Cathedral Homecare Ltd

# Cathedral Homecare

## Inspection report

Voluntary Action Rutland
Lands End Way
Oakham
Rutland
LE15 6RB

Date of inspection visit:
24 May 2017

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11 July 2017

## 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

We carried out an announced inspection of this service on 24 May 2017.

The service had 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 service is registered to provide personal to people in their own homes. At the time of our inspection 58 people were using the service.

During this inspection we identified areas that required improvements to ensure people received care that was safe, effective, responsive and well-led. We identified one breach 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 the report.

Staff were not given adequate information to protect people from risks associated with the delivery of their care. Risk assessments were not in place for people and records lacked information on how to mitigate risks posed to people in order to keep them safe.

Safeguarding incidents had not been reported and investigated fully at the service. There was a gap in staff training in relation to safeguarding vulnerable adults from the risk of abuse and in relation to the Mental Capacity Act 2005.

The registered manager did not understand the requirements of the Mental Capacity Act 2005 (MCA) and staff did not always understand what was meant by mental capacity, despite some people using the service having conditions which may have affected their mental capacity. We have made a recommendation to the provider about the MCA.

Medicines were being safely administered at the service although there were no protocols in place for medication given on an as and when needed basis.

Staff reported being rushed in their work and told us that they lacked time for travel between calls. People using the service told us that their carers arrived on time but some felt that they appeared rushed in their work.

We found that some incidents which had taken place at the service had not been reported to the relevant agencies as required by law.

There were some quality monitoring systems in place at the service, however, risks to people's care had not

been adequately assessed and the provider had failed to take action in relation to staff feedback about call times.

Staff reported that they could contact the management if they needed to and there were systems in place to ensure staff were supported.

People were protected by safe recruitment practices. There was a robust recruitment process in place.

People were treated with respect and staff were able to describe how they delivered care to meet people's individual needs. People's health and well-being was monitored and recorded by staff delivering care to people.

Staff were kind and caring towards people they supported and delivered care to ensure people's privacy and maintain their dignity.

There was a clear set of organisational values and objectives in place that staff were made aware of.

## 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.

There was a lack of risk assessments in place to ensure people received safe care and improvements were needed in relation to the management of medicines.

Staff had not received sufficient training and guidance in their roles and responsibilities in relation to safeguarding people against the risk of abuse.

Staffing levels meant that staff were often rushed in their work, however, people using the service described having their calls on time.

People felt safe with the staff who looked after them and described having positive relationships with the care workers who delivered their care.

Safe recruitment practices were in place.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The provider lacked an understanding of the requirements in relation to the Mental Capacity Act (MCA) and the principles of the MCA had not been considered across the service when planning and delivering care.

Training was monitored at the service, however, there were gaps in training in relation to the MCA and safeguarding vulnerable people from the risk of abuse.

There were systems in place to support staff although staff did not feel supported in relation to the time they needed to travel between calls.

Consent to care was obtained by staff delivering care where people were able to give it.

People's well-being was monitored and referrals made to health

professionals as and when needed.

## Is the service caring?

Good

The service was caring.

People told us that the staff who cared for them were kind and compassionate and staff knew people's likes and dislikes in relation to the delivery of their care.

People's privacy and dignity was maintained at the service.

Caring values were driven through the organisation and staff demonstrated that they worked to these.

People and their relatives were able to express their views about how the service was run.

## Is the service responsive?

Good

The service was responsive.

Care plans contained information for staff on providing individualised care to people and these were regularly updated with people who used the service and their relatives.

Staff knew people's personal preferences and ensured that people were able to do the things they enjoyed.

People knew how to complain and these were addressed in line with the policy in place at the service.

People were able to express their views about how care was delivered to them.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

Incidents which had occurred at the service had not been notified as required by law. Some incidents had not been recognised as being potential allegations of abuse.

Staff did not always feel supported and listened to, although systems were in place to provide support for staff.

Systems were in place to obtain people's views about how the service was run.

There was a clear set of values and objections within the organisation and staff knew and understood these.

# Cathedral Homecare

**Detailed findings**

## Background to this inspection

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

This inspection took place on 24 May 2017. The inspection was announced and was undertaken by one inspector. We gave 48 hours' notice of the inspection as we needed to be sure that the relevant people would be available.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with six people who used the service and five relatives of people who used the service. We also spoke with five care staff, the registered manager and the provider. We also looked at care records relating to four people who used the service at the time of this inspection. We looked at four records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service.

Requires Improvement

# Is the service safe?

## Our findings

People received care from staff who were not always given enough information about risks associated with the delivery of their care. People using the service had a plan of care in place which outlined people's care needs and preferences. Although there were risk assessments in place in relation to the environment people lived in, people did not always have risk assessments in place to outline any identified risks associated with the delivery of their care. For example, we looked at two people who were at a high risk of developing pressure sores. There was no risk assessment in place to guide staff on how to minimise this risk in order to keep these people safe. When we raised this with the provider and the registered manager they told us that this had not been done and that they would implement the risk assessments following our inspection visit. Although the care plans were regularly reviewed and updated, the lack of risk assessments put people at risk of unsafe care.

When we asked staff about the care records in place, one care worker told us, "I think there needs to be more information in the care plans, especially information for when we call the emergency services." Two of the staff we spoke with felt that the way in which care was planned at the service could be improved upon. They told us that although they knew how people liked to have their care delivered, they did not always have enough information in people's care records. We found this to be the case in relation to how people's risks were assessed and managed to ensure staff had adequate information to keep people safe.

People we spoke with were getting the care they required and nobody using the service had experienced any harm as a result of the care they received at the time of our inspection. Staff we spoke with were familiar with people's care needs as they knew the people they looked after. However, improvements were needed in the way in which care was risk assessed by the provider.

People were not always supported by staff that knew how to recognise when people were at risk of abuse. Staff were given a safeguarding policy when they began working at the service and most staff had carried out safeguarding training as part of qualifications they had undertaken. However, we saw from the training records we were provided with that no specific safeguarding training was delivered by the service. Although staff we spoke with knew what action they should take to keep people safe, not all staff had received safeguarding training to enable them to have the knowledge to recognise abuse and report to appropriate authorities. Allegations of abuse were not always reported and investigated appropriately by the provider. For example, we found that an allegation of theft by someone using the service had not been fully reported by the provider. Although the Police had been informed of the incident, the Local Authority who take the lead on safeguarding had not been informed.

Staff were safely managing people's medicines at the service and were provided with enough information to do this safely. Care plans we looked at contained information about people's medication needs and gave staff information on how much medicines people needed and when. We looked at the medicine administration records (MARs) and found that these were completed by staff and checked regularly by the registered manager. However, where people were given medicines on an as and when required basis, we found that there was no guidance provided to staff as to when and how to do this. For example, one person

was prescribed pain relief and staff were to administer this only when the person appeared to be in pain. There was no written guidance for staff to know when this pain relief should be administer and any instructions to staff had been provided verbally. We raised this with the provider who told as that these would be written and provided to staff in the future to ensure that this was clear for any staff member who may be looking after this person. People we spoke with were getting the pain relief they needed, when they needed it.

People using the service told us that they received their care on time and that care workers stayed for the allocated amount of time. One person who used the service said, "Within a quarter of an hour, they're always here on time. I'm more than happy." However, two relatives we spoke with described rotas changing at the last minute and the care workers seeming rushed in their work. One relative said, "They give them more work than they can manage." Another relative told us there were, "Short notice changes to shifts and too many hours." Three of the care workers we spoke with described being under pressure to meet calls and felt that they weren't given enough time to get from one call to another. One staff member said, "I feel put upon a lot of the time. Sometimes you have little or no time to get to your calls." Another care worker said, "We're rushing calls to get to the next call." We asked to see call times and how these were monitored. We were told that there was no system in place to be able to do this accurately. Although people reported to be getting their calls on time, staff felt under pressure to ensure that this happened. We raised this with the provider, who told us that this would be addressed.

People we spoke with told us that they felt safe with the care staff who delivered their care. Nobody raised any concerns about the conduct of the staff and everyone we spoke with described having positive relationships with the carers who looked after them. One person using the service told us, "There are some lovely girls." The relative of someone who used the service said, "I have no doubt that [relative] feels safe with them." Nobody we spoke with expressed any concerns about people's safety.

People could be assured that appropriate recruitment practices were in place; all staff had all their checks made to establish they were of a suitable character to provide people with care and support. Staff files we looked at contained written references, documents confirming staff's identity and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Requires Improvement

# Is the service effective?

## Our findings

We looked at the care records for people using the service to assess whether the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) as some people using the service had a diagnosis of dementia and may have lacked the capacity to make decisions in relation to their care. The MCA provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

We found the provider was unclear about the principles of the MCA and their obligations as a care provider. Staff had not been trained in this area of care and were also unclear about the principles. The MCA has not been considered in people's care planning and delivering. Some of the people using the service may have lacked the capacity to make decisions in relation to their care and this had not been considered by the service. The provider told us that they would look into this following our inspection. We recommend that the provider familiarises themselves with the Mental Capacity Act 2005 Code of Practice.

When we spoke with people who used the service, those who were able to speak with us described staff who sought their consent before delivering their care and we saw from daily care notes that people were offered choices and that their wishes were respected.

Staff training was being monitored at the service to ensure that people received care from staff who were adequately skilled and competent in their roles. Staff we spoke with were able to tell us about training they undertook on-line and some training which was delivered face to face. Several staff members described wanting more face to face training as they felt this would enhance the care they delivered. We did find gaps in training in relation to the MCA and safeguarding vulnerable people from abuse. The provider assured us that these gaps would be addressed. People using the service described being cared for by staff who were trained and skilled in delivering their care. Relatives were equally positive about the competence and skills of the staff working at the service. One relative said, "They're all fantastic. I don't think we have any serious doubts."

There were systems in place to support staff in their roles. Staff told us that they had regular review meetings where they were able to discuss any issues. Staff described being able to contact the office should they need to and that support was provided if they needed it. One staff member said, "I seek reassurance and I do get it." However, staff did feel that concerns raised about travel time between calls had not been taken on board by the provider and felt that this was impacting on their ability to do their jobs effectively.

We found that referrals were made to health professionals when needed and that people's health was monitored by the service. Daily records made by staff detailed people's well-being and action was taken if there were any concerns. For example, where there were concerns about the condition of people's skin, referrals were made to the district nurse.

Good

# Is the service caring?

## Our findings

People who used the service described being cared for by staff who were kind and compassionate. Everyone we spoke with described having positive relationships with the care staff who looked after them. One person told us, "I'm very happy." Another person commented, "I've never been worried about it. They've been very, very good to me."

Relatives we spoke with were equally positive about the care delivered to their relatives by staff working at the service. One relative said, "The actual care has been first class." Another relative told us, "The carers have always been lovely. They're always really cheerful."

Staff and the provider were able to describe the people they cared for and knew them well. People's likes and dislikes were detailed in their care plans to some extent but staff took the time to get to know the people they were delivering care to. Staff were able to describe people's individual care needs and knew how to provide the kind of care that they wanted. Staff we spoke with displayed a caring attitude to their work and to the people they looked after.

Issues raised by people using the service were reported in to the office by care staff and we saw this was the case during our inspection. Where staff were concerned about someone's well-being they reported this to ensure that the person received the care they needed. This demonstrated a caring approach to people.

People's privacy and dignity was maintained; staff described how they ensured people were respected. We saw in care plans that guidance was giving to staff about respecting people's right to privacy and directed them to maintain people's dignity. One relative we spoke with described how the care workers ensured that their relative had the time they needed and the respect to enable them to have personal care delivered without them feeling uncomfortable.

The provider demonstrated a caring approach to people and respected their wishes. We found that there were clear values within the organisation about people being respected and which promoted a kind and compassionate approach to care. These values were made clear to staff through the recruitment process and throughout their review processes. These values were reflected in the way in which people described the care workers who looked after.

People had a consistency of care workers delivering their care and this enabled people to develop meaningful relationships with the care staff coming into their homes. People knew how to contact the office should they need to and any issues or concerns raised were addressed by the provider.

We saw evidence that people and their relatives were able to express their views about how the service was run and were involved in the planning and delivery of their care.

Good

# Is the service responsive?

## Our findings

People's care records contained people's current care needs and these were regularly reviewed and updated when people's needs changed. Staff we spoke with knew people's needs, likes and dislikes and how they wanted care delivered to them.

People told us that they had positive relationships with staff who delivered care to meet their individual needs. One person described being able to have a laugh and a joke with the carers who looked after them, saying, "I can have a laugh with them. I haven't got any problems." The relative of someone using the service described how the care workers undertook activities with their relative to ensure they were kept active and engaged when they wanted to be.

People's care needs were assessed before they received care to determine if the service could meet their needs. Care records when people began using the service clearly indicated that people's needs and preferences had been taken into account and care planning was individualised. People were able to specify when their care calls were scheduled and the service was able to be flexible if these needed to be changes. People's care needs and preferences were reviewed on an on-going basis to ensure staff knew people's current needs and could respond accordingly.

People who used the service and their relatives were involved in planning their care. During assessments discussions took place about how people wanted to receive their care, for example their meal preferences, how they spent their time and how independent they wanted to be. People described being asked how they were and we saw that reviews of care were undertaken which involved asking people how they were finding their support. These were done as face to face meetings to enable people to easily express their views.

People received care in line with their personal preferences. Staff were given information about how people liked to spend their time and we were told about staff taking people out into the community and engaging in activities that people enjoyed. People were able to specify how their care was delivered to them and this was taken into consideration by the provider.

People felt confident that they could raise their concerns or make complaints to any member of staff. People and their relatives were given information about how to make a complaint and there was a complaints policy and procedure in place. We found that complaints had been logged and action had been taken and documented as a result, some of which resulted in some lessons learnt for the organisation.

Requires Improvement

# Is the service well-led?

## Our findings

A number of incidents had taken place at the service which the provider had failed to notify to CQC. We found records of three incidents which were required to be notified to us by law. Two of these were allegations of possible abuse. We raised this with the provider who stated that these incidents should have been notified. One incident we identified related to a person who had alleged that they had been prevented from leaving their property. This person had made an allegation against the staff caring for them. This allegation should have resulted in a safeguarding notification. This had not been considered by the provider. Incidents and potential abuse had not been acted on appropriately and in accordance with legal requirements by the service. Another allegation of financial abuse had not been report to CQC or to the local authority. We discussed this with the provider who told us that all required notifications would be made to CQC in the future.

We found that there were quality assurance systems in place at the service, however, these had not picked up on some of the issues we identified during our inspection. Feedback from staff had not always been acted upon and there were some areas of the service which needed improving.

Some of the relatives we spoke with expressed concerns about the organisation of the office and the ways in which staff were working. Relatives told us that staff appeared to receive their rotas late and that these often changed throughout the course of their working week. They described the care staff lacking time to travel between calls and felt that this was impacting on care staff's ability to do their jobs. One relative said, "I think the administration of the organisation is pretty hopeless." Another relative commented that, "They don't seem terribly efficient. The girls never seem to know what they are doing. The girls are quite fed up with it." Staff we spoke with also spoke of lack of time for travel between calls and felt that this impacted on their ability to do their jobs as well as they could be. One staff member said, "It impacts on everything." Four of the five staff we spoke with told us that calls times and rotas affected their work.

Staff did not feel that their feedback was always listened to and acted upon and felt that improvements were needed in relation to the planning of care calls. The provider did not have a system in place to accurately monitor calls and had not taken steps to enable staff to have enough time to travel from one call to the next. Staff told us that they had raised this with the office on several occasions prior to our inspection. As people using the service felt that this impacted on their care, this was an area that had not been effectively monitored at the service.

Staff described receiving an induction when they started at the service and undertook a period of shadowing prior to starting work with an experienced member of care staff. There were systems in place to support staff and training was being monitored at the service to ensure staff were adequately trained. However, we did identify some gaps in staff training in relation to safeguarding and the Mental Capacity Act.

There was a lack of systems in place to ensure that people received safe care. People did not always have risk assessments in place to mitigate any risks associated with their care delivery. For example, there was a lack of risk assessing in relation to pressure care. This had not been picked up as an area for improvement

by the provider prior to our inspection.

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

Staff told us that they felt supported in their day to day roles and said that they could call up and speak to the office if they were worried or concerned about anyone they cared for. We saw and were told that regular review meetings took place with staff where they could raise any concerns or issues they may have.

People who used the service were contacted regularly by the provider to establish whether they were happy with the care they were receiving and checks were carried out on the daily care notes made by staff. Checks were made on the safe administration of medicines and any errors were addressed through communication and training for staff.

The organisation had clear values and objectives which it communicated to staff through the recruitment process and through the communication staff had with the management. These values enabled staff to be clear on the vision and values they were working to and ensured they felt part of a wider organisation. The provider had devised clear systems to provide support for staff, although some of these needed to embedded more effectively.

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 17 HSCA RA Regulations 2014 Good governance<br><br>Quality assurance systems had not been effective at identifying the shortfalls we found during our inspection. Staff feedback had not been acted upon or addressed. |