

Cornerstone Care Management Ltd

Cornerstone Care

Inspection report

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Date of inspection visit:

16 October 2018

18 October 2018

Date of publication:

30 November 2018

Ratings

Overall rating for this service	Inadequate ●
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Is the service safe?	Inadequate ●
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Is the service effective?	Inadequate ●
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Is the service caring?	Requires Improvement ●
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Is the service responsive?	Inadequate ●
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Is the service well-led?	Inadequate ●
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Summary of findings

Overall summary

The inspection took place on 16 and 18 October 2018 and was announced. We gave the provider one days' notice to ensure somebody would be available in the office for the inspection visit. At the last inspection the overall rating for this service was Inadequate which means it was placed in special measures. At this inspection the overall rating for this service is 'Inadequate' and the service will remain in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It currently provides a service to three people.

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

Risk was not adequately managed to protect people from harm. They were not always safeguarded from abuse and harm. The systems in place to manage medicines were not adequate. There was little evidence of learning from when things went wrong. The systems in place to monitor staffing did not provide any assurance that people received the support they had been assessed for. Recruitment procedures were not sufficient to ensure staff were suitable to support people in their own homes.

Staff were not provided with the training and support they required to be competent to support people with complex needs. Care plans did not provide clear concise guidance for staff and were at times not available. There was limited guidance on how to support people with complex nutrition needs and staff did not

demonstrate a consistent understanding of this. Other professional's guidance was not always embedded to ensure people's health needs were met.

Complaints were not managed in line with the provider's policy. Some people with complex communication needs were not given the opportunity to give feedback on the quality of their care. The provider did not respect people's dignity and privacy.

The provider had not improved their oversight of the service provided and had not implemented the changes that they had assured us were in place. This put people at continued risk of harm to their safety and wellbeing.

When people had regular staff they developed caring relationships and those staff supported them to communicate their choices.

We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Risk assessments were not always followed to protect people from harm. Incidents were not always fully investigated and reported. Staff were not always available to provide the support that people required. Medicines were not managed to reduce the risks associated with them and the systems in place to learn from when things go wrong were not effective. Safe recruitment procedures were not always followed.

Is the service effective?

Inadequate ●

The service was not effective.

Staff were not provided with the training and support they required to be able to do their job effectively nor to meet national guidelines. Relationships with other professionals were not effective. Staff did not receive sufficient guidance to ensure people had enough to eat and drink

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

People's dignity and privacy was not always upheld. When people had regular staff they were able to develop good relationships. Staff assisted people to communicate their wishes.

Is the service responsive?

Inadequate ●

The service was not responsive.

People were not always able to pursue their interests and activities. Care plans were not person centred and contained contradictory information. Complaints were not managed in line with the providers procedures.

Is the service well-led?

Inadequate ●

The service was not well led.

The systems in place to review and improve the service were not effective or had not been implemented. The provider had not implemented the changes they told us that they would. Staff received insufficient support.

Cornerstone 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 18 October 2018 and was announced. We gave the service one days' notice of the inspection site visit because it is small and we needed to be sure that someone would be in the office, and also to check who we could visit in their home as part of the inspection. The inspection site visit was completed by two inspectors. After the site visit the two inspectors also made telephone calls to other staff and health and social care professional who worked closely with the provider.

On this occasion the provider did not send us a Provider Information Return. 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. However, we gave the provider the opportunity to tell us about the improvements they had made during the inspection.

We used a range of different methods to help us understand people's experiences. We spoke with two people who used the service and with the relative of one other person about their experience of the care that the people received.

We spoke with the registered manager and six care staff. We also received feedback from four health and social care professionals about their relationship with the provider and their opinion about the standard of care.

We reviewed care plans for three people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. We reviewed audits and quality checks for medicines management. We reviewed complaints, minutes of meetings and the results of surveys. We looked at four staff recruitment files during the site visit.

During the inspection we asked the provider to send us information about agency staff, staff training, late and missed call analysis for the past four weeks, response to additional complaints highlighted during inspection, rotas for three weeks and some employment details for one member of staff. The provider had been unable to locate or access these during the inspection visit and so we asked for all the information to be sent to us by 2.00 pm on 18 October 2018. We received the information, however it was half an hour late.

Is the service safe?

Our findings

At our last inspection we found that risk was not always managed to protect people from harm, and there was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that no improvements had been made in the areas we identified and people remained at significant risk of harm.

Staff did not have the competence, training or guidance to move people safely. One professional had recommended that one person had two carers for all moving and handling; including all care relating to showering, hoisting and personal care. The only training staff had received recently was delivered by the provider in a classroom setting rather than practical support and guidance. Staff had not been provided with an updated plan on how to move the person safely by the provider in order to reduce the risk of harm to the person. This was after errors in moving the person safely had been reported by a health professional. Staff told us that at times they had continued to move the person with one member of staff on the advice of the provider. This was not in accordance with the guidance from the healthcare professional.

Staff also did not have guidance to identify and respond to any deterioration in people's health. One person had suffered several periods of ill health and it was agreed at a meeting that the provider would ensure that staff knew what the signs were that the person was presenting when they were unwell. The provider did not meet this requirement and the care plans were not updated. Staff we spoke with did not have a clear understanding of when they would seek medical assistance. One staff member told us of their uncertainty when the person was presenting as unwell and they were unsure what action to take.

When risk assessments were in place they lacked detail and merely consisted of tick boxes with no explanation of how to manage the identified risk. Other risks had not been fully assessed; for example, one person spent all of their time sat in chair or lying down but the provider had neglected to complete a full assessment of their risk of skin damage from pressure. They had simply recorded, 'Need to watch.'

When accidents occurred, there was not always a review of them to understand the circumstances and care plans were not updated to reflect the incident. One person we spoke with told us that when they had an accident one member of staff assisted them to the floor. We asked how they got up from the floor and they told us they were lifted under their arms by the member of staff and another staff member who came to their property. When we spoke with the provider they were not aware this had happened and the report of the accident did not go into this detail. Therefore, the provider did not learn from when things went wrong because they did not fully analyse them; putting people and staff at continued risk of harm.

Medicines were not managed to ensure that staff had guidance to know when to administer them. There was limited oversight to ensure they were administered as prescribed. For example, one person was prescribed some medicines to take 'as required' or PRN. The person had a medicine's review with their GP because of concerns they were taking too many of these medicines and the impact this may have on their wellbeing. The provider confirmed this with us. When we reviewed the persons medicines administration records (MAR) we saw that they continued to take one of these medicines on a daily basis. When we asked a

member of staff about this they said, "Oh yes they take all of their medicines religiously." There was no written guidance for staff in line with those set by National Institute for Health and Care Excellence (NICE) in 'Managing medicines for people receiving social care in the community'. This meant that people had taken medicines which may not have been required.

There was limited guidance available for staff to know when to administer medicines. For example, some medicines need a gap between administration and one person having nutrition. One member of staff was not aware of this and told us that they did not leave a gap in between. Again, this was not in line with national guidance and could affect the integrity of the medicine or cause harm to the person.

Medicines records were not completed in line with national guidance and there was no record of disposal. Staff told us that the provider removed any leftover medicines from people's homes and returned them to the dispensing chemist. They had no record of this in line with NICE guidance. They had not reviewed why the medicines were not taken but informed us that there were minimal amounts. When we spoke with the dispensing chemist they told us that the previous week two carrier bags of medicines had been returned and they were able to tell us the quantities and that they had all been prescribed in the past five months. This included five bottles of one medicine. This demonstrated to us that people were not receiving their medicines as prescribed and there was no investigation into why. This put people at significant risk of harm and illness.

This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that people were not always safeguarded from the risk of abuse, and there was a breach of Regulation 13 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that no improvements had been made in the areas we identified and people remained at significant risk of harm.

People had raised concerns with us since the last inspection which had caused us to raise safeguard concerns with the local authority for five different individuals on different occasions. These included missed medicines and late and missed calls from staff which left people without the care they were assessed as needing. The provider had not reported these as safeguarding concerns to the relevant authorities. When the provider was advised to provide two staff to safely meet one person's needs when moving them there was a delay of two days before they implemented this. This put the person at increased risk of harm and the provider was not transparent about this risk. We had concerns raised about professional boundaries and some staff letting themselves into people's homes without permission. Again, this was not reported to the safeguarding authority and no investigation was carried out.

This is a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that suitable checks were not always in place when recruiting new staff to ensure they were safe to work with people and there was a breach of Regulation 19 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found limited improvements had been made and the provider did not demonstrate an understanding of their responsibilities under this regulation.

The provider had now completed police checks for all staff employed and there were identity checks in place. However, some staff had a risk assessment completed to ensure they received appropriate support

due to incidents in their personal or employment history. The risk assessments for some of them were not accurate or the control measures did not relate to the incident, or were not followed. The provider told us that the control measures they put in place was to meet with the staff on a monthly basis. We saw records which supported this. However, staff we spoke with told us that this did not happen. We also questioned the content of some people's references which were not fully completed. The provider was unable to give us a response because they had not followed up the gaps when the references were received.

This is a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found there were not always enough staff available to meet people's needs safely and there was a breach of Regulation 18(1) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found limited improvements had been made in this area, but the lack of monitoring made it difficult to evidence.

At the time of our inspection there were only three people receiving support from the organisation. They did have consistent staff provided and our concerns about staff working excessive hours without a break had been addressed for one person. However, we were told by one relative that they were concerned about the long hours their carer worked and felt the organisation asked too much of the individual. There was little oversight by the provider to ensure that staff worked the hours that the person required. Staff told us that the system the provider used for staff to log in was not reliable and some reported that they forgot to use it. One member of staff did not use it because they did not have the application on their mobile telephone. When we visited one person we saw that staff completed a form in their home which showed the times they supported the person. The person told us that they monitored this. However, when we reviewed it at the office the times on the rota were different. The provider told us that this was probably because the person had made a different arrangement directly with the staff member. Therefore, the lack of oversight meant that we were unable to evidence whether people received all of the support agreed in their care packages.

This is a continued breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood their responsibilities to protect people from infection. They described the measures they took, including using protective clothing. We saw that staff used protective equipment when supporting people.

Is the service effective?

Our findings

At our last inspection we found staff did not always receive the training and support that they needed to ensure that they met national guidelines when supporting people with complex healthcare needs. This was a breach of Regulation 18(2) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found no improvements had been made and staff were still not equipped with the skills and knowledge to provide safe care and treatment to people.

Concerns were raised with us by a healthcare professional about staff competency in moving people safely and monitoring people's wellbeing. One relative also told us they were confident in their regular carers ability but were not happy with other staff who covered their absence. They said they were not always knowledgeable or well trained and they felt no confidence in their ability to support their relative. One member of staff told us, "The training I received was poor and too basic; if I had been new to care this would not have been sufficient to perform the role. I raised this and the provider said he would organise more in-depth training but has not."

One days training was provided by the provider in the office in the month before the inspection. This covered four topics (administering medication, mental capacity, safeguarding adults, moving and handling) none of these were practical sessions. We saw that online training was not completed by four of nine staff employed by the provider. Staff told us they had received minimal training and had not received demonstrations when new equipment was introduced. The provider was unable to show us the training completed by staff on the day of inspection and we allowed them one and half days to forward it to us. In this time one staff member informed us that the provider had requested them to complete nine on line courses before the deadline we set. This demonstrated to us that the provider had not improved the quality or quantity of staff training since our last inspection.

This is a continued breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they were happy with the meals that were provided for them and we saw that a record was kept of what they ate. Another person received their nutrition through a percutaneous endoscopic gastrostomy (PEG). A PEG refers to a flexible feeding tube which is placed through the abdominal wall and into the stomach. There was limited guidance in place to ensure that they received nutrition in a safe way and in line with professional guidance. We asked staff how long the person received this nutrition for and received differing answers. Therefore, we could not be assured that this person received the quantity of nutrition prescribed as instructed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this

is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

People who used the service had capacity to consent to their care. They told us that staff always discussed their care with them and asked for their permission, demonstrating consent was sought.

The provider did work with other professionals. However, they did not always ensure that their guidance was followed. Professionals also told us that when they met the provider they received assurances but these often needed to be followed up at a later date.

Is the service caring?

Our findings

People's dignity and privacy were not always upheld. We had concerns raised with us about professional boundaries prior to the inspection visit. On the day of the inspection one person told us that the provider had entered their home unexpectedly early that morning to return their care plan without their permission. They had kept their plan for over one week. When we raised this with the provider they confirmed that they had gone to the person's home unannounced, but said that it was ok because the person was used to them popping in as they often provided their morning care. They also confirmed that they had removed all three people's care plans from their homes to work on them in the office. They did not recognise the infringement on the individual's human rights. They did not consider that the care plans belonged to the individuals and should be in their home with them.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us of the caring relationships they had with individual staff. Some people had the majority of their care provided by one member of staff. They worked closely with them to ensure the care they received met their choices. For example, one member of staff had supported one person to develop a week of activities which included seeing a friend and attending a church service. However, the person and their social worker told us that these developments had been led by the individual staff member rather than through the provider.

People were supported to communicate their wishes. One person used a communication tool and we saw that staff used it to help them to make choices. This was supported by a health professional we spoke with who said, "I do feel the care staff have done a good job with communication. They use the communication book when the assistive technology has failed; so, I would commend them all on that."

Is the service responsive?

Our findings

The provider was not always transparent about the complaints they received and did not keep an accurate record of the outcome in line with their procedure. We saw that there was a record of two complaints. When we asked about other people who had raised concerns with us the provider told us that they had the information about two further complaints on their computer but had not printed this out yet. They were unable to provide us with this on the day of the inspection visit because they cited problems with the computer system. When they did send us a record of these complaints they were scanned copies of handwritten records and not the computer copies the provider had said they were searching for. The outcome of these complaints were recorded but they were not in line with what the individuals had told us. In addition, we were aware of three further complaints made to the provider which had been shared with us that they had no record of.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection people were not always able to participate in the activities they chose or have their preferences met. At this inspection one person needed staff who could drive to take them out, however they had still not been provided with this support. The provider told us that they were the only person on the car insurance at the present time but they were organising it for other member of staff. Staff told us they had waited for several months for this to be done.

Staff were not always provided with guidance on how to support people. Prior to our inspection the provider removed the care plans from three people's homes. Two of these people received care from new agency staff and this meant they had no guidance available to check during this period of how to support people. The provider had updated one person's moving plan in line with the increase in staffing levels but this had not been shared with staff.

When care plans were available to staff the information in them was not person centred or detailed enough to inform staff about people's preferences and was very disorganised making information difficult to find. There was contradictory information; for example, saying that one person was mobile at one point and then not at another. Staff who worked closely with individuals told us they were not included in reviewing or updating care plans and it was all completed by the provider.

Some people who used the service had disabilities and sensory impairments. The provider had not complied with the Accessible Information Standard (AIS). This was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand. Information had not been shared in an accessible way for people who used the service. For example, the satisfaction survey which had been sent to other people had not been adapted for the person who used a communication system.

There was no one receiving end of life care and therefore we did not inspect against this.

Is the service well-led?

Our findings

At our last inspection we found that there were not suitable systems or processes embedded to ensure that the provider could assess, monitor and improve the quality of the services they provided. Staff did not always receive the training and support that they needed to ensure that they met national guidelines when supporting people with complex healthcare needs. This was a breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found no improvements had been made and people continued to be at significant risk of harm due to the lack of oversight by the provider.

There has been little improvement since the last inspection in the governance and oversight of the service. For example, on 9 October 2018 the provider told us, 'When we were inspected there were concerns about Nurse Buddy an electronic call monitoring system which the Local Authority had advised us to have in order to have a contract with them. We have migrated our system onto People Planner which is more robust and a lot more efficient'. On the inspection visit we found that the provider had not migrated to the new system and was still using the same system. At the inspection visit we asked them for an analysis of late and missed calls and they were unable to provide this. The provider told us that they looked at it weekly and had looked at it the day before; however, they were unable to show this to us. On 18 October 2018 they sent records of staffing logging in and out times. However, there was no overall analysis and the provider included a statement that one member of staff didn't use the electronic system and therefore wouldn't show on the information. This member of staff provided one to one care for one person six days per week and there was no oversight of times they arrived or left.

Staff and relatives told us that they arranged their own rotas. There was limited supervision or team meetings; for example, we saw a supervision record for a return to work after maternity leave for one member of staff. When we spoke with the member of staff they informed us they had not had a meeting on this date and the only contact had been a telephone call to discuss return to work dates and hourly rate.

There was no clarity about roles and responsibilities and there was confusion about which staff had a senior role. For example, one staff member's contract stated they were a senior carer. Another member of staff said there were no seniors and staff worked as a team. The provider told us two other staff were seniors. No one we spoke with was clear what the senior role entailed.

The only other audits we saw were for reviewing medicines but these did not pick up the concerns we identified. The errors and omissions we found were not in line with the provider's policy; for example, it stated that there would be a record of all disposed medicines..

This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us that the provider was not always approachable. When we spoke with one person they said, "I don't want the place to be shut down so I have to be careful what I say. The provider needs to try

harder." However, they said they were nervous to say anymore and the member of staff supporting them also stated that they didn't want to say anything in case they lost their job. Other professionals the provider worked with told us the provider did not always give clear explanations about failures to provide good care and support. We found the same because when we spoke with the provider about complaints they gave us explanations such as people were forgetful or influenced by ex-members of staff who had grudges against the company. They did not accept responsibility for the mistakes which occurred.

There was a registered manager in post who was also the provider. They had sent us some notifications for incidents that occurred so that we were able to review the action that they took in line with their registration. However, because we identified further incidents which should have been referred as safeguarding concerns we were not receiving all notifications as required.

We require all providers to display their latest CQC inspection report at the office and on their website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not met this requirement as our report was not displayed either at the office or on their website.

This is a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.
Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse
Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not always respond to complaints in line with their procedure.
Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure that fit and proper people were employed to support people.
Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider did not display their previous rating in line with CQC requirements.

Regulated activity	Regulation
Personal care	<p data-bbox="839 170 1490 208">Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p data-bbox="839 237 1430 353">The provider did not ensure that there were enough suitably qualified staff deployed to meet people's needs.</p>

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not provided with safe care and treatment

The enforcement action we took:

Urgent cancellation under S30

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient oversight of the service to provide good governance.

The enforcement action we took:

Urgent cancellation under S30