Three Sisters Care Ltd

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 22 June 2016. Breaches of legal requirements were found regarding consent to care, support of staff, suitability of staff, person centred care, safe management of medicines and good governance. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Three Sisters Care on our website at www.cqc.org.uk.

There was now a registered manager at the service. 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.

At our previous inspection we found that the provider was failing to obtain references for staff before they commenced work and was failing to assess people's capacity to make decisions about their care. We found that the provider was now meeting these requirements. The provider had obtained references from staff before they started work and these were checked by the registered manager to ensure they were correct. The provider carried out quarterly audits of staff files to ensure that records were complete. The provider was now carrying out assessments of people's capacity to make decisions for themselves, although it was not always clear whether relatives were signing people's care plans in a legal capacity or to reflect their agreement that the provider was acting in the person's best interests.

At our previous inspection we found that care plans did not accurately reflect the care that people received. We found that the provider was now meeting this requirement. Care plans had been reviewed and the registered manager carried out quarterly audits of care plans to ensure that these were accurate.

At our previous inspection we found that the provider was not managing medicines in a safe manner. This was because medicines recording charts were inaccurate and incomplete and were not checked by managers in a timely fashion, and that risk assessments for administering medicines were not being carried out. At this inspection we found the provider was still not meeting this requirement. Although risk assessments had now been carried out, and records of medicines administration were being checked by the manager, we found that records were still not accurately completed and did not always reflect people's current medicines. Staff had received training in administering medicines, but the provider had not carried out observations of staff to ensure they were competent to do this.

At our previous inspection we found that staff did not always receive training and supervision. At this inspection we found that staff were now attending team meetings and receiving regular supervision and

that there were systems in place to make sure this took place. However, the provider was not meeting this requirement as a significant number of staff had still not received mandatory training in areas such as safeguarding adults, basic life support, health and safety, fire safety and manual handling. The provider had training in these areas scheduled for the coming months.

At our previous inspection we found that the registered manager was not always checking records of care provided to ensure these were accurate. At this inspection we found that the provider was not meeting this requirement. We saw that records were being checked by the registered manager, however although these had improved we found that in some cases these were still not complete, and there were not records of what action had been taken in response to errors.

We found continuing breaches in relation to the safe management of medicines, staff training and good governance. We issued a warning notice to the provider in relation to the safe management of medicines and staff training.

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 still not safe in all respects.

Medicines were not safely administered. Medicines records were not an accurate description of what medicines a person received and how they were given. Although staff had had training, there were not measures in place to ensure staff could safely do this.

There were processes in place to ensure that pre-employment checks, including references had been carried out before staff started work.

Is the service effective?

Requires Improvement

The service was not effective in all areas.

Staff received regular training and attended staff meetings, however staff had not always received training in line with the provider's policy.

The provider had carried out assessments of whether people had the capacity to consent to their care in line with the Mental Capacity Act (2005).

Is the service responsive?

Good

The service was responsive.

Care plans accurately reflected people's needs and the care that was delivered, and were reviewed regularly and in response to changes in people's needs. There were systems of audit in place to check this.

We have improved the rating for this question from requires improvement to good because we found that concerns had been addressed and sustained over a period of time.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager had improved systems for checking

records of care. However, there were still some omissions in recording, and there was not a clear record of what actions had been taken in response to these.

Three Sisters Care Ltd

Detailed findings

Background to this inspection

We undertook an announced focused inspection of Three Sisters Care on 14 February 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 22 June 2016 had been made. We inspected the service against four of the five questions we ask about services: Is the service safe, is the service effective, is the service responsive and is the service well-led? This is because the service was not meeting some legal requirements.

This inspection was undertaken by an inspector and a pharmacy inspector. During our inspection we spoke with the registered manager and three directors of the service. We looked at eight care files, including those for four people we were told were currently supported with medicines. We looked at files relating to six staff, and records of care plan audits, supervisions and staff training.

After the inspection we attempted to speak with seven people who used the service and spoke with one person who used the service and two relatives. We also spoke with four care workers and one local authority commissioning officer.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in June 2016 we found that medicines were not being safely managed. This is because the provider did not maintain accurate and up to date records of what medicines people had been prescribed and there were not complete records of when medicines had been administered. We found that records of administration were not brought back to the office and checked in a timely manner, and that risk assessments had not been completed for people's medicines.

At this inspection we found some improvements had been made, but the provider was still not meeting this requirement.

We checked the care files in the office for four people we were told were currently on medicines and spoke to the registered manager. We saw that each person had a care plan and a risk assessment regarding medicines documented in their files including a signed consent form. One relative told us "They watch [my family member] and make sure they take the medicine…[the registered manager] made sure that medicines were put away safely." Staff told us that they received adequate training to give medicines and were required to bring records of medicines administration to the office each month. We saw that records of medicines were brought back to the office in a timely manner. Some care workers gave examples of when the registered manager had followed up with them about the content of these records. Comments from staff included "They're very strict" and "[the registered manager] checks and if there are any problems she talks to me."

We found only one out of the four care plans included a list of medicines that the person was taking at the time of the initial assessment. Staff told us they relied on the person or the person's family members to tell them and show them their medicines. They did not contact relevant health professionals to get an up to date list of medicines. Three care plans did not document the list of medicines the client was currently on, however the registered manager was able to find on a separate document a list of current medicines for each of the three patients.

We saw hand written notes in two of the care plans detailing when there was a change to medicines, however these did not include when the medicine was to commence from or cease, no information about the duration of use and no information about the frequency and directions for use. Also, they could not assure how this would be transferred into the care plan held at the person's home for the care workers to be updated. For example, we saw a hand written note in a person's care plan stating that a particular medicine was now to be administered at a particular dose. The registered manager told us that she was informed by the care worker and the registered manager looked the medicine up on the internet to search what time of the day the medicine should be administered. This was not verified with the person's GP. The person's medicines were all reported in the risk assessment as being packaged in a dosette box by the pharmacy, however the registered manager did not know if the new medicine had been included in the dosette box or was in its original packaging. We saw that the new medicine had been included onto the medicine administration record (MAR) to be given at lunchtime. For the same person we saw hand written notes on the care plan that stated antibiotics would be given to the person occasionally, but this did not state which

antibiotics, when or for how long. We saw that these had been included into the MAR by the care workers, but the registered manager could not assure us that the antibiotics had been administered by the care workers as prescribed by the GP.

We reviewed MAR charts for the four people receiving support with medicines between December 2016 and January 2017. We found a number of gaps across all MARs. We saw that the registered manager had audited these MARs and they told us that they were going to follow up the gaps with the relevant care worker at their next meeting on 22 February 2017. However, during the inspection we advised the registered manager to contact the care workers as there were consistent gaps for the same medicine daily and we could not be assured that people had received their medicines as prescribed. For example, on one MAR we saw that a particular medicine was the last medicine on the daily list on the MAR charts and had not been coded or signed by the care worker to show if it had been given or omitted, however the registered manager had not followed this up with the care worker.

We also saw on another MAR chart that two medicines were listed, however these were not signed as given. When we reviewed the up dated list of medicines, we found that these were no longer on the list but this had not been updated onto the MAR charts. We saw that one of these tablets was on the latest medicines list and had been hand written into the printed MAR charts by the care worker. We saw that the registered manager had updated the MAR on the computer to remove the two medicines not being given but had not included the new medicine on the new MAR. This meant that care workers following the MAR chart would not know that this medicine also needed to be given and when. During the inspection, the registered manager told us that a new MAR would be generated and a field supervisor would take it to the person's home.

We saw that one person was on 13 different medicines, some of which were to be given at 9am. We saw on the MARs that these were being signed by the care worker as given although the care worker started at 10am. The registered manager told us that the care worker would check if family members had given the medicines, if they had not then they would give the medicines to the person. However, this was not detailed in the care plan or risk assessment.

We saw that nine care workers had received medicines training between 2015 and March 2016. We saw that when rotas were generated for the four people receiving support with medicines, only the care workers trained to manage medicines would be sent to these people. However, we saw that the registered manager had not carried out any medicines competency assessments on these care workers and therefore could not be assured that the care workers were safely handling and administering medicines to people. The registered manager told us that they were currently working on producing a competency check list.

This meant we could not be sure that the medicines records were an accurate record of what medicines were administered, or that staff administering medicines or preparing MAR charts were competent to do so. This represented an continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At our last inspection in June 2016 we found that pre-employment checks had not always been carried out for staff because some staff had started work without adequate references. The provider had identified this in an audit and had taken steps to address this, but this was not completed by the time of our inspection.

At this inspection we found that improvements had been made.

We reviewed files relating to six staff, including three who had recently started work. We saw that recruitment processes were being followed appropriately, including obtaining references for staff before

they started work. The registered manager had carried out quarterly audits on staff files, and this included whether references had been obtained, and there was also a cover sheet on each file verifying that pre-employment checks had taken place. The registered manager had signed to confirm that she had seen these references.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that the provider was not providing adequate support to staff. This is because supervision and team meetings were not taking place regularly, and many staff had not received training in line with the provider's requirements.

At this inspection, we saw that the provider had made improvements in staff support, however the provider was still not meeting this requirement with regards to training.

Care workers we spoke with told us that they received training monthly, and staff files we looked at reflected this. There was a new supervision form in place, which showed that supervision was being used to discuss areas such as accountability, communication, punctuality, privacy and dignity, health and wellbeing, team work and equality and diversity. Additionally, supervision was used to review staff performance and to review training needs. In some cases supervision was taking place by telephone when staff found it hard to access the office. The provider carried out audits of staff files to ensure that supervision was taking place regularly. In one case we noted that a staff member did not have a recent supervision. This was highlighted by the staff audit and was scheduled, and we were shown records which showed it had taken place on the day of our inspection. We also saw that the provider maintained records of all supervisions which had taken place. This showed considerable improvement in the frequency of supervisions and also included supervisions which had been scheduled for all staff over the next two months.

We also saw that team meetings were now taking place monthly. These were scheduled to take place over two days so that all staff had an opportunity to attend. These were used to discuss requirements for staff including recording of care, timesheets, the need to bring in logs and medicines records monthly to the office, what staff should do in the event of an emergency and how to report accidents. Staff had signed attendance sheets to verify that they had been at the meeting.

The provider's policy stated that basic training for staff should include safeguarding, basic first aid or life support, health and safety (including fire safety), moving and handling, food hygiene, infection control, record keeping, promoting dignity and compassion in care, person centred approaches, equality and diversity and diet and nutrition. Many staff had undertaken formal qualifications such as National Vocational Qualifications and the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. Staff we spoke with told us that they thought they received enough training.

We asked the provider to review their records of staff training in these mandatory areas, including taking account of whether these areas could have been covered as part of these formal qualifications. The provider told us that out of 60 staff who were currently working, three had not received training in safeguarding adults, 22 had not received basic life support, health and safety and infection control. This meant a high proportion of staff had not received training in line with the provider's policy.

This represented a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had scheduled training for staff to take place over the next four months, which included sessions in safeguarding adults, manual handling, infection control, food hygiene and basic life support. Two staff had not received manual handling training, but the provider told us that these two staff did not undertake manual handling.

At our last inspection in June 2016 we found that the provider had not taken adequate steps to assess people's capacity to make decisions under the Mental Capacity Act (2005).

At this inspection, we saw that the provider was now meeting this requirement but we have made a recommendation about this.

The Act 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.

Where people were able to consent to their care, people had signed their care plans to indicate their agreement. Where people did not have capacity to make decisions about their care, the provider had carried out an assessment of capacity, including what decisions they were assessing for, practical help the person received in making a decision and outlined clearly whether the person had capacity and the provider's reasons for concluding this. However, in some cases where people had been assessed as not having capacity, relatives had signed the person's care plan on their behalf, and it was not clear whether they were signing as they had legal authority to do so, or if they were documenting that they had been consulted on whether the plan was in the person's best interests.

We recommend the provider take steps to document whether consent is given on behalf of a person under a legal authority or if a decision is being made in a person's best interests.

Good

Is the service responsive?

Our findings

At our last inspection in June 2016 we found that the provider was not planning people's care to meet people's needs. This was because support provided did not always match what was on people's care plans.

At this inspection, we found that the provider was now meeting this requirement.

Care plans had been reviewed in the past six months and clearly documented people's needs. We looked at logs relating to the care of four people, and saw that care was being delivered in line with these plans, including times of care visits, although medicines information was not always up to date. Where a person was no longer receiving support to bathe, the care plan was updated to remove this. Staff completed personalised logs for each person which contained check boxes which corresponded to what was required on the care plan.

Staff told us that they felt care plans accurately reflected people's current needs and the care that was delivered, and that these were a useful way of getting to know people and their needs. Relatives of people who used the service told us that these were reviewed as people's needs changed. One person told us "Before [my family member] returned home, a thorough assessment was done."

There was a system of audit in place for care plans which was being carried out every three months, this included a schedule for future checks to take place. As part of this audit, the registered manager verified that the care plan was up to date, accurately reflected people's needs and was person-centred.

We have improved the rating for this question from requires improvement to good because we found that concerns had been addressed and sustained over a period of time.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in June 2016 we found the service was not always well-led. This was because managers did not carry out checks of records of people's care.

At this inspection we found that the provider was not fully meeting this requirement.

Staff we spoke with told us that they were required to bring logs back to the office on a monthly basis, and gave examples of when the registered manager had raised issues with recording with them. This had been discussed with staff in team meetings and supervisions, and records were being brought back to the office for checking. Records of support had been personalised, which reduced the risks that staff would record people's support wrongly.

We saw that the registered manager was signing each person's daily log which showed that she had read each page. However, we still found anomalies in the records which had not been picked up by these checks. For example, one person was required to be supported by two staff, but only one staff had signed for visits on three occasions during a one week period. In some cases staff had not recorded the times that they had visited, and some individual visits had not been recorded. This meant that staff had not maintained an accurate record of care that they had provided.

The registered manager told us that she had noted some of these issues, and in some cases blank logs were marked with a question mark. However, although individual logs were signed on a daily basis, the registered manager did not have a system for recording what care logs had been audited and which actions had been taken in response to finding anomalies on these. Additionally, the provider told us that they would soon be taking on an additional 350 care packages, which meant that without such a system, it was unlikely that these audits would be effective or sustainable.

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

The provider was not displaying ratings from their previous inspection on their website at the time of our inspection, but provided a link to their page on the Care Quality Commission's website. This was resolved during our visit.

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 The provider did not maintain an accurate, complete and contemporaneous record in respect of each service users, including a record of the care provided 17(2)(c)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not properly or safely manage medicines 12(2)(g)

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provided did not receive such appropriate training as necessary to enable them to carry out the duties they were employed to perform 18(2)(a)

The enforcement action we took:

A warning notice was issued.