Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

SSA Quality Care

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Tel: 01296678589

Date of Inspection: 27 February 2014

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Records ✓ Met this standard

Details about this location

Registered Provider	SSA Quality Care Limited
Registered Manager	Mr. Stephen Twigg
Overview of the service	SSA Quality Care provides a domiciliary care service to people in their own homes. They do not provide a service for children.
Type of service	Domiciliary care service
Regulated activity	Personal care

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether SSA Quality Care had taken action to meet the following essential standards:

- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 27 February 2014, talked with carers and / or family members and talked with staff.

What people told us and what we found

When we visited SSA Quality Care in July 2013, we found concerns with record keeping. We found examples where assessment forms were incomplete and did not provide a clear picture of the person's assessed needs. They did not detail what level of help they required assistance with and what they could do themselves. We saw some risk assessments in relation to the working environment and moving and handling but we saw inconsistencies in relation to other areas of care which had the potential of placing people's welfare and safety at risk. Documentation containing tick boxes were not always completed and the daily reports were brief and did not detail the care provided in a personalised manner. Further concerns were in relation to the recording of the visit times compared to those on the electronic monitoring system which suggested poor recording by staff.

During this visit we found the service had made some progress on monitoring people's daily records to ensure they were accurate and in line with their individual care plans, provided a detailed account of the care provided in a personalised manner and the times of the visits matched those on the electronic monitoring system. Where omissions or poor recording were evident, appropriate actions had been taken to address the concerns with staff. This was to ensure they were aware of the importance and their responsibility to record the care given accurately.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Overall the service had made some progress on monitoring people's daily notes and the standard of staff's record keeping. They had taken appropriate actions where poor record keeping had been evident to ensure accurate records in relation to the care and support provided were maintained.

Reasons for our judgement

When we visited SSA Quality Care in July 2013, we the service was non compliant in this outcome area. This was because records were not accurately maintained and the provider had not ensured people were protected against the risk of unsafe and inappropriate care. Although people received the care and support they needed, records did not always reflect this. We also found inconsistencies in the times of visits recorded in daily notes to those on the electronic monitoring system and also noted some visits had not been recorded or logged on the electronic monitoring system to show they had been undertaken.

Following the visit in July 2013 the provider wrote to us and provided us with an action plan. This informed us they would review the standard of record keeping and put a system in place to regularly monitor people's care records to ensure records were accurate, person centred and the timing of the visits reflected those on the electronic monitoring system. This had entailed the recruitment of a care manager to assume these responsibilities. We were also supplied with a copy of a memorandum which had been circulated to staff. This ensured staff were reminded of their responsibilities in relation to maintaining accurate records.

At this inspection we were informed the appointed care manager had resigned in December 2013 and had not been replaced. However, the service had begun auditing daily notes and medication administration records which were returned to the office each fortnight. We viewed a recent audit undertaken in January 2013 which involved monitoring sixty three sets of daily notes and corresponding medication administration records, where staff assisted with medication administration. Of the sixty three audited, twelve were found to be not up to standard. Examples included the lack of detailed accounts of the care given, failure to sign, date and time the daily notes and writing the notes up in pencil. We saw actions had been taken and documented where poor record keeping had been evident. These included supervision sessions and discussions with staff. We saw evidence of documented supervisions to evidence this. This showed the provider was monitoring the

standard of record keeping and had taken actions where necessary.

We reviewed four people's care files and found there had been some improvements made however this was not consistent. The provider may wish to note that whilst assessments of people's care needs were completed with no gaps, there were instances in which these still did not detail the level of support and what people were able to do themselves. Similarly daily notes informed of the care provided but were not always written in a person centred way. We found two people's care plans did not reflect the number of visits detailed on the referral documentation from the funding authority. We were assured the number of visits detailed in the care plans were correct. This meant information in relation to the number of calls they required was not accurately reflected in their care plans. The provider made a call to the funding authority to request a copy of the variations. They informed us these would be placed in the individual's files so information held in their files were up to date, accurate and reflected their care plans. Following our visit we received a copy of the variation forms which showed the number of visits detailed in the care plans were correct.

One of these two files contained a referral from the local funding authority. This referral informed us the individual was prone to seizures. Whilst reviewing the individual's care plan there was no risk assessment or detailed plan of action staff were to take if the individual had a seizure. We also noted the person could become aggressive and verbal yet there was no risk assessment in place, or specific detailed instructions for staff to refer to in such situations. At the time of writing this report we received amended documentation which detailed how staff were to respond to such situations and what triggered the seizures. We also telephoned five carers who provided care and support to the individual to verify they had been informed of the changes. They all informed us they had read the updated care plan and risk assessment and were able to tell us what the changes made entailed. This meant the person's risk assessment and care plan had been revised to ensure staff knew how to respond. This confirmed to us the provider had acted swiftly to ensure the individual's records had been amended. This ensured information within their file was accurate and they were not placed at risk of unsafe and inappropriate care

Overall the service had made some progress on monitoring people's daily notes and they had taken appropriate actions where poor record keeping had taken place. This showed systems were in place and used to monitor people's records to ensure they were accurate and in line with their individual care plans, provided a detailed account of the care provided in a personalised manner and the times of the visits matched those on the electronic monitoring system. We were also informed the management team had discussed actions to be taken where continuous poor recording was evident and a memorandum was drawn up to circulate to all staff the day after our visit. We received a copy of this the following day.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - 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.

Moderate impact - 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.

Major impact - 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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