Litch Care Services Limited

Litch Care Services Limited

Inspection report

7-9 Campbell Place
Stoke On Trent
Staffordshire
ST4 1NH

Tel: 01782917749
Website: www.litchcareservices.co.uk

Date of inspection visit:
30 August 2017
31 August 2017

Date of publication:
31 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 August 2017 and was announced. The provider was given 24 hours' notice because the location provides domiciliary care services; we needed to be sure that someone would be in. Litch Care Services provides community support and personal care to people in their own homes. At the time of the inspection, four people were receiving a service from the provider. This was the first comprehensive inspection of the service following registration.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People's medicines were not always managed safely. People were supported by staff to reduce the risk of harm. However, this was not always clearly documented in their care plans. Staff understood how to safeguard people from the risk of potential abuse. However, risks of potential abuse were not always reported to the appropriate agencies. People received their support at the times they needed it and from consistent staff. People were supported by staff who had been safely recruited.

Where people lacked capacity to consent they were not having their capacity assessed and the registered manager was not checking those signing consent on behalf of people had the right legal status. People told us they thought staff had the skills required to support them. Staff told us they had an induction with training and the registered manager said this would be updated on a regular basis. People were supported by staff to eat and drink sufficient amounts to promote their health. When needed people were assisted to access relevant healthcare services.

People told us staff were caring. People were able to make decisions about their care and staff supported them to make choices. People were supported in a way which maintained their independence. People's privacy and dignity was respected by staff.

People were involved in the assessments of their care needs and had regular care reviews. People told us that staff understood their preferences for how care and support was delivered. However, this was not always detailed in peoples care plans. People understood how to make a complaint and there were systems in place to ensure complaints were appropriately investigated and responded to.

The systems in place to check the quality of the service and ensure people's needs had been met; were not always effective. People and staff said they found the registered manager was approachable and they felt able to share their views about the service.

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.

People were not always supported to take their prescribed medicines safely. People receiving topical creams did not have accurate records in place.

People were not always protected from harm as safeguarding matters were not always reported to the appropriate body.

People were supported to manage risks to their safety. However, guidance for staff was not always clearly documented in people's care plans.

People were supported by sufficient numbers of staff and received care from a consistent staff team.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not supported in line with the principles of the Mental Capacity Act.

People were supported by skilled staff that had regular updates to their training.

People were supported to eat and drink sufficient amounts.

People had support to access healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People had support from staff that were kind and caring.

People were able to choose and make decisions about their care and support.

People were supported to maintain their independence.

People were supported in a way that maintained their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in their assessment and care planning and staff understood their needs and preferences. However, some improvements were needed to ensure that people's preferences and assessed needs were detailed in care plans to ensure staff had sufficient guidance to provide individualised care.

People understood how to make a complaint and received a response.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to check the quality of the service were not consistently effective.

People and staff told us they were able to approach the registered manager.

People were able to share their views about the quality of the service.

Litch Care Services Limited

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 30 and 31 August 2017 and was announced. The provider was given 24 hours' notice because the location provides domiciliary care services; we needed to be sure that someone would be in. The inspection team consisted of two inspectors 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.

Prior to the inspection, we reviewed the information we held about the service. This included any statutory notifications we had received, which are notifications the provider must send us to inform us of certain events such as serious injuries. We also contacted the local authority and commissioners for information they held about the service. We used this information to help us plan our inspection.

During the inspection visit, we asked to speak with people that used the service, however people were unable to speak with us for various reasons. We spoke with four relatives. We spoke with the registered manager and four care staff. We reviewed a range of records about how people received their care and how the service was managed. These included four care records of people who used the service, six staff records and records relating to the management of the service such as complaints, safeguarding and accident records.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. We found that some people's risk assessments indicated they did not have support from staff with regards to their medicines. However, when checking with staff they told us they applied topical medicines such as creams for these people. We found there were no specific plans to guide staff on when or where they needed to apply these creams. We saw from people's daily records that staff regularly supported people to apply their creams. This meant the provider had not taken into account that topical medicines, such as creams, are a medicine should be clearly documented and instructions provided. We spoke to the registered manager about this and they confirmed they were unaware that topical creams needed to be recorded as medicines. They confirmed they had put a medicine administration record in place for people having topical cream applied during the inspection.

Medicine risk assessments and plans were not always clear. We found there were assessments and plans in place to show staff what support people needed with medicines. These were not always accurately completed. For example, we found two people were supported by their relatives to take their prescribed medicines; however the documentation had mixed information in some places stating relatives to administer and in others saying staff. We spoke to the registered manager about this and they confirmed relatives administered medicines. This meant there was unclear information for staff about how medicines should be administered.

Where people were receiving medicines from a blister pack which were administered by staff they told us they were happy with the support they received. One relative said, "Medication it's given and they keep very careful notes". Another relative said, "Medicine is given from blister packs and there is never a problem". Staff told us they supported people to take medicine from a blister pack and recorded what people had taken on a medicine administration records (MAR). Staff informed us that they had received medication training. This training ensured staff had the skills to support people to take their medicines safely.

People were supported to manage risks to their safety. One relative told us their relative was previously at high risk of falls but having staff there 24 hours a day had meant their relative was safe. Another relative told us about risks associated with the person's diet, they said staff understood these risks and kept the person safe. Staff we spoke with could describe people's risks and how they supported them to stay safe. For example, they could describe the actions they took to support one person to prevent them from falling. Staff could describe how they supported one person to manage their behaviour. Staff were aware of things that made the person anxious and unsettled and knew how to support and reassure them. However, when we looked at people's records we found they did not always contain guidance for staff to refer to in order to manage these risks to people's safety. This meant if new staff were supporting people they would not have guidance to manage risks to people's safety.

People and their relatives told us they felt the service was safe. One relative told us, "[My relative] is not unsafe at all. The staff are better at safety than I am". I can't give you any example, it's just a feeling I have". Staff could describe the signs of abuse and could tell us how this was reported to the appropriate authority. They described how they would document their concerns and raise these with the registered manager so

they could be investigated. However, we found not all incidents had been appropriately investigated and escalated to the local safeguarding authority. For example, we saw evidence of a safeguarding concern that had not been investigated or referred to the appropriate body. The registered manager had not recognised the requirement to report this incident. We reported this incident to the local safeguarding authority to ensure this was investigated appropriately. This showed the systems in place to safeguard people from potential harm or abuse were not always effectively investigated.

Staff understood how to support people if they had an accident. One staff member said, "If someone had a fall we would check them over and call for an ambulance to attend". We saw the registered manager had a system in place to investigate accidents and incidents and we saw appropriate action had been taken to reduce the risk of reoccurrence. This meant appropriate action was taken in the event of accident and the provider was working in ways to mitigate the risks of incidents reoccurring.

People received their care on time and this was provided by regular members of staff. One relative said, "The staff come in the morning, afternoon, and half an hour in the evening. They come on time, and stay the right amount of time". Some people required continued care and support and were provided with staffing throughout the day and night. One relative told us, "There's one staff member there at all times, they alternate and could live-in for one week or two". The relative added, "They are all familiar to [my relative], and they are quite settled. It's not very often that they get a new face". Staff told us they felt there were sufficient staff to meet the needs of people as the service was very small. We asked to see the records of staff visits, the registered manager told us they did not currently use rotas to document which staff attended calls and the times they attended. They explained as the service was small they used mobile phones to allocate staff to calls and this was currently effective. The registered manager confirmed they planned to invest in an electronic system as the service increased the number of staff employed and people supported. They had a system in place where if a staff member was going to be late they would alert the registered manager and they would contact the person to let them know. We looked at people's daily care records and found people had consistently had their care delivered at the times they required it. This was also confirmed by the relatives we spoke with. This demonstrated that there were sufficient staff provided to meet people's assessed care and support needs.

People received support from staff that had been recruited safely. Staff told us they had been interviewed for their role and pre-employment checks were carried out before they started work for the agency. The registered manager told us these checks included two references and Disclosure and Barring Service (DBS) which helps employers make safer recruitment decisions. Records we looked at confirmed what we had been told.

Requires Improvement

Is the service effective?

Our findings

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.

We checked to see if the service was working within the principles of the MCA. We found two people that we were told did not have capacity to make certain decisions. We saw care records which showed others were making decisions on their behalf. Staff confirmed that these people may not have capacity to make some decisions. The registered manager had not understood the need to assess if these people had capacity to consent. The consent to care had been signed by people's relatives and no checks had been carried out to see the relatives had the legal right to sign. To sign an agreement on behalf of someone else that does not have capacity to make their own decisions you must have a Lasting Power Of Attorney (LPOA) for health and welfare in place. In another example, decisions were being taken for one person by a family member; this was documented on a mental capacity assessment. However, the assessment did not indicate which decisions were taken by the family member or show any record of whether these decisions were in their best interests. This meant the registered manager had not understood and followed the principles of the MCA.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

Where people had the capacity to consent to their care staff were able to tell us about the importance of gaining consent. For example, one staff member said, "[Person] has capacity to consent to their care, it is a matter of checking and asking them if it is ok to do something". This showed staff understood the importance of gaining consent. Relatives confirmed people were asked for their consent.

People were supported by skilled staff. The staff we spoke with confirmed they had access to regular training that provided them with the skills to meet people's needs. Relatives told us they felt staff had the required skills to meet people's needs. One relative said, "I don't know anything about what skills and training they have, but they know what to do, it's evident". Another relative told us, "Staff are quite keen to learn the things I teach them, so that's good". For example, like how to cook a steak".

We looked at how the provider supported new staff into their role. Staff told us they had an induction which made them feel confident in their role. They told us the induction covered safeguarding, medicines management, health and safety and manual handling. The registered manager told us, the induction included shadowing more experienced staff and at the end of the process staff competency was assessed. Staff confirmed this when we spoke with them as did the records we saw. The registered manager told us staff were completing a range of training which was delivered online and staff had some face to face training. They also had staff trained as trainers in manual handling. The registered manager informed us that observations of staff's care practices were carried out to ensure the skills they had learned were put into

practice. Staff confirmed they received a questionnaire to see if they had any areas for further development. The records we saw supported what we were told. Staff told us they received regular supervisions, the registered manager confirmed these took place every three months and the records we saw supported this. This showed staff received support in their role.

People were supported to prepare meals which met with their needs and preferences. One relative told us, "[My relative] eats most things; the staff cook whatever she wants". Another relative said, "[My relative] has to have a specific diet, staff understand this and provide what they need". Staff described how they offered support to people with their meals. For example one staff member was able to describe in detail how one person's meals had to be prepared to minimise risks associated with their diet. Staff described how they offered people a choice of meals and drinks and how they had spent time getting to know how people liked their meals prepared. We saw care records detailed people's preferences for food and drinks and recorded what people had eaten and drank during the day. This showed that people were supported by staff to eat and drink sufficient amounts to promote their health.

People received support to monitor and maintain their health. One relative told us, "The staff had to call an ambulance on one occasion, and they contacted me straight away". Another relative said, "The staff have phoned the paramedics and the pharmacist on several occasions". Staff told us they would request the registered manager sought health advice if needed, and would contact an ambulance if anyone needed one. People were appropriately referred to healthcare professionals where required. We saw records that showed staff had raised concerns about people's health and wellbeing and action had been taken to seek advice from a relevant health professional. For example, one person had a visit from the district nurse after staff requested contact was made with them following their observations. This meant people were supported to access relevant healthcare services when needed for treatment and to monitor their health.

Good

Is the service caring?

Our findings

People were supported by caring staff. One relative said, "I don't think there's anything better they could do for [my relative]; we have all got to know each other and things are quite settled". Another relative said, "The staff are all caring and they support [my relative] as best as they can. It was a bit strange at first but we got used to it". Relatives told us staff were good at communicating. For example, a relative said, "The staff know how to contact me, they will phone about things like shopping, health problems, if the chemist hasn't delivered the medication quick enough, if clothes need replacing. Generally, we're quite happy in that regard". Staff spoke about people in a kind and caring manner, they told us they spent time getting to know what people liked and their preferred routines. One staff member said, "I know the people I support quite well, there is plenty of time to talk with people and get to know them". Staff told us they felt confident they understood people's likes and dislikes. They could share details with us about how people liked their care and support delivered. For example, one person liked to brush their teeth in the middle of the day and another person liked to watch the news with their meals. This showed people were supported by caring staff.

People were supported to maintain their independence and make choices for themselves. One relative told us their relative wanted to remain living at home and retain their independence. They commented, "Their major choice was to stay in their home and I had to get the care put in place to enable that". Staff told us, people were encouraged to maintain their independence. One staff member said, "For example with [person name] we encourage them to make their own bed and tidy their bedroom". Staff told us people were supported to make choices for themselves. One staff member told us how they would try to redirect if someone was making a choice which left them at risk, such as attempting to walk without the correct equipment. One staff member said, "I offer choices of what food people want, where they want to sit and what they want to do for example". This showed people were encouraged to maintain their independence and choose things for themselves.

People's right to privacy and dignity was respected by staff. One relative said, "The staff always leave the room when I visit to give us time alone." Discussions with staff confirmed their awareness of the importance of maintaining people's privacy and dignity. For example, one staff member told us, "When I assist people with their personal care needs, I always ensure the door is closed." The registered manager informed us that information was contained in care plans to remained staff of the importance of addressing people in a dignified manner and we saw evidence of this in people's care records.

Requires Improvement

Is the service responsive?

Our findings

People's needs and preferences were understood by staff. One relative told us, "My relative has a routine, the staff know what to do, for example they have a bed bath, every day". Another relative told us, "My relative can do activities or go out if they want to, they prefer to watch sport on television most of the time and they enjoy having a chat with staff". They could describe in detail how they supported people. For example, one staff member said, "[Persons name] likes to go to bed at a particular time each evening; they like to have their personal care done after breakfast". Another staff member told us they learned things such as how people liked to take their drinks and said where communication was difficult they observed for signs of body language to see what they liked or disliked. However, the records we viewed did not always contain details of how people preferred their support to be carried out. This meant that improvements were needed to ensure that new staff were aware of how to support people in line with their preferences.

People were involved in the assessment of their needs, care planning and reviews. One relative told us, "My relative was involved in planning their care." Relatives confirmed that regular care reviews took place to reflect people's changing care and support needs. One relative said, "We have a care review coming up soon". The registered manager told us they received assessments from the agency that was funding the persons care then during a visit to the person they would complete their own assessment and care plan. They said people and relatives were involved in the assessment and planning process and this was fully documented. Staff confirmed they had access to these records that supported their understanding about how to care for the person appropriately. Records showed that as part of the assessment people were asked about their cultural and spiritual needs. Staff told us assessments, care plans and reviews were detailed and helped them offer support to people, with any changes to peoples care and support needs following a review being notified to them. However, we saw that people's needs were not always detailed in their care plans to ensure that staff had a clear view of the support required. For example; one person required a special diet, there was no detailed plan of how staff should provide this in the person's records. In another example one person needed support with their behaviours, there was no detailed plan in the persons care records for how to support this person. In another example one person was receiving end of life care, there was no plan in place which detailed their wishes. This meant that improvements were needed to the planning of people's care to ensure that all information required was detailed in people's care plans.

People and their relatives understood how to make a complaint. One relative said, "I have never had to complain, I suppose it would be the registered manager I would contact". The registered manager told us they had not received any complaints. We saw there was a policy in place to enable complaints to be investigated and responded to by the manager with appropriate action taken. This showed the registered manager had a system in place to investigate and respond to people's complaints appropriately.

Requires Improvement

Is the service well-led?

Our findings

The registered manager told us they had a system of audits in place which checked people's care plans and the records of care delivery on a regular basis. However these checks were not consistent in identifying concerns. For example, the lack of guidance for staff and recording of topical medicines had not been identified. The registered manager had not realised these medicines needed to be administered and recorded in the same way as oral medicines. The registered manager told us they would commence this straight away after the inspection. This meant we could not be assured people were receiving their topical medicines as prescribed.

In another example we found whilst staff understood people's risks and how to minimise them, there was not always clear documentation in place to guide staff. For example, we found staff understood the risks associated with choking for one person and could describe the actions they took to keep the person safe. However there was no assessment of the risk of choking, no detailed description of the actions staff took to keep the person safe. The registered manager told us they would update this persons care records and make sure staff had the correct guidance in place to keep this person safe. This meant we could not be assured staff had up to date guidance on minimising the risks.

People did not always have a documented care plan in place to guide staff with meeting their assessed needs. For example, staff could tell us how they supported one person to manage their behaviour. They were able to describe in detail the actions they took to support the person and what may trigger the behaviours. However, there was no behaviour management plan in place to guide staff and no monitoring of these behaviours to try and identify triggers. This meant the person continued to display these behaviours and this caused them distress. People's assessed needs and preferences were not clearly documented. For example, we found people that were receiving end of life care had no plan in place to share their wishes with staff. This meant we could not be assured the person's needs were being met in the most appropriate way.

We also found whilst staff had reported a safeguarding concern this had not been escalated to the appropriate authority for further investigation by the registered manager. The registered manager told us the person had alerted the appropriate authorities themselves and no further action had been taken. They confirmed they had checked and been advised they did not need to refer the matter to another agency. This matter was referred to the local authority safeguarding team during the inspection so we could be sure the matter had been appropriately investigated. The registered manager said they would ensure all future incidents were reported to the appropriate body.

Where people lacked capacity to consent to their care and treatment we found the registered manager had not ensured their capacity had been assessed in all cases, there was no evidence of documented decisions taken in people's best interests and where others had provided consent, it was not clear they had the legal right to do this on people's behalf. This meant the registered manager had not ensured people's rights were upheld in line with the principles of the Mental Capacity Act.

This was a breach of regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

The provider carried out spot checks on staff's care practices and to ensure people's care needs were being met. Records showed where concerns had been identified; action had been taken to address this and to improve the service provided. Audits relating to staff files to check everything was in place for safe recruitment were also in place. These checks ensured people were suitable to work for the agency. The registered manager told us they would be purchasing an audit from an external body once the service had grown to having 20 packages of care in place.

Relatives and staff told us the registered manager was approachable. One relative told us, "I know who is the registered manager is and they are very approachable. My relative has had care from the registered manager and we are on first name terms". The relative added that the registered manager made contact with them regularly by telephone to see if there's anything they want to know. Staff told us they could always seek guidance and support from the registered manger. One staff member said, "There was a situation which was causing some concerns, I spoke to the registered manager about this and they immediately met with those involved and sorted the matter out". The registered manger told us they made regular contact with people, relatives and staff to see how things were going, this was confirmed by what people, relatives and staff told us.

People and their relatives had been asked for their feedback on the quality of the service they received. One relative told us, "I have completed questionnaires". We found questionnaires had been completed by people and their relatives and these included some positive feedback about the service for example, one questionnaire said, "Carers are kind and friendly and dedicated, they are competent." Another survey showed that staff were kind and considerate. The registered manger told us, they used these questionnaires to find out people's views about the service. We also saw the registered manager had received compliments about the care people had received, For example, "You are diamonds, wonderful care". This meant people were able to tell the provider about their experience of using the service.
The staff told us they had good communication systems in place and received support from the registered manager to perform their roles. One staff member said, "The registered manager does supervisions with us and they complete check visits every couple of weeks, they speak with the person and relatives weekly by telephone as well". Staff told us they had regular supervisions and the registered manager used these to discuss their progress. The registered manager told us they carried out staff meetings and gave an example of discussing a recent safeguarding concern with staff in a meeting; the records we saw supported this.

The registered manager understood their statutory responsibilities. A provider is required to submit a statutory notification to notify CQC of serious incidents such as injuries, deaths or allegations of potential abuse. We had not received any notifications at the time of the inspection. However, the registered manager was able to describe what information they would need to share with us in the future.

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 11 HSCA RA Regulations 2014 Need for consent The registered manager was not meeting the requirements of the MCA which meant people were not having their capacity assessed and decisions taken in their best interests.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not identifying areas for improvement which meant people were at risk of receiving ineffective care.