Review of compliance

Satellite Consortium Limited Satellite Consortium Limited	
Region:	London
Location address:	27b Clarendon Road Hornsey London N8 0DD
Type of service:	Domiciliary care service
Date of Publication:	August 2012
Overview of the service:	Satellite Consortium is a domiciliary care agency that specialises in providing culturally specific care and support to people of ethnic minority backgrounds in the London Borough of Haringey. Satellite Consortium provides support for individuals living in their own homes. The service is provided to adults who need assistance due to age, ill health or disability.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Satellite Consortium Limited was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Satellite Consortium Limited had taken action in relation to:

Outcome 11 - Safety, availability and suitability of equipment
Outcome 14 - Supporting workers
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 2 July 2012, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We spoke to six people who have care provided by Satellite Consortium Limited or have a relative who receives care. They all told us they were mostly happy with the quality of care they received. Comments included the following: "The care is absolutely fine. I have no concerns"; "It is a very good service. I have no problems"; and "[it is] excellent. Very, very, very good".

People told us their carers were polite and usually turned up when they were meant to. When there were some problems, people said they could contact the management and they would address their concerns.

Some people told us they liked the fact that the carers were from similar backgrounds to themselves. They liked the fact the staff spoke the same language and had an understanding of their cultural needs.

What we found about the standards we reviewed and how well Satellite Consortium Limited was meeting them

Outcome 01: People should be treated with respect, involved in discussions about

their care and treatment and able to influence how the service is run

People's privacy, dignity and independence were respected.

The provider was meeting this standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this standard.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

People were protected from unsafe or unsuitable equipment.

The provider was meeting this standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. The registered person did not have suitable arrangements in place in order to ensure that persons employed had received appropriate supervision and appraisal. This may potentially put people at risk.

The provider was not meeting this standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider did not have an effective system to regularly assess and monitor the quality of service that people received.

The provider did not have an effective system in place to identify, assess and monitor risks to the health, safety and welfare of people who use the service.

The provider was not meeting this standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

People were protected from the risks of unsafe or inappropriate care and treatment.

The provider was meeting this standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke to six people who have care provided by Satellite Consortium Limited or have a relative who receives care. People told us the carers they or their relatives had were polite and respectful. For example, one person said, "the ones I've had are really nice and helpful. They are very polite."

People told us they liked the fact the carers were from similar backgrounds to themselves. For example one person said "It is good to have an Asian. It is good they have our language." Another person explained they were very happy their relative only received care from women.

Other evidence
People who use the service were given appropriate information about their care. Before receiving care people receive a service user guide. This details what people can expect from their care and how to raise concerns should they have any. When we last visited Satellite Consortium Limited in July 2011 we suggested they update this guide to reflect updated contact information for the Care Quality Commission. However, this has still not been updated. The provider may want to note that this guide has still not been updated since May 2009 and contains out of date contact information. This means people using the service are receiving the wrong information.

People's diversity and values were respected. This is because Satellite Consortium limited matched people who were receiving care to carers who were from the same cultural backgrounds as themselves.

People expressed their views and were involved in making decisions about their care and treatment. We looked at six care plans for people who use service. In all cases an assessment involving the social services team was carried out before their care package was developed. The initial assessments allowed the person and their families to discuss their needs, which were taken into account in the development of care packages.

Our judgement
People's privacy, dignity and independence were respected.

The provider was meeting this standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke to six people who have care provided by Satellite Consortium Limited or have a relative who receives care. Most of the people told us they felt they were receiving good care and that the carers were good. However, one person said they felt one of the carers they had was not very good.

All of the people we spoke to said it was rare for carers not to turn up. When this did happen they told us they usually had warning this was going to happen and the management would usually get someone else to cover the delivery of the person's care.

Other evidence
People's needs were assessed and care and treatment was planned and delivered in line with their individual care plans. We looked at the care plans for six people who receive the service. These showed people had had their individual needs assessed before receiving the service and that these were updated to reflect people's changing needs. Risk assessments were completed and these were used to develop the care plan for the person. For example, if someone's needs were assessed as requiring the help of two members of staff, these were provided.

We also looked at the daily records of care, which had been completed by the carers. We noted the records of care were not detailed enough to provide full information about the care people needed or received. The provider may want to note that the daily records of care were often limited in nature and did not detail the actual care delivered.

We looked at daily communication book used by management. This recorded any missed calls. We found these had only happened infrequently and management had usually got a replacement carer. When other concerns were raised there was evidence the management would act swiftly.

We looked at the responses that had been received to the provider's service user survey for 2012. When we visited the service had received 19 responses. Thirteen of these had answered 'good' or 'very good' to the question "Are you satisfied with the personal care given to you?" only one person had responded 'poor'. This showed that most people felt the care they - or their relative – received was good.

Our judgement
People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this standard.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
* Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with Outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
We spoke to three people about the equipment they - or their relative - needed for their care. They all told us they felt they had access to all the correct equipment to meet their needs.

Three people told us the care workers who delivered care to them or their relative knew how to use a hoist. One person said they had concerns with one care worker.

Other evidence
When we visited last time we found that some care workers were found to be unfamiliar with using hoists to help to move people whilst they were receiving care. Most of the people who spoke to this time who used hoists - or had a relative who required a hoist - said they had no concerns with the staff knowledge of how to use a hoist.

Our judgement
People were protected from unsafe or unsuitable equipment.

The provider was meeting this standard.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is non-compliant with Outcome 14: Supporting workers. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us

People – or their relatives - who use the service told us they felt the staff were good. They told us they felt staff delivered good care. However, one person said they had one carer they felt was a bit 'slap-dash'. They had told the management about this and had been reassured by the fact this individual always worked with a colleague.

Two people said the management had visited their homes to check the quality of care being provided by their care workers.

Other evidence

When we visited last time we found the provider was not compliant with this outcome because care workers did not receive regular supervision sessions and refresher training. When we visited this time we found the provider did not yet have a robust system in place to ensure all staff were receiving supervision.

We looked at the files of six members of staff but did not see clear evidence that staff had been receiving supervisions. One member of staff did not have an individual supervision recorded since 2008 and another had last received a supervision in July 2010. The provider was also not able to provide us with a list of when staff had received supervision or when they were next due to receive supervision. This meant the provider did not have suitable arrangements in place to ensure the staff were suitably supported to deliver care.

The management told us that team meetings only take place for management. Group supervisions are held for all staff. One of these had been held in March 2012; the

previous one had been in June 2011. Twelve members of staff had attended these and discussions had included safeguarding, holidays and the cancelling of shifts.

When we spoke to staff they told us the management was supportive. They told us they had received training, for example in safeguarding and moving and handling. However, staff members were not able to tell us when they had received supervision recently.

We also looked at the training records for six members of staff. These did not always show people had received recent training. For example, some members of staff did not have training in safeguarding since 2008. The manager was able to show us some staff had received training that was not recorded in their files. We looked at the forthcoming training courses Satellite consortium had planned. These showed they had training planned in safeguarding, moving and handling and health and safety. However, the provider may want to note that it was not always clear which staff members had received training or when they required updates to their training.

Our judgement
People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. The registered person did not have suitable arrangements in place in order to ensure that persons employed had received appropriate supervision and appraisal. This may potentially put people at risk.

The provider was not meeting this standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People told us they had been asked for their opinions of the care provided by Satellite consortium through being given a questionnaire.

People told us they had received spot checks at their homes. However, some people told us it had been a long time since they had last received such a visit.

Other evidence
When we visited last time we found the service was not able to demonstrate that it was routinely assessing and managing risks to the safety of people who use services. The registered manager had told us that monitoring visits to people's homes were meant to be carried out every six months, and led by a care manager. The service had recognised that this had not been happening, as they had been responding to urgent calls to people's homes. When we visited this time we were not provided with evidence that showed this was happening.

When we looked at the management communication book it noted the district nurse had telephoned to say she had seen staff members using an inappropriate lift. She had told the carers and they were still doing it. It was not clear whether the management had suitable arrangements in place to ensure such problems were picked up internally through regular spot checks. This meant people could not be sure the provider had an effective system in place to identify, assess and monitor risks to the health, safety and welfare of people who use the service.

The provider had carried out a survey of service users in early 2012. They had received 19 responses to this questionnaire and most were positive about the care they received. When we visited this had still not been analysed. The last analysis of trends available was one from the August 2010 survey.

We asked to look at the complaints file and incident files. Although there was recorded evidence to confirm individual concerns had been addressed, the provider may want to note there was no evidence that overall trends in complaints and incidents were being analysed.

Our judgement
The provider did not have an effective system to regularly assess and monitor the quality of service that people received.

The provider did not have an effective system in place to identify, assess and monitor risks to the health, safety and welfare of people who use the service.

The provider was not meeting this standard.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
People told us records of care were kept at their homes and that staff had access to these when they received care.

Other evidence
When we visited last time we found that some of the records kept at people's homes were not always up to date or filed in a clear manner.

When we visited this time we found people's personal records including medical records were accurate and fit for purpose. We looked at the care plans for six people who were receiving care from Satellite Consortium Limited. All of these had up to date recording of their needs and outlined the care they needed to receive.

Our judgement
People were protected from the risks of unsafe or inappropriate care and treatment.

The provider was meeting this standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting workers
	How the regulation is not being met: People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. The registered person did not have suitable arrangements in place in order to ensure that persons employed had received appropriate supervision and appraisal. The provider was not meeting this standard.	
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. The provider did not have an effective system in place to identify, assess and monitor risks to the health, safety and welfare of people who use the service The provider was not meeting this standard.	

The provider must send CQC a report that says what action they are going to take to

achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA