Just Ask Domestic Services Community Interest Company

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Just Ask Domestic Services Community Interest Company provides personal care and support to people who live in their own homes. The service currently supports people who need support with tasks such as washing, dressing and medicine administration. The service currently provides personal care to nine adults and older people. One person was living with the early stages of dementia.

This inspection took place on 14 December 2016 and was announced. This was the first inspection of the service which was registered in May 2015.

Prior to this inspection we received information from the local authority regarding concerns about the service following a quality monitoring visit.

There was no registered manager in post at the time of our inspection, which is a condition of the provider's registration. 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 manager in post had started the process to register with the CQC.

During the inspection we found breaches in the Regulations relating to good governance, fit and proper persons employed, and staffing. You can see what action we have asked the provider to take at the back of the full version of the report.

There was a lack of experienced management and clear leadership within the service. Complete and accurate records, in relation to the care and support that people received, were not maintained. This included records relating to risk management, medicines, mental capacity and team meetings. This presented a risk to people of receiving inappropriate care and treatment. The provider did not have systems in place to assess and monitor the quality of care they provided.

Recruitment procedures were not being followed and there was not a robust system for checking the backgrounds of staff before they started work. Some staff were working without references or background checks. The lack of a robust process for checking that staff were 'fit and proper' placed people who used the service at risk of improper care or support.

There were gaps in training and care staff did not receive a formal supervision. This meant that staff were not fully supported in their development and did not have opportunities to learn about wider areas of good practice.

The systems in place for the administration of medicines did not make sure that medicines were safely managed. Risk assessments and information about how to reduce risks was not always in place where risks

to people had been identified.

Although the provider considered issues of capacity and consent, documentation was not always clear. Where people had capacity to make their own decisions the provider had not always gained consent before providing care and support.

People told us that they received good support from caring staff, who supported them in the way they wanted. People were supported to maintain good health, and the service worked closely with other professionals where necessary.

The manager and registered provider were open and receptive throughout the inspection. They accepted the situation required urgent improvement. The provider has decided to suspend new placements while improvements are made. Staff told us that there was a supportive working atmosphere and that they like working for the provider.

Following the inspection we shared our findings with the local authority. An action plan has since been received from the registered provider, in relation to the concerns identified at the local authority quality monitoring visit which took place in November 2016.

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 registered provider did not have a safe system for the recruitment of new staff. Background checks were not always carried out.

The management of medicines was not robust and placed people at risk of not receiving their medicines as prescribed.

Risks to people had not always been identified or mitigated against.

There were sufficient numbers of staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive formal supervision or appraisal to support them with their roles. Not all staff had received appropriate training to support them in providing an effective service.

The provider did not always consider issues around consent to make sure people had agreed to the care provided.

People were supported to access relevant services such as a GP or other professionals as needed.

Is the service caring?

Good

The service was caring.

People told us that they received good care and support from the service.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of recorded information about people's needs and how these were to be met.

People knew how to make a complaint or compliment about the service. The provider responded appropriately to any concerns received.

Is the service well-led?

Inadequate

The service was not well-led.

Accurate and up to date records relating to people's care and support were not maintained.

The provider did not have a formal system in place to review people's needs and identify any changes.

The provider did not have systems in place to assess, monitor and improve the quality of care.

There was a lack of experience in the management team.

Just Ask Domestic Services Community Interest Company

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.

Prior to this inspection we received information from the local authority regarding concerns about the service following a quality monitoring visit.

This inspection took place on 14 December 2016 and was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included any notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Return (PIR). The PIR is a form that asks the provider 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. We looked at four people's care planning documentation and other records associated with running a community care service. This included four recruitment records, training records and policies and procedures.

We met with the manager, registered provider and office manager and spoke with one member of care staff. After the inspection we spoke over the phone with five people who received a service, and five members of staff.

Requires Improvement

Is the service safe?

Our findings

The registered provider did not carry out all the necessary background checks to make sure new care staff had the required skills and background to work with vulnerable people. Although application forms included details of referees and an employment history, there were no references in the three recruitment records we looked at. The registered provider said that most of the care staff previously worked for the service as a 'home help' or had been recommended by other care staff. They told us it was difficult to get references for staff who had not worked for a while previously. However, there was no evidence that the lack of references had been considered during the recruitment process. There were no interview notes for any of the applicants to show how it had been decided they were suitable for the position.

Two care staff were working on their own without a full criminal background check through the Disclosure and Barring Service (DBS). These checks help employers make safer recruitment decisions. The registered provider showed us evidence that these staff had had an initial 'adult first' check which identified if they were barred from working with vulnerable people. The registered provider thought that this was sufficient to allow staff to work on their own. However, the online DBS system, shown to us by the provider, included clear guidance stating that recruitment decisions should wait until the full DBS certificate is returned.

The registered provider accepted that recruitment checks were not sufficient but stressed that they were confident care staff were suitable to work in a care service. We noted that the comments people made about staff competence were entirely positive. However, the lack of a robust process for checking that staff were 'fit and proper', placed people who used the service at risk of improper care or support. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people required assistance to take their medicines or to apply skin creams. This is called medicine administration. The service made use of Medication Administration Records (MARs) to record when medicine or cream had been administered. We looked at three MARs. These were completed inconsistently and did not provide an accurate record of medicine administration. One person's MAR included a description of the medicines, dose and time of administration. There were no unexplained gaps. However another person's MAR did not include the dosage details of a medicine, Pantaprozole, although it had been administered. One medicine had been added by hand to the MAR at the top of the sheet, without explanation or countersignature.

MARs did not identify if a medicine was in a prepared 'dossett box', or if it was separately boxed. Also, MARs did not differentiate between medicines which were to be taken regularly and those that were taken 'as required'. There was no information in care plans about the use of 'as required' medicines and when they may be needed. This meant there was a lack of clear instruction for care staff. Care plans included details of the doctor, if needed, as well as pharmacy details and any allergies.

The provider showed us their policy on medicines management. This was generic and did not provide clear guidance specific to the service. Training records showed that staff had received online training in medicines administration. Although the provider said that staff were assessed as competent by a manager before

administering medicines on their own, there was no evidence that this happened. One member of staff said that they had completed medicines training but had not been observed in practice.

There were risk assessments in people's care plans which identified risks to people's safety. However, these were brief and contained little detail. One risk assessment showed the person was at high risk of falls, but there was no detail and no description of how the risk could be reduced. One person's care plan stated their mobility was poor and they used crutches. However the mobility risk assessment stated they could mobilise independently. Another person's risk assessment showed there was a high risk in relation to pets, but again no further detail as to what this meant. Although we did not find that these issues had directly impacted on people's support, there was a potential risk of unsafe care to people who used the service. It also meant that staff could be placed in risky situations without being fully aware of what the risks were.

The concerns highlighted above meant the provider did not have robust systems in place to keep people safe. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had received recent training in safeguarding people who use services. However, although care staff had been trained in safeguarding, for some of them, this had not been refreshed since they worked in the home help side of the service, over two years ago. Staff told us they were confident about identifying abuse and taking action to keep people safe. The registered provider explained they were making improvements to safeguarding procedures, which included developing a safeguarding policy as one was not in place. They added that, in addition, they would be giving all staff a leaflet called 'Keeping people safe' which provided additional safeguarding information.

None of the people we spoke with raised any concerns about their safety. They said they had confidence in the care staff to provide them with safe care. Records showed that care staff took appropriate action in response to any accidents, incidents or concerns. For example, after a person fell over the care staff called 111 and stayed late to sit with a relative. Another carer identified a wound on a person's back and contacted the community nurse. Accidents and incidents were appropriately recorded. We noted that any safeguarding concerns had been notified to the correct authorities.

There were sufficient numbers of staff to provide people with the support that had been agreed. The registered provider explained that a schedule was drawn up each week using a care planner 'app' so that staff knew who they would be visiting. This was confirmed by the staff we spoke with. The registered provider added that because it was a small service they could be flexible in accommodating people's needs. People told us that there were no problems with missed or late calls and they generally received support when they expected. One person commented, "They always turn up on time". The registered provider explained that, at weekends and out of hours, contact numbers were given to people who used the service with management on call details. This was confirmed by one person, who said, "If I need to speak to someone I can get hold of them".

Requires Improvement

Is the service effective?

Our findings

The registered provider told us that when care staff started at the service they were provided with an induction. They told us that this consisted of a half day to a day in the office for training and then shadowing other staff for a week. Training was mostly provided through online courses, with practical training, such as moving and handling carried out by external trainers. After this they were able to work on their own. There was no evidence that staff were assessed as competent before working alone and the registered provider did not carry out 'spot checks' on staff to check their practice whilst at work. This was of particular concern due to the lack of proper recruitment checks. The registered provider told us that they wanted to improve induction and were in the process of doing this.

Although care staff felt supported, they had not received formal supervision or yearly appraisal with a manager to discuss their development and support needs. It was clear from staff feedback that there was regular contact between management and care staff and that informal discussions took place regularly. The registered provider told us, "We have a lot of informal supervisions and chats", but he was not aware there needed to be formal supervisions. The lack of recorded supervision meetings meant the provider was not fully supporting staff in their roles and professional development.

We identified a number of gaps in the training provided to care staff. Records showed that staff had been provided with training in safeguarding, medicines, food hygiene and manual handling. Four staff had received first aid training from an approved training provider. However, some training had not been renewed in a timely manner. There was no formal training in infection control or mental capacity, and no training in how to support people living with particular conditions, such as dementia. A training programme for staff was not in place. The provider told us that all care staff were now completing the Care Certificate, which is a national set of standards for care work. This was confirmed by records and the staff we spoke with. Care staff also told us that they felt the training they received was sufficient. Although we identified no direct impact on people that used the service, the lack of a clear training programme did not support staff in their roles.

Shortfalls in training and supervision meant that care staff were not fully supported in carrying out their roles. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we identified the concerns above, the staff we spoke with told us they enjoyed working for the provider and that they did feel supported. Comments included, "I feel absolutely supported. I can always get hold of a manager" and "I used to do home help and just started on the care side. I find it brilliant". The people we spoke with were positive about the care staff who supported them. One person said, "[Care staff] is absolutely excellent" and another person told us, "The lady who comes is superb".

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 provider told us that no one was currently subject to any restrictions by the Court of Protection.

The registered provider explained that all people who used the service were able to consent to the care and support provided, although this was not always clearly evident in care plans. One person's medication consent form had been signed by a relative, although there was no information to show that the person was unable to sign for themselves. We noted that people's care plan information made reference to whether there was a 'Do Not Attempt Resuscitation' (DNAR) agreement in place, by stating 'yes' or 'no'. However, where this was 'yes', there was no supporting evidence, such as the DNAR agreement, and no guidance for care staff about what this meant and how this may impact on their work. This placed people at risk of receiving inappropriate care and support, contrary to their wishes.

Care plans made reference to people's health needs, however there was a lack of detail about how this impacted on people's lives 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 services when a concern had been identified. For example, a care staff member made a doctor's appointment for one person after they appeared unwell during a care visit.

The registered 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. There were no people who required special diets or support with eating and drinking. Records showed that one person was diabetic and their care plan stated that they had an ordinary/low fat diet. However, there was no further detail or guidance for staff about whether they needed to consider this during their visits.

Good

Is the service caring?

Our findings

We received positive comments about the service from all the people we spoke with. Feedback included, "They are very nice people. They even do extra things for me like make my bed", "I can't fault it", "They are very good" and "Absolutely superb". One person said "I have a right laugh [with care staff]. They are very good. Very friendly". All of the people we spoke with were happy with the care and support they received.

The care staff we spoke with also demonstrated a caring attitude to the people they supported. One member of staff told us, "We provide more time for people. I never feel rushed. The team is caring. They match clients to the carer [care staff] to make sure they get on well". They went on to explain how they made sure a person was involved and respected, saying, "One [person] I help is nearly blind. I always ask their permission before doing anything. I don't just do things. She [person who used the service] said she likes the way I give her choices for lunch. One [person] has dementia. I have looked into it. I am looking at a memory box. I think of ways to explain. For a sandwich, I get the bread and butter out and show them. I give visual clues".

Staff were aware of the importance of promoting people's dignity and respecting their privacy. People we spoke with confirmed this. One person said, "I'm treated with respect" and another person told us, "I couldn't ask for a nicer person". Daily records written by care staff were respectful of the people they were about. Entries made reference to what was talked about and the person's mood and emotional well-being, rather than just the care given. This showed that care staff saw people as individuals and had sufficient time to engage with them socially.

People told us that there was good communication and that they felt involved. People knew what to expect from the service and were involved in any changes. The provider told us that there was frequent contact between the office, care staff and people who used the service, often informally. This meant they were able to develop positive relationships which promoted good communication. Because there was a small team of care staff, people were supported by people who they were familiar with and with whom they had good relations.

A service user guide was in place, however, this was very lengthy and not in an easy to understand format. We recommend the provider review the service user guide to make sure it is accessible to people who use the service. The guide made clear the expectations people could have of the service. These included the right to privacy and to be treated with respect.

Although we received positive feedback about the care and support received, the concerns identified elsewhere in this report showed that the provider was not operating a Safe, Effective, Responsive or Well-Led service. This was contrary to their own policies and procedures and the information provided to people who used the service. This did not demonstrate respect for people's rights. The registered provider demonstrated a lack of care by failing to ensure risks to people and staff were adequately assessed and minimised, potentially putting people at risk. Therefore, overall improvement was required in order to demonstrate that the service was consistently caring.

Requires Improvement

Is the service responsive?

Our findings

We found that the quality of written care plan information varied and was generally lacking in detail. Each person had a brief care plan which summarised the support to be provided, such as 'help to get dressed', however, there was no detail. However, there was no specific detail or information about how people liked to be supported or their preferences, likes or dislikes. Information included people's mobility, communication and medical conditions, but again there was a lack of detail. For example, one person had poor vision and hearing, but there was no information about how this impacted on communication and what staff needed to be aware of. Another person's care plan stated, 'Clear away incontinence pads', although there was no information about how to dispose of them.

The registered provider told us that they had not been carrying out formal reviews of the support needed for people who used the service, which meant care plans were updated only when new information was received. The provider told us that they did not currently support anyone with complex care needs and they knew the people who used the service well. There was evidence of the involvement of people and their relatives about the care and support received, for example we saw a good record of a discussion with family members. However, the lack of reviews meant that the provider could not be certain they were providing care and support which met people's current needs.

We noted that the people we spoke told us they received the support they needed, had regular contact with the office, and most of them had been with the service for under a year. We found no evidence to suggest people's current needs were not being met.

Most care staff told us that care plans contained the information they needed, although one member of staff commented, "There is always room for improvement". Each person had a record at their home which care staff used to record details of their visit. We looked at some of the daily records which showed that care was given in line with the agreed support. The people we spoke with raised no concerns about the care and support they received.

The registered 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. The registered provider had a half hour minimum call time and most calls were for an hour. People told us that care staff didn't rush and had time to socialise. As well as supporting people with care at home, the service helped people get out in the community, with shopping or attending appointments.

There was a detailed complaints policy in place which included details of the CQC and Local Government Ombudsman. However, the policy was lengthy and not in an easy to understand format. The provider explained that the service currently didn't have a leaflet, but that they gave people contact numbers and met with people frequently during the course of their work. There was one complaint recorded. This had been responded to in writing and in further communication. Learning points had been considered to make sure there was no reoccurrence. None of the people we spoke with during the inspection had any complaints to make about the service.

Inadequate

Is the service well-led?

Our findings

The registered provider explained that, prior to registration with the CQC in May 2015, the service provided home help such as cooking and cleaning. The registered provider had identified that there was a demand in the local community for care as well as home help, so registered to provide personal care in people's homes.

Since the service was registered there had been four changes in manager. Only one of these had been registered with the CQC. The current manager had been in post since November 2016 and had started the application process to register with the CQC. The registered provider explained that there had been difficulty in retaining managers. This was concerning as the registered provider had limited experience in care and did not demonstrate a full understanding of the Regulations during the inspection. The current manager used to be a senior carer but had no prior management experience. They had not had any specific management training but told us they were keen to get an NVQ level 5 in management, although they had not started this.

During our inspection we found a number of areas where records were not maintained to an appropriate standard. These included records for recruitment, training, care planning and risk management. The records for consent to aspects care and support were also incomplete and had not always been signed by the relevant people. Where decisions had been made regarding changes to support there was a lack of recorded information, and discussions with people who used the service were not always noted. Although we did not identify that this had impacted on people's care, the lack of records presented a risk to people of receiving inappropriate care and treatment.

The registered provider did not carry out any formal auditing or monitoring of the service. This meant there were no formal management checks on records, training, recruitment or staff competence. The registered provider told us that they became aware of a lot of the shortfalls after a recent monitoring visit by the local authority, and had started to make improvements, such as new policies and procedures.

We looked at some of the policies and procedures used for the management of the service. The registered provider used a manual which had been provided by a company which develops policies and procedures for different types of services. Although this contained all the required information for the management of the service, polices were lengthy and generic rather than being specific to how the service operated in practice. In some instances the registered provider was not following the policies in place, such as with regard to recruitment or record keeping.

Although the provider told us there were regular team meetings, which was confirmed by care staff, these were not recorded which meant there was no record of decisions made or the action taken. There were no formal systems for gaining the views of staff or people who used the service, in order to assess and monitor the quality of care and support provided.

The above shortfalls, and the failure to identify concerns described elsewhere in this report, mean that the provider was failing to mitigate the risks relating to the health, safety and welfare of people who used the

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

The provider recognised that they had a lot of work to do to make improvements and said they were committed to doing what was necessary. Because of the potential risks to people who used the service, they have agreed to suspend any further referrals for personal care until improvements have been made.

Although we identified a number of issues in relation to governance, care staff made positive comments about the registered provider. These included, "I like the company", "I prefer this [employer] to others I have worked with" and "It's the best company I've worked for".

The registered provider had a set of values which they believed were essential to the service. These included, "We are committed to maintaining and refining the quality of our service. We will be innovative, accountable, adaptable and person centred". The registered provider explained, "I believe my passion and enthusiasm is relayed to staff. We discuss culture in induction and team meetings. We get staff involved in describing the service. Discuss what we could do better. We don't take minutes though. Give positive feedback to staff. I want to provide the level of service we would be happy for a family member to receive".

Although there were no records of team meetings, we were shown the results of a recent team 'think tank' exercise. The team had got together to discuss what was done well and what could be done better, with suggestions as to how changes could be introduced. This was focussed on care and support and included ideas such as creating a trusted tradesmen list for people. Although the actions from this meeting had not been completed, there was the potential to explore different and innovative ways of supporting people.

The registered provider had notified the CQC, and other relevant authorities, of any incidents or concerns as required.

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 Insufficient and incomplete records relating to the care and treatment of each person placed people who used the service and employees at risk. Failure to assess, monitor and improve the quality of the service to ensure compliance. Regulation 17(2)(a)(b)(c).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The lack of a robust recruitment process for checking that staff were 'fit and proper' placed people who used the service at risk of improper care or support. Regulation 19(2)(3).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing A lack of formal supervision and appraisal, as well as gaps in training, meant that staff were not fully supported in their development and did not have opportunities to learn about wider areas of good practice. Regulation 18(2)(a)