought during

their care reviews.

The registered manager told us staff meetings had taken place and communication with staff was also through emails and texts. We reviewed the meeting minutes from November 2018 and noted that it reminded staff of their responsibilities to complete training and keep good records. The staff we spoke with told us they received regular updates from the service about best practice and any changes in guidance. They were happy with this arrangement.

Staff told us they were happy with the management of the service and felt that people received good quality care. Comments included, "We get told when anything changes." Staff told us they felt fairly treated and well supported by the registered manager. The staff we spoke with were clear about their responsibilities and the visions of the service. One staff member told us, "We want to provide good care above all else." Staff told us their roles and responsibilities were addressed during their induction, training, spots checks and supervision sessions.

Records showed that the service worked in partnership with other agencies. These included social workers, dietician and district nurses. The registered manager told us the nutritionist trained the staff on how to use the Percutaneous Endoscopic Gastrostomy feed. This helped to ensure that people received the support they needed.

Our records showed that the registered manager had submitted statutory notifications to CQC about certain events and incidents, in line with the current regulations. A statutory notification is information about important events which the service is required to send us by law.

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<br><br>Care and treatment was not always provided in a safe way. Risks to people had not been assessed and the management of medicines was not always safe. |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes had not been established and were not operating effectively. |