Leonard Cheshire Disability

Wiltshire Care at Home Service

Inspection report

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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?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

Leonard Cheshire - Wiltshire Care at Home Service is contracted by Wiltshire Council to provide a care at home service for people who live in Swindon, Malmesbury, Calne and surrounding areas. At the time of our inspection over 400 people were receiving personal care from the service. The service was last inspected in October 2014 and was found to be meeting all of the standards assessed.

This visit to the service took place on 1 December 2015 and phone calls were made to people who use the service on 30 November and 2 December 2015. This was an announced inspection which meant the provider knew two days before we would be visiting. This was because the location provides a home care service. We wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf.

The service did not have 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 and associated Regulations about how the service is run. The service has a condition of their registration that a registered manager must be in post. Since the last registered manager left in September 2015, the service has been managed by one of the locality managers. The manager told us she had submitted an application to CQC to be the registered manager shortly before the inspection. Records confirmed this application had been received by CQC and was being assessed.

The systems in place to manage risks related to the administration of medicines were not completed consistently. Information on how to provide support to people with their medicines was not always available. The missing and contradictory information increased the risk that staff would not provide support that people needed with their medicines or provide support to people that was unsafe.

The provider's systems for gaining and recording consent for care and treatment were not always followed by staff. This meant it was not possible to say whether some people consented to the care and treatment they were receiving, or if they did not have capacity to consent to their care that requirements of the Mental Capacity Act had been followed.

People who use the service and their relatives were positive about the care they received and praised the quality of the staff. Comments from people included, "They are very good, very caring", "Yes, they are caring. They are not rude or clumsy, they're very nice" and "They are very kind to me". A relative also expressed satisfaction with the caring way staff supported their family member, commenting, "They are definitely kind and caring. They talk to (my relative) and tell him what they are going to do".

People told us they felt safe when receiving care and were involved in developing and reviewing their care plans. Systems were in place to protect people from abuse and harm and staff knew how to use them. People said the care workers generally arrived on time, and they would receive a call to inform them if there

were any problems.

Staff understood the needs of the people they were providing care for. Staff were appropriately trained and skilled. They received a thorough induction when they started working for the service and demonstrated a good understanding of their role and responsibilities. Staff had completed training to ensure the care and support provided to people was safe and effective to meet their needs. However, the training records were not all up to date, which made it difficult for the management team to keep a track of training staff had completed and to plan future training events.

The service was responsive to people's needs and wishes. People had opportunities to provide feedback about their care and there was a complaints procedure. Although people said they would raise any concerns with staff, they were not all aware of the formal complaints procedure for Leonard Cheshire. The manager said they would look at the information they were sending out to review whether it could be provided in a clearer way.

The provider regularly assessed and monitored the quality of the service provided. Feedback from people and their relatives was encouraged and was used to make improvements to the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what 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. The systems in place to manage risks related to the administration of medicines were not completed consistently. The missing and contradictory information increased the risk that staff would not provide support that people needed with their medicines or provide support to people that was unsafe.

People who use the service said they said they felt safe when receiving care. There were sufficient staff to meet people's needs safely.

Systems were in place to ensure people were protected from abuse.

Is the service effective?

Requires Improvement

The service was not always effective. The systems for gaining and recording consent for care and treatment were not always followed by staff. This meant it was not possible to say whether some people consented to the care and treatment they were receiving, or if they did not have capacity to consent to their care that requirements of the Mental Capacity Act had been followed.

Staff had suitable skills and received training to ensure they could meet the needs of the people they cared for.

People's health needs were included in their care plans and staff supported people to stay healthy.

Is the service caring?

Good

The service was caring. People spoke positively about staff and the care they received.

Care was delivered in a way that took account of people's individual needs and in ways that maximised their independence.

Staff provided care in a way that maintained people's dignity and upheld their rights. People's privacy was protected and they were treated with respect.

Is the service responsive?

Good

The service was responsive. People were supported to make their views known about their care and support. People were involved in planning and reviewing their care.

Staff had a good understanding of how to put person-centred values into practice in their day to day work.

People were confident that they would be taken seriously if they raised any concerns or complaints about the service.

Is the service well-led?

Good

The service was well led. There was a strong leadership team who promoted the values of the service. The manager was aware of improvements that were needed and had plans in place to implement them. There were clear reporting lines from the service through to senior management level.

Quality assurance systems involved people who use the service, their representatives and staff and were used to improve the quality of the service.

Wiltshire Care at Home Service

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 visit to the service took place on 1 December 2015 and phone calls were made to people who use the service on 30 November and 2 December 2015. This was an announced inspection which meant the provider knew two days before we would be visiting. This was because the location provides a home care service. We wanted to make sure the registered manager would be available to support our inspection, or someone who could act on their behalf.

The inspection was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection, we reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider.

As part of the inspection we spoke with 13 people who use the service, three relatives, the manager, and 14 staff involved in the delivery of care to people. We looked at the records relating to care and decision making for nine people who use the service. We also looked at records about the management of the service. We received feedback from three health or social care professionals who have contact with the service.

Requires Improvement

Is the service safe?

Our findings

The systems in place to manage risks related to the administration of medicines were not completed consistently. Information on how to provide support to people with their medicines was not always available. Of the nine care records we inspected, there was missing or contradictory information relating to support for people with their medicines in seven of them. Examples included sections in the medicines care plan and risk assessment being left blank; one person had a medicines risk assessment stating they did not need any support, and a care plan that stated they did need support with medicines; another person had a care plan which stated the person was prescribed paracetamol and co-codamol to be taken 'as required', with no information about how the person communicated the need for the medicine, what support staff should provide and the dosage or frequency with which the medicine should be administered. The missing and contradictory information increased the risk that staff would not provide support that people needed with their medicines or provide support to people that was unsafe.

This was a breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the lack of information in the care records relating to medicines, people who were assisted with medicines felt confident in the support they received from staff. Staff kept a record of medicines they had supported people to take. Staff told us they had received medication training and underwent refresher training and received competency assessments. Training records we viewed confirmed this.

Other risk assessments were in place to support people to be as independent as possible, balancing protecting people with supporting them to maintain their freedom. Assessments included details of how to access the person's home, environmental risks and actions to minimise the risk of falls. The staff we spoke with demonstrated a good understanding of people's needs, and the actions they needed to take to keep people safe.

People told us they felt safe when care staff visited them. Comments included, "Yes, I feel quite safe. We have a very pleasant relationship, like a friend", "Yes I feel safe, we've had no problems" and "I'm quite happy with them". Three relatives told us they were happy with the service provided and didn't have any concerns about the safety of their family member.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. Staff were confident senior staff would listen to them and act on their concerns. Staff were aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with. The service had reported issues and worked with the safeguarding team where any concerns had been raised.

There were arrangements in place to deal with emergencies. Staff confirmed there was an on call system in place which they had used when needed. This enabled staff to receive support and guidance from senior managers in the organisation if needed. The service also had an emergency plan to deal with situations that could prevent them providing care to people, for example due to adverse weather. There was a priority list of people who used the service that were most vulnerable, because they lived alone or had time critical medicines that staff administered.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. We checked the records for four staff employed in the last year. These showed that the provider's recruitment procedures had been followed and staff were thoroughly checked before they started providing care to people.

Sufficient staff were available to support people, although staff and social care professionals raised concerns about the provider's capacity to take on new care packages. The manager told us the service had a contract with Wiltshire Council to take all referrals that are made to them. However, staffing issues had resulted in a high number of missed calls. As a result of this, the provider made a decision to default on their contract and only take on work where they were confident they were able to provide staff to meet people's needs. This resulted in a significant decrease in the number of missed calls and a service that health and social care professionals told us was safer.

People told us staff usually arrived on time and they usually knew who the staff were. Most staff said they felt there was a realistic schedule, with sufficient travel time built in so they could get to people in reasonable time. Staff said they were able to provide the care people needed.

Requires Improvement

Is the service effective?

Our findings

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 legally authorised under the MCA. For people receiving care in their own home, this is as an Order from the Court of Protection. The manager confirmed there were no Orders from the Court of Protection for anyone using the service at the time of this inspection.

The provider's systems for gaining and recording consent for care and treatment were not always followed by staff. Of the nine care records we inspected, there was missing or contradictory information regarding consent in four of them. Examples included staff signing the consent form for a person; staff completing a consent form without stating that the person was either unable to sign the record or giving details of how the person communicated that they consented to the care and treatment being planned; staff asking family members to sign consent forms on behalf of people without obtaining confirmation that the relative had the legal authority to do so. This meant it was not possible to say whether these people consented to the care and treatment they were receiving, or if they did not have capacity to consent to their care that the MCA had been followed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff understood their needs and provided the care they needed. People felt staff had the skills and knowledge needed to provide the care they needed. Comments about the skills of staff included, "They are very good", "They are very knowledgeable" and "They seem well trained".

Staff said they received regular training to give them the skills and knowledge to meet people's needs. New staff completed an induction and there was an on-going training programme for all staff on meeting people's specific needs. The manager told us they had experienced problems with the system to record the training staff had completed and when further training was required. This meant it was not possible to say what training all staff had completed and when their next refresher training was required. As a result, the manager had started to record all training separately and to review all training staff had completed to ensure any gaps in refresher courses for staff were filled.

Training was provided in a variety of formats, including on-line, classroom based, observations and assessments of practice. Where staff completed on-line training, they needed to pass an assessment to demonstrate their understanding of the course. Staff told us the training they attended was useful and was relevant to their role in the service. The manager told us they had started using the Care Certificate for new recruits, which is a nationally recognised baseline induction for staff in the care sector. The manager said there had been some issues completing the work in the required time-scales but was positive about the certificate. The manager felt it would provide a more confident and competent staff team at the end of the induction process.

Staff told us they had regular meetings with their line manager to receive support and guidance about their work and to discuss training and development needs. These supervision sessions were recorded in staff files. Staff said they received good support and were also able to raise concerns outside of the formal supervision process. The manager told us the organisation had an appraisal system, but these had not always been done with staff in the past. The manager had developed a timetable of appraisals and said all staff that were due an appraisal would have one in the first quarter of 2016.

Where people were assisted with meal preparation, they were given a choice. People felt they were never rushed and said staff were able to identify a change in their condition and would contact the relevant professional, such as the district nursing service or GP as required.
People's care plans described the support they needed to manage their health needs. People told us staff provided support for them to follow exercise programmes set by their physiotherapist.

Good

Is the service caring?

Our findings

People told us they were treated well and staff were kind and caring. Comments included, "They are very good, very caring", "Yes, they are caring. They are not rude or clumsy, they're very nice" and "They are very kind to me". A relative also expressed satisfaction with the caring way staff supported their family member, commenting, "They are definitely kind and caring. They talk to (my relative) and tell him what they are going to do".

A health care professional told us staff were approachable and they received good feedback from people about the way staff treated them.

Staff had recorded important information about people, for example, personal history and important relationships. People's preferences regarding their personal care were recorded. Staff demonstrated a good understanding of what was important to people and how they liked their support to be provided, for example people's preferences for the way staff supported them with their personal care needs. This information was used to ensure people received support in their preferred way.

The care plans demonstrated that people were involved in making decisions about the support they received. People we spoke with and their relatives explained they felt involved in planning the care they received. One of the health care professionals we received feedback from said they had seen significant improvements in the way the service involved people in developing and reviewing their care plans. They said this involvement and greater communication from the service had given people a greater understanding of what they could expect from staff.

Staff demonstrated a good understanding of what was important to people. People explained how they were involved in regular review meetings with staff to discuss how their care was going and whether any changes were needed. Details of these reviews and any actions were recorded in people's care plans.

Staff received training to ensure they understood the values of Leonard Cheshire and how to respect people's privacy, dignity and rights. This 'working in an empowered way' training formed part of the skills expected from staff. People told us staff put this training into practice, treating them with respect and maintaining their dignity.

Good

Is the service responsive?

Our findings

People said the staff had enough time to meet their needs in the way they wanted them met. People were generally happy with the timings of their call, although two people commented that they felt their call was too early and staff were not available at a time that would suit them better. Comments from people included; "Mostly on time. They are late sometime, but they ring me" and "They are normally on time. Occasionally late, but they always apologise". A relative described how the service responded to their family member's needs, commenting, "Most of them are wonderful. Our doctor can't believe the good care he is getting"

One of the health care professionals said the service responded well to changes in people's needs and responded to changes in treatment from the health team. The manager told us they had established good relationships with the local health and social care teams and team leaders met with the health teams on a weekly basis. This enabled all of the agencies involved in the person's care to receive up to date information about their changing needs and ensure referrals to different services were made where needed, for example physiotherapy and community nurses.

Each person had a care folder in their home, which contained a care plan and records of the care staff had provided. Copies of these records were also available in the office for staff to access if necessary. People were aware of the care plan and most remembered being involved in the development of it. Records in the care plans showed people and their representatives were involved in the development and review of their plans. People felt the staff knew what was in the care plan and the care records reflected the care that was provided. Care plans were individual to the person and contained specific information about the person's needs and how they would like them to be met.

People said they were confident any concerns or complaints they raised would be responded to and action would be taken to address their issue. The provider reported the service had a complaints procedure, which was provided to people when they started using the service. Staff were aware of the complaints procedure and how they would address any issues people raised in line with it. Although people said they would raise any concerns with staff, they were not all aware of the formal complaints procedures for Leonard Cheshire. We discussed this with the manager, who reported that a copy of the complaints information had been sent out to people. The manager said they would look at the information they were sending out to review whether it could be provided in a clearer way.

The service had a system to track complaints that were received and all complaints were initially screened by a senior manager before being assigned to local managers to investigate and respond. This helped to ensure senior managers were aware of emerging issues and could respond to urgent issues if necessary. Records showed that complaints had been investigated and a response provided to the complainant.

Good

Is the service well-led?

Our findings

The service did not have a registered manager in post. Since the registered manager left in September 2015, the service has been managed by one of the locality managers. The manager told us she had submitted an application to CQC to be the registered manager shortly before the inspection. Records confirmed this application had been received by CQC and was being assessed. Since being in post the manager had developed an action plan to address concerns with the way the service was operating and make improvements.

The manager and members of the management team had clear values about the way care and support should be provided and the service people should receive. These values were based on providing a person centred service in a way that maintained people's dignity and maximised independence. Staff valued the people they supported and were motivated to provide people with a high quality service. Staff recognised the improvements that had taken place and were planned, with comments including, "There is room for improvement, but it has moved forwards a lot over the last six months. There is much better communication between the management team and support workers", "We have a good management team, they try to sort out problems" and "(The manager) will be very good. She's one who will listen".

Staff had clearly defined roles and understood their responsibilities in ensuring the service met people's needs. There was a leadership structure and staff told us managers generally gave them good support and direction, although some staff raised concerns about the number of recent changes in the management of the service. Comments from staff included, "I'm always speaking with a different manager" and "Staff morale is not good". The manager was aware that some staff felt this way and was working to address these issues.

There was a quality assurance process which focused the way care was being provided. This included 'spot checks', in which team leaders checked how support workers were working by directly observing their practice. Following these observations, support workers were provided with feedback and an action plan to address any issues noted with the support they were providing. Other audits were completed of the systems and records in the service, with outcomes being used to create a development plan to address issues. The development plan included issues identified with the processes to assess and plan people's care with them, the management structure and training for staff.

As part of the Wiltshire help to live at home contract, the Wiltshire and Swindon Users Network completed regular phone calls to people to receive feedback about the service being provided. There were records to demonstrate the management team followed up any concerns raised with people directly and made changes to the service where necessary.

The management systems included reviews of incidents and accidents to ensure action was taken to prevent a recurrence. Notifications were submitted to CQC when incident occurred which required notification under the regulations. The manager was aware of their responsibility to submit these notifications.

The provider used an outside agency to conduct a staff survey. The results of the survey had been used to plan improvements in the support staff received, training for staff and ways of supporting staff to contribute to the running of the service. There were regular staff meetings, which were used to keep staff up to date and to reinforce the values of the organisation and how they expected staff to work.

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 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 11 HSCA RA Regulations 2014 Need for consent The registered provider had not ensured they had obtained the consent of people before providing care or treatment to them or acted in accordance with the Mental Capacity Act 2005 where people were not able to consent to care or treatment. Regulation 11 (1) and (3).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured risks relating to the administration of medicines had been assessed and action taken to mitigate the risks. Regulation 12 (2) (a) and (b).