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 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 22 June 2016 and was announced. At our previous inspection on 12 February 2014 the provider was meeting the regulations we inspected.

Three Sisters Care is a domiciliary care service which provides care to people in their own homes, including to older people and people with physical or learning disabilities and people with mental health needs. At the time of our inspection there were 31 people using the service.

The service did not have a registered manager. 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 of the service had been in post since February 2016 and was in the process of applying to become the registered manager.

People who used the service praised their care workers and said that they benefited from consistent staffing from staff who spoke their first language. People were treated with dignity and respect by staff. People understood how to make complaints, and we saw that complaints were handled appropriately by the provider who was responsive to people's concerns.

Managers took steps to ensure that people were happy with their care. However, there was not enough oversight by managers to ensure that care plans and records of care were correctly completed, meaning that we could not be sure that people were receiving the care they needed.

Staff were not recording when people had received their medicines and there was insufficient information recorded and checks carried out by managers to ensure that people had received their medicines safely. Risk assessments were detailed in their scope, and risk management plans were in place, however some needed revising to ensure they accurately described how risks to people were managed.

Safer recruitment processes were not being followed, and a number of staff had been supporting people despite the provider failing to take up references and ensure that they had a complete work history for the person. Internal audits had identified and addressed this, although one person was still working with incomplete references.

Staff said they were well supported by their managers, however we found that staff supervisions and team meetings were not taking place regularly. Although a number of staff had been supported to achieve nationally recognised qualifications in care, there were significant gaps in staff training and this was not properly identified by managers.

The provider had failed to meet its responsibilities under the Mental Capacity Act (2005), by assessing whether people had the capacity to consent to their care, and frequently sought consent from people's

relatives for their care rather than demonstrating that they were acting in the person's best interests. People were supported to maintain good health, and staff supported people to access health services as required.

We found a number of breaches of regulations relating to consent to care, support of staff, suitability of staff, person centred care, safe management of medicines and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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 safe in all respects.

The provider was failing to carry out safer recruitment processes, including obtaining references and a detailed work history for new staff.

Medicines were not appropriately recorded and checked. A lack of audit systems meant that discrepancies on medicines records were not followed up to ensure that people received their medicines safely.

Risk assessments were comprehensive in their scope, however in some instances needed revising to ensure that risks to people were managed effectively.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive adequate levels of training and supervision to ensure they had the appropriate skills and knowledge for their roles.

The provider had not met its responsibilities under the Mental Capacity Act 2005 to assess people's capacity and demonstrate care was being provided in people's best interests. The provider was not seeking appropriate consent for people's care.

Care plans had detailed information on how to meet people's nutritional needs, however staff were not always following people's care plans.

People were supported to maintain good health, with staff liaising well with health services and ensuring people visited health professionals when necessary.

Is the service caring?

Good

The service was caring.

People were supported to form caring relationships with their care workers as they were supported by the same staff where possible who often shared a common language.

People were offered choices, and were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not responsive in all respects.

Care plans contained detailed information about people's needs, preferences and wishes, however this did not always reflect the support that people received. We could not be certain that people were receiving the correct support. Care plans were reviewed regularly according to people's needs, and the provider had taken steps to change plans when they no longer met people's needs.

Complaints were correctly recorded and investigated, and appropriate action taken. People told us they knew how to complain and were confident that managers would respond.

Is the service well-led?

Requires Improvement

The service was not well led in all areas. Managers did not have sufficient audit systems in place to ensure high quality care was provided.

Managers took steps to ensure that people were happy with the service they received. Staff said they were well supported by managers, but team meetings were not taking place regularly.

Three Sisters Care Ltd

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 22 June 2016. The 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 a single inspector, who was supported by an expert-by-experience who made calls to people who use the service and to their relatives. 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 carrying out this inspection we reviewed information we held on the service, including notifications of incidents concerning the provider. We spoke with the care manager, the CEO and three care workers, and spoke with one person who used the service and seven relatives. We reviewed the care records of five people, including records of care and support delivered and medicines records. We looked at four staff files and information relating to the running of the service, such as audits, policies and rotas. We also spoke with two local authority contracts officers.

Requires Improvement

Is the service safe?

Our findings

The provider was not operating safe recruitment processes. Of the four staff files we looked at, we saw that two people had gaps in their employment records and in one case, dates of employment were inconsistent between the person's application form and the CV they had submitted, which had not been explored by the provider as part of the recruitment process. We saw that the provider had carried out checks prior to employment with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including criminal records, in order to help providers make safer recruitment decisions. The care manager had carried out an audit of staff files in May 2016, which verified that DBS checks were in place for all staff.

The staff files we looked at showed that the provider had obtained references for people from previous employers, and where people did not have previous employment, obtained character references, although these references were not always verified by managers, despite this being the provider's policy. The audit of staff files in May 2016 showed that 12 staff members had been working without any references being taken up by the provider, and a further 9 had a reference missing. We saw that the provider had taken steps to rectify this, and now had two references in place for all but one staff member who had one reference in place.

This constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Staff files showed that the provider had obtained proof of identity and people's right to work in the UK, including viewing passports and official correspondence.

The provider's risk assessment was comprehensive in its scope, and covered areas such as the person's living environment, risks to the person due to their mobility, health and medicines and how people could be safely moved. We saw that these were carried out as part of the assessment process and were reviewed regularly. However, one risk assessment stated that the person could only be safely moved with the support of two staff, but we saw that only one staff member was visiting them. The provider told us that this person's needs had changed and that they no longer needed two staff to support them safely, and that the risk assessment either needed to be updated or was in error. We saw that the provider had sought advice from an Occupational Therapist on how best to manage the risks to this person in relation to their mobility.

We saw that the provider assessed people's home environments for safety. As part of this assessment, staff were required to identify whether a person had a working smoke alarm, and if not to state what actions had been taken. In one instance it was recorded that this person did not have a working smoke alarm, but no action had been taken to rectify this, which meant that the person could be at risk in the event of a fire.

In another person's records, we saw that the provider had completed an assessment of the risks of a person developing pressure ulcers. The care plan from the referring agency had also identified this risk, and identified that staff needed to move the person on each visit, which was taking place. The provider's assessment was thorough and identified that this person was at high risk, but did not specifically identify

actions for staff. However, the person's care plan from the referring agency stated that they were to be moved on every visit, and records showed that this was taking place.

Care plans were clear about the level of support people required with their medicines. However, we viewed medicines records for two people, and found that files did not record what people's prescribed medicines were, and in one case although there was a photograph of a person's blister pack, this was three years old and therefore we could not be assured it was an accurate record of their current medicines. Medicines Recording Charts (MRCs) did not record what a person's medicines were, and had a blank space for people to write what medicines were administered and prompted each time. We reviewed one person's MRC from November to December 2015, and found that on some days the staff member had recorded 'no' without any explanation. In this period, we found 13 days when medicines administration had not been recorded at all, with no evidence that this had been noticed or followed up by managers. The manager told us that medicines records from the past six months were still at the person's house, and had not been checked by managers. There was therefore a risk that further discrepancies had occurred and not been followed up.

In another instance we found that a person's care plan said to apply a cream, without any details of what needed to be applied and when. Staff had recorded that they had applied two different creams at different times, but had not recorded that they had administered the person's prescribed medicines at all.

The provider's medicines policy stated that a risk assessment should be completed whenever a person had prescribed medicines, but this had not been completed for any of the people whose records we looked at.

This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers showed us the training syllabus for administering medicines, which included an assessment from an external provider and competency tests for administering oral medicines. Staff training records showed that twelve staff had received this training, and the provider told us they ensured that only staff who had had this training administered medicines.

Staff had undergone training on safeguarding adults, and staff members we spoke with were able to tell us about how they would recognise signs of possible abuse and their responsibilities to report these to managers. Staff were clear about their responsibilities to report suspected abuse and confident that managers would take their concerns seriously. Where abuse was suspected, we saw that the provider had met their responsibilities to inform the local authority and CQC. The "Welcome Pack" for people who used the service contained information about the provider's safeguarding policy and information about different forms of abuse. Where incidents and accidents had occurred, we saw that these were recorded appropriately, and actions were taken as a result. For example, in response to a person suffering a fall, we saw that their risk assessment and care plan had been reviewed, and the provider had also reviewed their own falls policy.

Requires Improvement

Is the service effective?

Our findings

People were not supported by staff who had received appropriate training to ensure they had the skills and knowledge to meet their needs effectively. Out of the staff team of 41, we saw that 16 staff members had undertaken the Care Certificate. This is a nationally recognised qualification in which staff learn and demonstrate their knowledge in 15 areas, including understanding the role of the care worker, duty of care, equality and diversity, person-centred care, fluid and nutrition, mental health, dementia, safeguarding adults and children, basic life support, health and safety and infection prevention and control. In addition to this, a further seven staff had undertaken a national vocational qualification in care.

Training records showed that out of the staff who had not undertaken the care certificate, 19 had not received training in basic life support, 17 in food hygiene, 16 in dementia care, 22 in diet and nutrition, 17 in health and safety at 21 in infection control. This meant that more than a third of the staff team had not had training in these areas.

Out of the areas that were not covered by the care certificate, 23 staff had received training in safer moving and handling and there was no record of staff receiving training in pressure ulcer care and prevention. This meant that most staff had not received training in these areas.

Ensuring that staff had received training in these areas required comparing the syllabuses of the qualifications that they had undertaken to the training they had undertaken in the service, but this was not being recorded in the staff training matrix. Staff had not received appraisals, although the staff files that we saw showed that people had training and development plans in place. Supervisions discussed personal development, but most staff had received only one supervision session since joining the organisation, most of which had happened since the new care manager had joined the service. We saw that one staff member was receiving supervision for the first time on the day of our visit despite being employed for over a year. Staff we spoke with told us they typically received supervision every six months, but this did not correspond with the records we reviewed.

The above issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the provider had not taken adequate steps to assess people's capacity to make decisions under the Mental Capacity Act (MCA) 2005. 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.

We saw that most of the staff team had not had training in the MCA. Staff we spoke with did not appear to understand the principles of capacity and consent, and told us that if there were doubts about a person's capacity that they would ask a relative to consent on their behalf. We saw that relatives were signing

people's care plans on people's behalf, without any evidence that the person's capacity to consent to their care had been assessed, that care delivered was in the person's best interests or that the person had the legal power to sign on the person's behalf. There was a space in the care plan to indicate the reasons why a person may not be able to sign their plan, however this had been left blank. The manager of the service told us that they intended to deliver training on mental capacity to care workers that was specific to their roles, however this had not yet taken place. The provider told us that they intended to introduce a new care plan which clearly demonstrated issues of mental capacity and consent.

This constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that staff were meeting their nutritional needs. One person said, "They give it, they prepare my food", and a relative told us "[my family member] likes to drink water, which they give to her." We saw that care plans contained detailed information to make sure that people received the food that they wanted in line with their needs. However, logs of support delivered did not always record this. For example, one person's care plan stated that a person needed support to eat and drink, however, logs did not show that this support was provided. Staff we spoke with told us that they would raise any concerns about weight loss or poor appetite with family members and their managers.

We saw that people were supported to maintain good health. One relative told us that their family member was supported to, "go out to the park and for walks on a daily basis", and a person who used the service told us "They do whatever I want to stay well." We saw that the provider had arranged a referral to a physiotherapist in order to improve how they made transfers, and that people were supported to attend hospital appointments and that staff had liaised with GPs and hospitals in order to make sure people received support with complex health conditions. Where there were concerns about a person's mobility, the provider had contacted an Occupational Therapist and requested advice on how to improve this. In one instance, a staff member had contacted the office to say that they had stayed significantly beyond the end of their shift as the person they were supporting appeared unwell, and the staff member supported them to attend a walk in clinic. The staff member stated that the person probably would have left the clinic without support, and received hospital treatment as a result of this staff member's actions.

Good

Is the service caring?

Our findings

People told us that they were happy with their care workers. One person said "They are very approachable and amenable", and a relative said "they are polite and caring."

Managers told us that they ran a social enterprise which was focussed on providing good quality care and providing an opportunity for women to enter the workforce and access training for the first time. Staff told us "They open up training for anyone who needs it, not just for staff."

Rotas showed that the provider tried to ensure that people received support from the same staff, which allowed people to build relationships with their care workers. Comments from people who used the service and their families showed a range of experiences. One person said "It's one staff we get all the time" and another said "When we started we had three different [staff], now we have one person…and they get on well. We've had no complaints since." Some people told us that although they did not always have the same staff member they still received consistent care, with one relative telling us, "There's a backup if a normal carer can't make it…an alternative carer comes in which is also the same one at the weekend. This helps make them familiar with my parents." Another relative told us "Sometimes it's the same staff, sometimes they rotate." One relative told us that they did not receive a consistent service, telling us "We don't know who's coming tomorrow, sometimes that will upset [my family member]."

Staff spoke of the importance of making sure that people were supported to make choices. One staff member said "I give [the person] ideas but [they] make the decision". One relative said "Whenever I say do this or give him/her that, they listen to me" and another said "[my family member] decides where he/she sits, if they want a shower or what they eat." Relatives told us that they felt involved in their family member's care plan, and staff spoke of the importance of making sure that the person and their family were involved in decisions about their care.

Several family members we spoke with told us that staff had the right language skills to support their relatives. One person said "They speak Urdu, they are fluent in Urdu and that means [my family member] can speak with them", and another person said "They make sure they speak properly in Urdu."

Staff told us how they made sure that people's dignity was maintained, for example by ensuring that the door was closed and that there was no one else in the room before providing personal care. A relative said "My [family member] is very religious and they make sure there is no-one [of the opposite gender] before changing." People told us that their relatives were treated with respect. Comments included "They address [my relative] by their surname, polite and friendly", "When they come round, they give a compliment. They say thank you, hello and goodbye. They are good carers, they treat [my relative] like a real person". Several people told us that their relatives were addressed by the honorific titles of "Auntie" and "Uncle", and that this indicated the proper respect was shown by care workers.

Requires Improvement

Is the service responsive?

Our findings

People's care plans contained detailed information about their needs and wishes, however support logs did not always reflect this care and support and therefore we could not be assured that people's individual needs were met. Plans contained information on the person's history and current priorities, and these needs were translated into goals the person wished to achieve. Plans contained information about how people's health conditions affected them, what care and treatment they were currently receiving and information about tasks and duties that staff needed to carry out. There was also information in care plans about people's current arrangements for receiving their medicines. Staff told us that care plans contained sufficiently detailed information on people's needs and preferences to enable them to provide support. A relative told us "They know what my [family member] likes and doesn't like and how to look after her."

However, logs of support showed that these plans did not always match the care that was actually provided. For example, one person's plan stated that they received a visit at 5pm where they were supported with personal care and to receive a meal and another at 10pm where they were supported with personal care and to receive a drink. Logs of support delivered showed that this person actually received a visit at 7pm where they were supported with personal care and a meal, and there was no evidence that they received a drink. Another person's plan stated that they were to be supported with meals three times a day, but this was not recorded by care workers. One person's plan stated that they were to be supported to access the community, but this did not appear to be taking place, and the reasons why were not recorded. The manager told us that in some cases family members had chosen to provide this support themselves, but care workers were not documenting this, which meant we could not be certain that people had actually received this support.

One person had two care plans in place, and it was not clear which plan was current. The more recent plan showed daily support, but managers told us that this had been abandoned as the person had refused this daily support, and that the old plan had been resumed. Managers had a form which they used to show when a service had been interrupted or stopped, which recorded the date of the service ceasing. There was a section for when visits resumed, but this was not always completed.
This meant that we could not be certain that care plans reflected people's needs, and that people were receiving the care and support they were supposed to. This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Logs of support provided were not personalised, but contained check boxes for staff to complete to record they had provided the support. The provider told us this was a requirement from the local authority and commissioners, but that they intended to personalise these in future. There was also a section which asked staff to record how a person was feeling that day, however we found that this was often not completed. The provider maintained a record of when visits were missed.

Managers told us that once a care plan was implemented they set an initial review date of 3 months and subsequently every 6 months, or sooner if required. Care plans indicated that this was taking place, and that when it was felt a care plan was not meeting people's needs the provider had taken steps to change the

package. For example, managers were concerned that one person needed a visit during the night to provide personal care, and had contacted the local authority to request an increase in the number of hours provided.

People told us they knew how to make complaints and felt confident raising concerns with managers. We saw that the welcome pack provided to people who used the service contained the provider's complaints policy and details of who to contact. The provider maintained a complaints file which recorded when people had complained, and the actions that managers had taken in order to investigate and address the complaint. For example, concerns about staff conduct and punctuality were investigated, and there were records of the discussions held with staff afterwards. One person had raised concerns about the way staff used resources in their relatives home, and a memo had been sent to all staff making it clear that this was unacceptable. We saw that when the provider was at fault, managers had apologised to people and offered to make amends, although managers had not recorded whether people who had complained were satisfied with the outcome. One person told us "If there is something I don't like I will tell them and they will sort it out."

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since February 2016, and had devised a programme for carrying out audits of the service. This had started with checking staff files, which had identified that a substantial number of staff had been working without the provider carrying out appropriate checks. There was a tool in place for checking the content and quality of care files, but this was not always used effectively. For example, the section of this form which asked managers to check if support was delivered in line with care plans was often left blank, which meant that discrepancies between care plans and support delivered were not addressed.

There was no evidence that support logs were being checked by managers. Our own checks showed significant gaps in support provided, for example in one 28 day period there were 9 days where no support had been recorded. We checked these days against staff timesheets which indicated that the care workers had provided support at this time, but managers had not checked this. This same person's records of care showed that there were 13 occasions in a two month period where their medicines had not been recorded, and this was not noticed by managers, who had also not carried out a spot check of this person's care.

On another set of support logs, we saw that a staff member had recorded on a daily basis that they had administered a percutaneous endoscopic gastrostomy (PEG) feed to a person, despite this not being on their care plan. On other days they had also indicated that they had prepared a meal for the person, even though a person with a PEG feed would not be able to safely eat solid food. When we brought this to the attention of managers, they determined that the staff member was not familiar with the term PEG feeding, and had ticked this box to indicate that they had supported the person to eat. This discrepancy had gone unnoticed by managers despite this being on the support logs for several months.

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

People told us that they were contacted regularly by managers to find out their views on the quality of the service. One person said "Yes [the manager] came around two weeks ago and asked me" and another said "I'm contacted by email to ask if everything is going well or if I have any concerns. I get a reply back really quickly." Managers told us that they made phone calls to people who use the service and their families or "sometimes we just turn up unexpectedly." Records of audits showed that this year managers had carried out 16 assurance visits with people who used the service, in order to assess the quality of the service.

Managers told us "When something happens out of the ordinary we tend to discuss how we can learn from it." We saw that records of incidents and accidents showed that relevant policies had been updated in response, and all policies were reviewed on a yearly basis. We saw that rotas ensured that people had sufficient time to travel between care visits, which staff confirmed.

Staff told us that they enjoyed working for the provider and felt well supported by managers. One person said "Whenever I have a problem I talk to them", and another said "she always supports us, straight away we

take action." Team meetings were planned on a monthly basis, where the manager had drawn up an agenda to discuss issues concerning the entire service, such as new policies, changes to care plans and risk assessments and how staff were to report absence. However, only one meeting had actually taken place this year which had been in February, and before that the last meeting was in August 2015. Managers told us that they had difficulty in getting staff to attend team meetings and supervisions, as they did not pay staff to do this. The manager told us "I think we will have to pay people to attend."

We found that managers were responsive to our concerns. Immediately after the inspection, we were sent minutes of a meeting where the manager and directors had agreed an action plan to address the areas of concern we had raised. For example, there was a new process in place for ensuring that gaps in employment history were discussed with candidates at the interview stage. The manager showed us a new process for auditing medicines and auditing care plans.

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 9 HSCA RA Regulations 2014 Person-centred care The care of service users was not always designed with a view to ensuring people's needs were met 9(3)(b).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was not provided with the consent of the relevant person in line with the Mental Capacity Act 2005 11(1)(3).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service uses as medicines were not managed safely 12(1)(2)(a)(b) and (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operated effectively to ensure the provider maintained an accurate, complete and contemporaneous record in respect of each service user 17(1)(2)(c)

Regulated activity	Regulation

Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not operated effectively to ensure that persons employed were of good character and had the skills and experience necessary for the work to be performed by them. 19(2)(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they were employed to perform 18(2)(a)