Trident Reach The People Charity

Dudley and Wolverhampton Domiciliary Care

Inspection report

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Date of inspection visit:
20 September 2018
24 September 2018

Date of publication:
26 October 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 20 and 24 September 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because we wanted to give the provider enough time to prepare information we needed as part of our inspection process. This would ensure the registered manager would be available because the service was small. The inspection was prompted in part by information provided by the local authority about an incident following which a person using the service sustained a serious injury. This incident is subject to a safeguarding investigation by the local authority.
This inspection was carried out to check on how people were being supported due to concerns identified by the local authority about risks to people. The last inspection of this service in September 2015 rated the service as 'Good' overall with a 'Requires Improvement' in the Safe question.

Dudley and Wolverhampton Domiciliary Care is registered to provide personal care services to people in their own houses and flats in the community and specialist housing. This service is a domiciliary care agency. It provides a service to older adults, younger disabled adults and children.
This service provides care and support to people living in a number of 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

On the day of the inspection there were 26 people receiving support. There was no registered manager in post as they had recently left. 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.

Care staff were trained to recognise risks to people to keep them safe. There were enough care staff to ensure people were supported timely and medicines were administered. Care staff were provided with personal protective equipment to support people in a way that reduce the risks of infection.

Training was provided to care staff so they had the skills and knowledge to meet people's needs. People made their own decisions as to how they were supported. The provider adhered to the Mental Capacity Act (2005).

Care staff supported people in a friendly and kind manner. People were involved in the assessments and care planning process so they could be supported how they wanted. People were supported respecting their privacy, dignity and independence.

People's views were listened to in how they were being supported. The provider had a complaints process in place to enable people to raise concerns they may have.

The provider carried out spot checks and audits but these were not effective in ensuring the quality of the service was maintained. Care records did not consistently reflect accurately or clearly people's support needs.

While people could complete a questionnaire to share their views on the service they received, the provider did not ensure the outcomes and actions from the process was shared with people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe by care staff who were suitable trained to keep them safe.

People were supported with medicines as they were prescribed.

There was enough care staff to support people safely.

Is the service effective?

Good

The service was effective.

Care staff received the appropriate support to meet people's needs.

The provider ensured the Mental Capacity Act 2005 was implemented.

People could get support with their health care as required.

Is the service caring?

Good

The service was caring.

Care staff were kind, caring and friendly.

People were supported to share their views as to how they were supported.

People's privacy, dignity and independence was respected.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and they were involved in the process.

The provider had a complaints process so people could raise

concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

Care records were not consistently clear, concise or accurate enough to ensure care staff would always know how to support people.

Spot checks and audits were taking place; however, they were not always effective in identifying areas of concern/ improvement.

While people could share their views by completing a questionnaire the provider did not ensure the analysis from the process was being shared with people.

Dudley and Wolverhampton Domiciliary Care

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.

Our inspection site visit was on the 20 and 24 September 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because we wanted to give the provider enough time to prepare information we needed as part of our inspection process and to ensure the registered manager would be available because the service was small.

The inspection was prompted in part by information provided by the local authority about an incident following which a person using the service sustained a serious injury. This incident is subject to a safeguarding investigation by the local authority.

However, the information shared with CQC about the incident indicated potential concerns about the management of falls, unsafe medicines management and unsafe use of equipment. This inspection examined those risks.

The Inspection team consisted of one inspector 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 service.

We reviewed information we held about the service this included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts, which they are required to send us by law.

We visited the provider's main office location and we spoke to three people, three relatives and four members of staff. The registered manager had recently left the service and the provider was in the process of

recruiting to the post so the regional service lead was available to support the inspection. We looked at the care records for three people, the recruitment and training records for three members of the care staff and records used for the management of the service; for example, staff duty rotas, accident records and records used for auditing the quality of the service.

Good

Is the service safe?

Our findings

At our last inspection in September 2015 we rated the registered provider as 'Requires Improvement' in this question. We found that where people were administered medicines via their stomach, guidance and training for care staff as to how this should be done was not in place.

We found at this inspection that the appropriate training and guidance was provided so care staff had the knowledge and skills to be able to support people safely where they used a Percutaneous Endoscopic Gastrostomy (PEG). A PEG is a device which allows someone to have nutrition, fluids and or medicines directly into their stomach. A care staff member we spoke with said, "I have medicines training and managers do spot checks and I have to answer questions to make sure I am competent".

A person said, "I am able to get pain relief if I am in pain". A relative told us, "They [care staff] do his meds for him. He has tablets and they get them out of the blister pack and make sure he safely takes them with some water". We found that a Medicines Administration Record (MAR) sheet was being used to show when people were supported with their medicines and what medicines they were given was being completed. Where people received medicines 'as and when required' we found that the appropriate guidance was being used to advise care staff as to how these medicines should be administered. While we found gaps in the MAR care staff we spoke with knew how to administer people's medicines.

The provider had systems in place to keep people safe. A person said, "I am very safe". A relative told us, "I feel safe with all the carers. He [service user] needs four calls a day with a double up call as is bed bound. They [care staff] are so careful when tending to him and I have no issues or worries over his safety". Care staff we spoke with could demonstrate an understanding of how people should be kept safe, they were able to give examples of what abuse was and explain the actions they would take where people were at risk of harm. The regional service lead could demonstrate an understanding of the importance of keeping people safe and the process of raising a safeguarding alert or contacting another relevant body like the police where people were at risk. We saw evidence where safeguarding alerts were raised with the local authority.

The provider had systems to manage risks to how people were supported. Risk assessments were carried out to inform care staff how risks should be managed and or reduced. We found where people were supported with their medicines, equipment was being used or people's behaviour put them and others at risk that the appropriate risk assessments were in place showing how these risks should be managed to reduce the risk of harm to people. We found where people were being supported in a supported living environment, that where a PEEP was required this was being implemented. A PEEP is a Personal Emergency Evacuation Plan, this is a bespoke escape plan for individuals who may not be able to reach a place of safety unaided in an emergency. Care staff we spoke with could tell us that risk assessments were in place where they supported people and how risks were managed. However, we found that some information was not always up to date. A care staff member said, "Risk assessments are in place and I ensure I read them regularly in case things change".

A person said, "I think there is enough staff, they always arrive at the correct time". Another person said,

"They [care staff] are usually on time and always turn up. If they [care staff] are held up for any reason like in traffic they [care staff] always call me to tell me, but always stay my full hour in the morning and half hour in the evening. I do get different ones [care staff] that come but there is a group of them [care staff] and I know them [care staff] all". A relative told us, "They [Care staff] are good on time for him and will call if held up for any reason. No missed calls". We found that there was enough care staff employed to support people safely. A care staff member said, "There is enough staff". The regional service lead told us they trained agency staff to become permanent care staff over a ten-week process so they could recruit to enough hours to ensure the hours they were contracted to deliver they could meet and sometimes exceed to support people safely.

The provider as part of their recruitment process, carried out checks on potential care staff to ensure they were of sound character and to ensure they had suitable skills and knowledge to support people. Where gaps in knowledge were identified relevant support was made available. Care staff we spoke with told us they were required to complete an application form, provide two references and completed a Disclosure and Barring Service (DBS) check as part of the recruitment process. This check was carried out to ensure the provider had employed suitable care staff to support people with personal care type tasks. We found that references and DBS checks were being sought and the employment history of potential care staff checked.

The provider had systems to record where incidents or accidents had taken place. Care staff we spoke with could explain the actions they would take where an accident or incident had taken place. We saw evidence of the information being captured from previous accidents/incidents and where an investigation took place the outcomes and actions taken were noted. The regional service lead told us that trends analysis was taking place so the number of accidents/incidents could be reduced.

The risk of infections being transferred between people was being reduced by the provider ensuring all care staff received protective personal equipment and all received infection control training. Care staff we spoke with confirmed this. One care staff member said, "I have received infection control training and I get personal care gloves and aprons". The regional service lead also informed us as part of their own internal checks that care staff would all shortly be given hand sanitising gel. A hand sanitising gel is an antibacterial liquid used to decrease infectious agents on the hands.

Good

Is the service effective?

Our findings

At our last inspection in September 2015 we rated the registered provider as 'Good' in this question. We found that the assessment process and the support care staff needed was effective in meeting people's needs.

We found that pre-assessment was carried out by the provider before the service started so they could check people's support needs so a decision could be made as to whether they had the appropriate knowledge and skills to meet their needs. Whilst we found that people's specific needs were being identified through the pre-assessment process, for example, people sexual orientation, their gender, spiritual/religious beliefs and their cultural needs. Care staff we spoke with were not aware of the Equality Act 2010 and its purpose. The regional service lead assured us they would ensure all staff received the relevant training and knowledge as soon as possible.

People told us that care staff knew how to support them and they felt the care staff had the skills they needed to support them. A person said, "There are no issues with their training and skills at all". Another person said, "The staff know how to support me and they have the training and skills". A relative said, "I have no concerns with any of that [training and skills]. They know how to turn him on the slide sheets to wash him and deal with his catheter".

The care staff we spoke with told us they could get support when needed. A care staff member said, "I can get support when I need it". Another member of the care staff told us, "I get regular supervision and I am able to attend staff meetings". We could confirm this from the staff records we saw and we also saw that care staff were able to discuss their development needs through an appraisal system.

Care staff could access regular training which the provider required all staff to take part in. We found that some of the training care staff took part in were as follows, moving and handling, food hygiene and mental awareness. We also found that care staff could also get support as needed where people had specific support needs. For example, Dysphagia and diabetes. Care staff we spoke with confirmed this.

An induction process was in place which also included elements of the care certificate. The care certificate is an identified minimum set of standards that health and social care workers adhere to in their daily working life.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

The support people received followed the principles of the MCA and that training was provided so care staff

understood the MCA and impact it would have on the way they supported people. We found where people lacked capacity best interest decision meetings were taking place and we saw the evidence of the outcome from these meetings. While there was no one at the time of our inspection being deprived of their liberty. We saw evidence from previous applications where decisions had been made to deprive a person of their liberty by way of the appropriate applications being made through the court of protection. Care staff we spoke with had limited knowledge of the Deprivation of Liberty Safeguards (DoLS). Care staff could tell us if anyone they supported was on a DoLS but were unable to explain the process of depriving a person of their liberty. The regional service lead had already set up further refresher training in this area to support care staff knowledge and skills.

People we spoke with told us their consent was always sought before care staff supported them. A person said, "They [care staff] always ask me if I am ok and what I would like to have done first, they always also ask if there is anything more they can do before they leave". A couple of relatives told us the following, "Yes they do. He [service user] still has his mind and speech and they always ask him first how is he and is there anything he wants doing first" and "They do and when they go out with her [service user] they always ask where she [service user] would like to go and what to do". Care staff we spoke with told they would never support people without seeking their consent. A care staff member said, "I always get consent even if people lack capacity. They consent through gestures and body language. Once you get to know the service users you know what they are saying".

We found where people's support needs required the use of a communication passport and or hospital passport that these documents were being used to ensure people's health care needs were being identified appropriately. People told us they could see a doctor, dentist or optician when needed. A person said, "Care staff will get the doctor if I am not well". A care staff member said, "People are all able to see their doctor or nurse for an annual health check and people are able to see their doctor or dentist when needed. They get reminder letters from the dentist". We could confirm this.

A person said, "I decide what I eat and drink". Another person said, "They [care staff] prepare my breakfast and get my cereal or fruit with a cup of tea. I can eat that myself and if I want anything different they [care staff] will get it for me". A care staff member said, "I try and encourage service users to eat healthy and sometimes suggest healthier options. I will offer fruit and veg instead of some other less healthy options". Care staff received training in diet and nutrition to aid their knowledge to be able to encourage and support people to eat healthy options.

Good

Is the service caring?

Our findings

At our last inspection in September 2015 we rated the registered provider as 'Good' in this question. We found that the support people received was caring.

People we spoke with all told us that care staff were kind, caring and friendly. They expressed how good the care staff were. A person said, "Most certainly. I am very happy. They [care staff] are all lovely caring, kind girls [care staff] so kind and considerate with everything they do. I can share anything with them". Another person said, "The staff are caring and kind to me". Relatives told us, "They [care staff] are all nice, caring and friendly all wonderful in fact" and "Not half. Very much so. Pleased with them [care staff] all. They [care staff] listen and talk to him and he likes that, have a good laugh, yes well pleased".

We found that the provider ensured they could communicate with people by using picture formats to illustrate what they were saying. Care staff also used people's body language, gestures, visual aids, relatives and advocates where needed to be able to support people to share their views. We found that advocates were used as we found a person was using advocates to support them to share their views. Care staff we spoke with were aware of the use of advocates and how people could access them. We found that the provider regularly arranged meetings where people were supported to attended so they could share their views about the service in their offices.

Where people's first language was not English the provider had matched them to care staff who shared their first language. This allowed people to not only share their views but get the service they needed as they were able to communicate their views.

We found from what we were told that care staff respected people's privacy, dignity and independence. A person told us, "When washing they [care staff] close the door and wait outside until I call them. Same if I have a bath and they [care staff] will bring me a towel and let me dry myself". A relative said, "Very much so. He has a full body wash and they [care staff] cream all his body keeping him covered up where necessary and closing the curtains and door". Care staff we spoke with explained the importance of respecting people's privacy, dignity and independence. Care staff could give examples of how they ensured the support people received respected them. A care staff member said, "I always shut the door when doing personal care and people are encouraged to support with the preparation of meals to promote their independence".

Good

Is the service responsive?

Our findings

At our last inspection in September 2015 we rated the registered provider as 'Good' in this question. We found that the service people received was responsive to their needs.

People we spoke with told us their support needs were being met and care staff responded to changes as and when needed. People told us their needs were assessed and they or their relatives were involved in the assessment process and care plan. A person said, "My daughter and son-in-law deal with all that for me but they do ask me if I want to add anything. I have got a copy here and it is up to date". Relatives we spoke with told us the following, "I do it with them and it is reviewed and have a copy here. They [office staff] come out to us, he [service user] has his say and any changes are made accordingly" and "Yes, I do it and it is all reviewed and up to date. We have a copy here and they [office staff] come and we discuss any concerns". Care staff told us they could access people's assessments and care plan where needed. We found that assessments were in place describing the support people needed and care plans showed how the support people needed would be delivered. The support people received was reviewed monthly which we found involved people, their relatives or an advocate.

Relatives were kept informed regularly on the support needs of people or where they became unwell. Relatives told us the following, "If they [care staff] see anything untoward when out with her [service user] they [care staff] will call me immediately" and "They [care staff] are so on the ball with this. Like I have already said like they [care staff] called me last Sunday about him [service user]. Also in the past they [care staff] have called out the community care if they [care staff] have found him unwell and let me know. They [care staff] act if they [care staff] see a problem and let me know immediately like if they [care staff] spot a sore on his bottom for instance which has happened". This meant the service was responsive to people's needs.

The provider used technology to improve the service people received. Care staff were required to log in electronically so office staff knew that people received the support they needed on time or that care staff had no arrived so action could be taken to ensure people received the support they needed.

The provider had a complaints policy so people could raise concerns they had. A person said, "I know how to complain, who to complain to and I have raised complaints in the past that have been dealt with". Relatives all told us while they have never had to complain they knew how to complain and have been given a copy of the complaints process. A care staff member told us, "They would pass all complaints made to the manager". We saw that a complaints logging system was in place to show how complaints were managed and resolved. We found that the provider had not had any complaints for over 12 months. The regional service lead told us that all complaints were analysed so trend could be identified to reduce the number of complaints.

The provider told us they had no one currently within their service who was in receipt of end of life care.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2015 we rated the registered provider as 'Good' in this question. We found at this inspection that the provider did not manage all elements of the service as well as they should, so the service was not always well led.

We found that care records within the service were either not clear as to how people should be supported, miss-leading in that the information was not correct on close inspection or were not accurate. For example, we saw information pertaining to medicines being given 'as and when required' that was out of date and should have been removed. There was a risk that newly appointed care staff could have followed the instruction putting people at risk and potentially leading to people not being supported as they expected. We discussed our findings with the regional service lead who agreed with our findings and told us they were already aware of these concerns and had acted to rectify them. We were shown a record keeping action plan the provider was working on to improve record keeping.

The local authority shared concerns with us that people were at risk of not being administered their medicines correctly due to the number of unexplained gaps they had found within the provider's medicines administration records. We found the same concerns identified by the local authority. We discussed our findings with the regional service lead who told us that as part of the action plan they were working towards for the local authority this was an area they were working towards improving. We could confirm this from the action plan we saw.

The manager was undertaking spot checks but we found that these were not effective in identifying more recent unexplained gaps within the medicines administration records. We found that these gaps had happened after the local authority's visit. The regional service lead assured us care staff were all receiving medicines training as part of the action plan they were working to.

We found that the provider did not take appropriate action to ensure care staff and managers received training into the Equality Act (2010). The regional service lead assured us this training would be arranged to ensure care staff knew the purpose of the legislation.

We found that people could share their views and the Accessible Information Standard (AIS) was being met. However, care staff and managers, we spoke with were not aware of the AIS. The AIS legislation was introduced by the government in 2016 to make sure that people with a disability or sensory loss were given information in a way they could understand. The regional service manager was unaware of this legislation and told us they would get the relevant information on time to update all staff.

People had completed questionnaire surveys on the quality of the service they received. A person said, "Yes I have given it to them [provider]. In fact, I keep telling them all the time how good they [care staff] are". Relatives we spoke with all told us they completed a questionnaire and would recommend the service to others. However, the provider did not ensure care staff could also complete questionnaires to share their views as part of this process. A care staff member said, "No I have never received a questionnaire". People

we spoke with told us they had never been given a copy of the outcomes from previous surveys conducted. We were unable to determine whether analysis from these surveys were taking place and being made available to people, relatives and care staff to show how the information gathered was being used to improve the quality of the service people received. We found while the provider gathered people's views they had not ensured any outcomes were shared with people so they knew how the information was being used to improve the service.

People and relatives we spoke with felt the service was well-led. A person said, "The service is well-led, I am happy with the support I get". Care staff we spoke with felt the service was well-led but there were areas of the service that could still be improved. For example, the recruitment of more care staff.

We found that care staff could attend team meetings on a regular basis where they were able to discuss concerns and issues they had in a collective way to get support. We saw from the minutes that discussions ranged from safeguarding people to staff attitude and forthcoming changes within the service.

The provider had an out of hours on call service that people told us they were aware of. This enabled people and care staff to be able to contact a manager in an emergency outside of normal office hours. For example, on bank holidays, weekends or on an evening. Care staff we spoke with confirmed this.

The provider had a whistle blowing policy that care staff we spoke with were aware of and knew when they could use it to highlight concerns within the service, but had not raised any whistle blowing.

It is a legal requirement that the overall rating from our last inspection is displayed within the service and on the provider's website. We found the provider met this requirement and their last rating was displayed.

The regional service lead understood the requirements within the law to notifying us of all deaths, incidents of concern and safeguarding alerts as is required within the law. The registered manager had left the service just before the inspection, so their line manager the regional service lead was able to cover the management of the service.