Care Signature Christian Homecare Services Limited

Number 12 Chapeltown Enterprise Centre

Inspection report

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12 February 2018

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Number 12 Chapeltown Enterprise Centre is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults. The service supports people in Leeds and surrounding areas, such as North Yorkshire. At the time of the inspection there were eight people using the service.

This announced inspection took place on 1, 5 and 12 February 2018. We gave the provider 48 hours' notice because it was a small service and we needed to make sure someone would be at the office. This was the first inspection since the service was registered in July 2016.

There was a registered manager in place. 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.

Quality assurance systems and processes, that included audits, were not sufficiently robust to maintain standards and drive improvements for everybody. People told us it was it was difficult to get hold of a manager if they wanted to speak with someone.

People knew how to make a complaint and had opportunities to feedback their views at reviews. However, there had been no recent formal survey to find out people's satisfaction with the service.

The systems in place to make sure that people were supported to take medicines safely required improvement. Medicine records were maintained but had not been used consistently. Auditing processes had not identified areas of medicines practice that required improvement.

Recruitment records showed that there were gaps in references for new staff. This meant the provider could not be certain they had the required skills and were of suitable character and background to work in the care sector.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were offered choice. Care staff sought consent before supporting with personal care.

People were treated with dignity and respect by the care staff who supported them. Care plans were in place for each person who used the service. These contained detailed information about people's individual preferences and how staff should provide person centred care.

People were supported to maintain their health and had access to health services if needed.

Risks to people in relation to their needs had been assessed. Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns.

Care staff were trained in infection control practices. They were provided with protective equipment such as gloves and aprons to use as required.

There were sufficient numbers of staff to make sure people's needs were met. Staff told us they were supported in their roles and could meet a manager to discuss any issues.

People's needs were reviewed and appropriate changes were made to the support people received if required. Risk assessments contained clear information about how risks should be minimised.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely 'Good governance'. You can see what action we told the provider to take at the back of the full version of the report.

This is the first time the service has been rated 'Requires Improvement'.

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 required recruitment checks were not always carried out on new staff.

The systems for managing medicines were not sufficiently robust.

People told us they felt safe at the service.

Staff had a clear understanding of their safeguarding responsibilities.

There were systems in place to protect people from the risks associated with care and support.

Is the service effective?

Good

The service was effective.

Staff received the training and guidance they needed to carry out their roles effectively.

Care staff asked people for consent before providing care and support.

People received support from care staff to manage their health needs.

Is the service caring?

Good

The service was caring.

People received good care and support from the service.

People were treated with dignity and respect whilst being supported with personal care.

Care staff promoted people's independence.

Is the service responsive?

Good

The service was responsive.

People received person centred care and support.

Care plans were up to date and described how people's individual needs were to be met.

People knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were not robust systems in place to monitor the quality of care and identify where improvements were needed.

The roles of the manager and provider were not clearly identified.

There was a clear team culture which promoted respect and independence.

Number 12 Chapeltown Enterprise Centre

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 1, 5 and 12 February 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. We made telephone calls to people who used the service on the second day and spoke with members of care staff on the third day.

The inspection was carried out by one adult social care 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. The expert by experience for this inspection had experience of supporting older people.

Before the inspection we sought feedback about the service from the local contracting authority. We reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is legally required to send us as part of their registration with the CQC.

We used information the provider sent us in the 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.

During this inspection we visited the office and looked at records which related to people's individual care and the running of the service. We looked at three people's care planning documentation, and medicine records, as well as recruitment records, the staff rota, notifications and records of meetings.

We spoke with three people who received a service and one relative. We met with the provider, new manager and office manager. We also spoke with three care staff over the phone.

Requires Improvement

Is the service safe?

Our findings

Some people who used the service required assistance to take their medicines or to apply skin creams. The service used Medication Administration Records (MARs) to record when medicine or cream had been administered. The MARs we looked at had been handwritten, although the registered manager told us they were due to be typed up. MAR contained details of the medicine to be taken, dose and time of administration. However, there were some gaps in recording that had no explanation which meant the provider could not be sure people had received their medicines as required. One MAR for the month of January 2018 had been extended into February by hand, because a new form had not been available.

Some people had 'as required' medicine, such as pain killers. There was inconsistent use of codes to show when these types of medicine had been administered and an explanation of why they had been needed was not always recorded. This is important so that any trends can be monitored.

Care staff were not provided with sufficient information to support them in managing medicines safely. There were no medicine profiles for people, which described each type of medicine, why it was needed and any side effects. Care plans contained limited information on people's medicines and one care plan had no information at all.

Staff were trained in managing medicines and were observed in practice by a manager before being assessed as competent. Care staff confirmed they would not be asked to administer medicines until they were confident. The people we spoke with raised no issues about how their medicines were managed by care staff. Although we found areas for improvement, there was no evidence that the issues had impacted on people who use the service.

A medicines policy was in place but this was not dated and did not cover all aspects of medicines management. We recommend the registered provider review their policy and practice in line with National Institute for Clinical Excellence guidance.

We looked at the systems in place to make sure new staff had the right qualities to care for people in their own homes. We reviewed staff recruitment files and saw that applicants had completed an application form which was discussed at interview. Although the manager told us interviews included a discussion about any gaps in employment history, this was not recorded. References were sought prior to employment. However, some records contained only one reference, and not always from the last employer. There was no evidence to show this had been considered by the provider before offering a position, or any risk assessment to show how the provider would make sure the applicant was suitable.

Prior to an offer of employment, a criminal background check was provided by the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. These checks help employers make safer recruiting decisions and help to prevent unsuitable people from working with vulnerable adults.

People told us they felt safe when they received care and support. Comments included, "Yes, I certainly do feel safe. They (staff) are very good with me", "Safety is really important to me as I am blind. The care workers do make me feel safe and comfortable". A relative told us, "I have the total peace of mind that my relative is safe. The care workers are good. This gives me re-assurance that if I am not here my relative will be comfortable and safe".

There were risk assessments in care plans which identified risks to people's safety and well-being, relevant to the care they received. The risk assessments we looked at were up to date and covered areas such as moving and handling, nutrition and mobility. This meant that staff had information about how to support people safely. There were no risk assessments regarding the home environment, such as trip hazards or pets. We spoke with the registered manager about this who said this was considered at an initial assessment. They said they would add environmental risk assessments to care plans.

All staff had received recent training in safeguarding people who used the service. The staff we spoke with told us they understood their responsibilities and were confident about identifying and responding to any concerns. There was an up to date safeguarding policy in place, however, guidance in the Staff Handbook contained out of date reference material.

We looked at safeguarding records which showed the provider took appropriate action where concerns had been identified. Where necessary, they had been reported to the local safeguarding authority and properly investigated.

The provider showed us forms for the recording of accidents and incidents, such as falls. However, they told us there had not been any since they introduced the new recording system. They explained that, because they were currently a small service, they knew people well and acted immediately if they had any concerns about people's wellbeing.

There were sufficient numbers of staff to provide people with the support that had been agreed with the service. Care staff were provided with a schedule of visits for the week and tended to support the same people, for consistency. The provider added that because it was a small service they could be flexible in accommodating people's needs. People and their relatives told us that care staff turned up on time and there were no missed calls. Comments included, "The care workers are always on time. They have never missed a call. They stay and complete all the tasks I need doing" and "No issues with timings. They turn up on time". Staff told us they were given sufficient travel time and did not have to rush with anyone's care and support. One member of staff told us, "I get a chance to sit and chat".

During our telephone calls with people who used the service, no issues were raised regarding the hygiene practice of care staff. People told us care staff wore gloves and aprons, as appropriate, when they supported with personal care. All staff were trained in infection control practice and food hygiene.

Good

Is the service effective?

Our findings

People told us they were supported by competent and trained staff. Comments included, "The training and skills are excellent. They (staff) are compassionate. They take their time with me", and "Yes, they are certainly trained and skilled. I do not need physical support but have mental health issues. They know totally how to support me".

Care staff received the training they needed to provide them with the skills to carry out their roles. Records showed that training was provided in areas such as moving and handling, medicines and information governance. Practical moving and handling training was provided so that care staff could practice techniques. The provider had a background in health care training and led much of the training themselves. They told us if a person used a hoist at home, they asked permission to train all staff in how to use it, before starting care visits. A member of care staff confirmed this and said, "We are shown how to use equipment".

New staff had an induction for three months to settle them into their roles. Care staff also told us that they felt the training they received was sufficient and helped them in their roles. One staff member told us, "Initially I shadowed the team leader. I worked with them until I felt comfortable" and added, "Training has helped". One staff member described the support they had been given to help with reading and writing and said, "Someone comes to the office each week to help me". Some staff told us they had been supported in gaining additional qualifications, such as National Vocational Qualifications (NVQs).

Senior staff carried out occasional observations of staff during care visits. These were used to assess care practice. People were asked for any feedback at the same time. Observations were later discussed with staff. Care staff told us that management was supportive and they had supervision meetings where they could discuss work issues and performance. The provider told us they would be starting annual appraisals with staff after a year and these would be used to review work and look at developmental needs over the next year.

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. The application procedure for this in care settings is called the Deprivation of Liberty Safeguards (DoLS) and can be legally authorised by the local authority. However, this is not relevant for people who receive domiciliary care in their own homes. This means any decision to deprive a person of their liberty in a domestic setting must be legally authorised by the Court of Protection.

The registered manager told us that no one was currently subject to any restrictions by the Court of

Protection. They explained that all of the people they supported with personal care had capacity to make their own decisions.

All staff were trained in the MCA and had an awareness of their responsibilities under the Act. The people we spoke with confirmed that care staff sought their permission before carrying out personal care or some other task. We noted that care plans stressed the importance of gaining consent before carrying out any personal care tasks. However, care plans had not been signed by people to show they had agreed to them. Records showed some people could get confused and it was unclear how this affected their ability to consent and make their own decisions. We discussed this with the provider who agreed there could be more detail.

The provider told us that they were not directly responsible for making sure that people had sufficient amounts of food and drink. However, they did assist some people with food preparation and cooking. One person told us, "They prepare food for me. This is to my satisfaction". There were no people who required particular diets or support with eating and drinking.

Care plans provided information about people's health needs and the support they required. There was evidence of the involvement of healthcare professionals, such as a district nurse or doctor, when required. Care records showed that staff were quick to liaise with health professionals, such as a doctor or district nurse, when a concern had been identified.

Good

Is the service caring?

Our findings

We received positive comments about the service from the people we spoke with. These included, "The care workers are marvellous. They are always caring and kind" and "I am extremely happy with the care and support given. The care workers are excellent. Always sensitive. Caring".

The care staff we spoke with told us they tended to support the same people each week. This meant people were usually assisted by staff who were familiar to them. One person told us, "They are absolutely marvellous. They really make me happy. They are extremely friendly. Very professional".

The care staff we spoke with demonstrated a caring approach to their work and the people they supported. One staff member said, "I love it. I get to know people. Have a chat" and another stated, "I make sure I give them the care they need. They (people) always come first. They always seem happy".

People told us they were treated with dignity and respect. One person said, "I am always given respect and dignity" and a relative commented, "They give [Name] respect and dignity at all times". Care plans emphasised the need to promote privacy and dignity whilst supporting with personal care. For example, 'Cover with a towel' and 'Maintain privacy and dignity at all times'.

Care plans promoted the need for good communication to encourage people to be involved in their care, for example, 'Communicate with every step. It helps [Name] to be involved' and 'Offer choice'. In fact, choice was stressed throughout care plans. This supported people to make day to day decisions and retain their independence.

The provider took account of any equality or diversity needs in relation to the people supported by the service. One person had a visual impairment and the provider spoke with them about their communication preferences. Information was subsequently provided in the way the person wanted. It was also agreed that daily notes, completed at each visit, would be read back to the person so they were aware of what had been recorded.

We talked with the provider about how they promoted equality and diversity within the service. They told us, if they identified a need in this area, they would discuss it at the assessment stage, and include associated guidance in the care plan. They demonstrated a clear commitment to providing a service which took account of individual needs, whilst being inclusive and safe for people to be themselves.

Good

Is the service responsive?

Our findings

People received person centred care which was responsive to their needs. Before carrying out any care and support a senior staff member visited people to carry out an assessment of needs, to make sure the service was appropriate. Once it was certain that the service could meet the person's needs, a care and support plan was set up, to describe how their needs were to be met.

The registered provider explained that care plans had been rewritten following advice from the local contracting authority, to make them more personalised and informative. Staff members told us that support plans contained sufficient detail for them to be confident in supporting people. One member of staff said, "Care plans are really helpful".

Care plans focussed on how people's needs were to be met in line with their preferences. There was background information for each person which provided a brief personal history and gave staff an understanding of their character and personality. There was a clear description of the care tasks to be completed at each visit.

Care plans were very person centred and contained clear information about how to support people. For example, there was guidance on people's drink preferences. Rather than just say people liked tea or coffee, there was additional detail about how it should be given. For example, "Place coffee on the table with handle facing [Name] so they can easily pick it up" and "[Name] prefers to use the brown cup with the broken handle".

Care plans also contained information about what was important to people, such as what they wanted to achieve, family relationships and interests. This assisted staff in seeing people as individuals and supported social conversations.

Care plans were up to date and reviewed as necessary. Not everyone we spoke with could remember having a review, but records showed these took place. People and their relatives were involved. The provider explained that because they operated a small service they were able to respond quickly to any urgent requests for support or changes in needs.

There was a complaints procedure in place which had been given to people who used the service. The provider told us there had been no complaints since they started.

People told us they knew how to make a complaint. Comments included, "I am aware of the complaints procedure, but I have no complaints", "I know if I have any issues I would call the office. I have the number. I have not had any reason to call" and "I have the details to make a complaint. But I have no reason to complain at all".

The service did not currently support anyone during their end of life so we did not look at this during the inspection. The provider told us that they would like to complete palliative care training as a future area of

interest.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. At the time of our inspection, the registered provider was also the registered manager. However, a new manager was in place who had begun the process to register with the CQC, so the provider could concentrate on service development.

The management team carried out a range of checks and audits to monitor standards. These included regular checks of daily notes, medicine records and care plans. There was evidence of making improvements where shortfalls were identified. For example an audit in January 2018 picked up that some daily notes had not been signed and there were gaps in the recording of medicines. This had been addressed with staff at a team meeting shortly afterwards.

However, some issues with regard to quality and safety had not been identified or acted on. These included the issues highlighted in this report about medicines management and recruitment, which included a failure to maintain accurate up to date records. The provider told us they had a new quality monitoring system ready but this had not been started at the time of the inspection.

Some people felt that, although the care was good, there was a lack of contact with the management of the service. One person said, "This is not an official complaint but the management should make an effort to come to see me. They do not come or contact me. The office should also answer the telephone. I do ring but it takes a long time to answer. Or they do not answer". Other people raised issues about not being able to contact the office when needed. The provider recognised this had been an issue and said that now there was a new manager in place there would be improved availability at the office and time to meet with people face to face.

We talked with the registered provider about how they sought feedback from people who used the service. They told us that questionnaires were sent out when they first started, but not since. The aim was to complete them every six months. Records showed that care reviews were used as an opportunity for people and their relatives to give feedback and make suggestions. However, as highlighted by the people we spoke with, there was a general view that contact with managers was limited.

The issues highlighted above showed a failure to properly assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people who used service. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17: Good Governance.

People told us that, generally, they were happy with the service provided. Comments included, "I can compare this company to another company I had. This company is excellent. They have done me proud" and "I am delighted with the service. They are very supportive. The care workers are excellent".

We also noted there was not a clear definition of roles between the provider and new manager. This meant the approach to quality monitoring was uncoordinated. We recommend the provider review responsibilities

with the new manager so there are clear expectations for each of their roles.

Care staff told us they were happy with the management of the service. One staff member said, "It's a good agency to work for" and another told us, "Managers are extremely helpful". Care staff told us a manager was always available if needed. They told us about a phone app which was used as a group chat and messaging system for care staff and managers which supported prompt communication.

The provider explained that because it was a small team of staff they had regular contact and frequently discussed how they were getting on. This was supported through the mobile phone communication app and monthly team meetings.

The provider demonstrated a good knowledge of the people supported by the service. They were able to describe improvements which had been made over the last few months, as well as ideas and plans for the future. They spoke passionately about providing a person centred service which met people's needs.

The service is a Christian based organisation and this underpins the core values and ethos of care. These values were detailed in the Statement of Purpose, which stated, 'The standards of our care flow from our Christian moral belief and principles'. The provider told us that the service supported people of any religion and provided a non-judgmental approach in line with their equalities statement.

The registered provider told us they had good working relationships with the contracting authority, North Yorkshire County Council (NYCC) and listened to any advice given to make improvements. We received feedback from NYCC quality monitoring team before the inspection who had found improvements at the service.

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 There was a failure to properly assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people who used service. Regulation 17(1)(2).