Windrush Care Ltd

Windrush Care

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

Summary of findings

Overall summary

This was an announced inspection which took place over two days on the 23 and 27 March 2017. Windrush Care provides personal care for two older people who live in their own homes in Gloucestershire. In addition they provide services to another ten people in their homes who do not need help with personal care. The minimum visit time Windrush Care considered was one hour.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been appointed and they had applied to become registered with CQC.

This is the first inspection of Windrush Care which was first registered in September 2015.

People had not been protected against the risks of employing unsuitable staff. Safe recruitment and selection procedures had not been followed. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Quality assurance systems, although in place, had not identified the shortfalls around the recruitment of staff. Staff had not been receiving individual support and for some staff their competency to carry out their roles had not been assessed by observations of their practice or spot checks. The provider had appointed a new member of staff to take responsibility for this. A medicine administration record had not been put in place for the administration of cream. This was done during the inspection.

People had been assessed to make sure their needs could be met by Windrush Care. Their wishes and preferences were taken into account when developing their care records which were individualised and promoted their independence. People's capacity to make decisions about their care and support was considered. People had information about the service they received and had agreed to their care and support. Any hazards people faced in their homes or in the receipt of their service had been assessed and minimised. Accident and incident records were kept and analysed to make sure they would not reoccur. People's rights were protected. Staff had a good understanding of how to recognise abuse and what to do in response.

People were supported by staff who had access to training to develop the knowledge and skills to meet their needs. They said communication was good and they spoke positively about the management team in the office. People benefited from effective emergency systems which included out of hours support for staff. People had information about how to make a complaint and were confident talking over any issues with the manager.

The nominated individual and manager worked closely with national organisations and other care at home agencies to keep up to date with best practice and changes in legislation. Their long term business plan included expanding the service at a sustainable rate. People, relatives, health care professionals and staff were complimentary about the quality of service being provided.

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 consistently safe. People were not protected by robust staff recruitment practices. Improvements had been introduced to make sure medicines were managed and administered safely.

People's rights were upheld and they were kept safe from the risks of harm or injury. There were sufficient staff employed with the right skills and knowledge, to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective. The assessment of the competency of staff through observation of practice and individual meetings was inconsistent.
Staff had access to training to equip them with the knowledge and skills they needed to meet people's needs.

People's capacity to make decisions about their care and support was considered in line with the Mental Capacity Act 2005.

People were supported to stay healthy and well. Staff liaised closely with health care professionals.

Is the service caring?

Good

The service was caring. People had developed positive relationships with staff and were treated with kindness, respect and dignity.

People were involved in the planning of their care and staff understood them really well. People had information about the service provided to them.

People at the end of their life were supported with compassion and sensitivity.

Is the service responsive?

Good

The service was responsive. People's care was individualised based on their wishes, like and dislikes and care records were

kept up to date with any changes in their needs. People were encouraged to be as independent as they could be.

People were supported to access social activities and events if this is what they wished.

People had information about the complaints process. They would talk with the manager if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led. Quality assurance processes whilst seeking to improve the quality of service provided had not always been effective in making sure the records being maintained were of the correct standard.

There were plans to further develop the service. Quality assurance processes included feedback from people using the service and staff.

The management team worked closely with national organisations and other providers to monitor best practice and changes in legislation.

Windrush 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.

The inspection took place on 23 and 27 March and was announced. One inspector carried out this inspection. The provider was given notice of this inspection because the location provides a domiciliary care service; we needed to be sure that the manager would be there.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we spoke with two people using the service and two relatives. We spoke with the manager, the nominated individual and three members of care staff. We reviewed the care records for two people including their medicines records. We also looked at the recruitment records for four staff, training and individual records for an additional three staff, accident and incident records and quality assurance systems. We have reflected feedback the provider received as part of their quality assurance process. We received feedback from two health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

People were supported by staff who had been appointed without all the necessary information being obtained. The recruitment process was not as robust as it could be; not all the checks required had been completed. Each applicant had completed an application form but they had not provided a full employment history. The gaps had not been explored with them. References had been sent out for applicants and for one person these had been resent but two staff had been appointed with one reference only in place. Three staff had also worked previously in adult social care but the reasons why they left this employment had not been investigated with their previous employers. Two people had given the names of staff in their former employment who were not in a managerial or human resources position. One referee had forwarded this reference request to their human resources department. Reference requests did not identify who they were sent to and who they were for. The manager said the nominated individual had questioned this and amendments had been made to make these more robust. People were not being protected against the risks of unsuitable staff being employed.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other checks had been completed prior to new staff starting work. This included obtaining a satisfactory Disclosure and Barring Service (DBS) check. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. Evidence had been obtained to verify the identity of applicants as well as to confirm any training they had completed. The manager had introduced a new checklist recording when information had been returned and said they would include further prompts to address the issues highlighted.

People benefited from sufficient numbers of staff to keep them safe and meet their needs. People and their relatives reflected about the importance of having the same staff who knew them well. One relative said the service had provided different staff during the first week but since then the same staff had been allocated. One person said they liked having care staff they knew and the continuity of care was vital to their on-going rehabilitation. A relative confirmed they were informed about late visits and if a last minute replacement was needed (due to a car breakdown) this was always provided. They all confirmed visits were on time and for the correct length. The manager said recruitment was on-going to make sure there were sufficient staff employed to enable the service to grow. If needed, in an emergency, to cover last minute sickness or leave the manager and care co-ordinator were able to provide personal care. The manager discussed how they assessed the competency and suitability of new staff during induction training. They had clear disciplinary procedures in place which would be used when needed if poor or unsafe practice was identified.

People's medicines were managed safely but records had not always been kept correctly. One person was having cream applied occasionally and although the daily records mentioned this there was no corresponding medicine administration record (MAR) in place evidencing when the cream had been applied. During the inspection the MAR and a body map, to illustrate where the cream should be applied,

were put in place. People in receipt of personal care were managing other medicines. MAR charts were in place should they be needed. They would list all the medicines prescribed including those supplied in blister packs so staff would be able to check they were correct. Staff confirmed they had completed medicines administration training at different levels reflecting their responsibilities for the administration of medicines. For example, basic level medicines training would exclude staff from administering medicines listed as controlled drugs.

People's rights were upheld. One relative told us their mother had told her she felt safe with her care staff. Another relative said they it was "very reassuring" having the care staff in their home. A health care professional commented, "I saw no evidence of them being unsafe." Safeguarding training had been provided to staff as part of their induction. Staff had a good understanding of how to recognise abuse and what they should do in response. They talked us through the records they would keep and the action they would take. They had confidence that managers would make the appropriate alerts to the local authority safeguarding team and the police if needed. Safeguarding policies and procedures included the contact details of the safeguarding team and their procedures were accessible to staff.

People were kept safe from the risk of harm or injuries. One person said, "They made sure I was safe in the shower and saw me safely to bed." An assessment of risk to people highlighted any hazards to them when providing their care and support. Risk assessments had then been completed to reduce these risks for example, falling or moving and handling. Accident and incident records had been kept for instance detailing an unexplained injury. There was evidence a thorough investigation had taken place to ascertain possible causes for this and the necessary action taken to prevent it from reoccurring. Each person's home was also assessed for risks and staff informed if there were any actions they needed to take to ensure their own safety as well as that of the person they were supporting. For example, using equipment which was provided such as a commode or walking aid. Staff were prompted to make sure people were wearing their lifelines (personal alarms connected to their telephone) when they left them.

People were supported during emergencies. Staff described how they had supported a person and their relative when they were alerted to an accident. They attended the person before their normal visit times and called the emergency services. They stayed with them until the person was admitted to hospital. The person's relative said this had been "very reassuring". Out of hours support was available for staff and they described advice they had been given in response to their calls. Staff commented, "There is always someone to call" and "We know who to call if there is an emergency out of hours."

Requires Improvement

Is the service effective?

Our findings

People's care and support was provided by staff who had inconsistent access to individual support meetings, known as supervisions. Staff were mostly lone working and this could potentially impact on the care and support they provided to people and their individual performance. This shortfall had been recognised by the manager who had been unable to schedule individual meetings with staff on a regular basis. They had requested additional help to achieve this and a newly promoted member of staff had been appointed to carry out these meetings, do spot checks and observations of staff carrying out their work. A schedule for these had not yet been put in place. There was evidence two members of staff had received a supervision and observation of their practice in October and November 2016. This had not been carried out however for new staff who had started in post since October 2016. The nominated individual said they had only one member of staff in post for 12 months and they had an annual appraisal to discuss their performance and training needs. Two further annual appraisals were due. Office meetings took place to discuss people's needs, prospective clients and staffing. Staff said they were kept informed and had good communication with staff in the office.

People were supported by staff who had access to training to equip them with the knowledge they needed to meet their needs. Each new member of staff completed a three day induction programme in training considered mandatory by the provider. Windrush Care information leaflet stated, "Every Windrush carer is given specialist training to the new care certificate standard." The care certificate is a set of national standards that health and social care workers adhere to in their daily working life. The induction included first aid, moving and handling, food hygiene, nutrition and medicines awareness. The training was delivered mostly by the manager who had a train the trainer's certificate to provide this training. This certificate was not seen during the inspection and the manager said they would make sure it was obtained and available. They were also completing a national teaching award. They had completed training in all the subjects they were delivering as well as being affiliated with the association of first aiders. Additional training specific to the needs of people likely to use the service included dementia care, multiple sclerosis and managing challenging behaviour. External providers had also been used to train staff. Staff who had recently been promoted were registered for training to equip them with the skills to carry out their new roles. Staff had also been invited to apply to register for the Diploma in Health and Social Care at levels two and three. Staff commented, "Training was very informative and thorough" and "I learnt a lot more from the way we were taught and with the interactions and discussions."

People's capacity to make decisions about their care was considered in line with the Mental Capacity Act 2005 (MCA). The 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. At the time of the inspection people were able to make decisions and had signed their care records to agree to the care and support being provided. Best interest decision forms and MCA assessment forms were in place should they be needed if people were assessed as unable to make decisions about their care.

People were supported to stay healthy and well. A person described how staff had worked closely with health care professionals when they were discharged from hospital and also with the physiotherapist. They said staff provided continuity of care by encouraging them to complete their physiotherapy exercises helping towards their rehabilitation. A health care professional told us, "The staff had my number and worked closely with the district nurses. I felt that they communicated with me in a way that wasn't pushy but did draw my attention to problems that they could see building up. They were responsive to my feedback and I felt very well supported by their team in my clinical management."

People's nutritional needs would be considered when necessary and staff were prompted to make sure they had enough to eat and drink. Further training had been planned around hydration and nutrition. People currently being supported did not need any additional help in this area.

Good

Is the service caring?

Our findings

People had developed positive relationships with staff. People said staff were "conscientious" and "caring". They said they were happy with the care they received from staff. Relatives confirmed they and the person receiving care and support had positive relationships with staff. Another relative said the person receiving care and support was "pleased and happy" with their care and found staff very helpful. They said staff "just pick up on anything which needs doing". Staff reflected, "We provide brilliant care" and "People make it worthwhile." One member of staff when talking about the management said, "They actually care about people and care about staff." The customer charter for Windrush Care said they aimed to be "caring, kind and considerate" and "respect people's dignity and privacy and chosen lifestyle". This was confirmed by compliments paid to the provider; "carer most helpful, kind and considerate" and "girls were lovely".

People's personal preferences and backgrounds had been discussed with them and included in their care records. Staff understood people well, respecting their wishes and likes and dislikes. Staff were professional in their approach and showed concern for people's health and well-being. People's communication needs were identified and whether they needed any equipment to help them with sensory disabilities. Staff were prompted to check hearing aids and glasses were accessible and being used. People's spiritual needs had been identified in their care records and when requested staff were able to support them to attend places of worship. If people had a particular preference for the gender of staff supporting them with their personal care this could be respected. People's right to have their personal information kept securely and confidentially was also promoted. They were asked to give permission to store copies of their care records securely in the office.

People were involved in the assessment and planning of their care and support. They said, "Staff follow the care plan" and "There is good communication with staff and the office." People had been given information about the service they received, including visit schedules and fees. The manager said they encouraged people to talk about their wishes and needs from the first telephone call so a picture could be built of the type of service they were looking for. This conversation continued during visits to them in their home and with their relatives. People were introduced to key staff including office staff so they could "put a face to a name".

People were treated with dignity and respect. Staff spoke respectfully about people and people's care plans prompted staff to treat them with dignity and respect their right to privacy. For example, when providing personal care to ensure a towel was available to cover them. Guidance given to staff during the winter including offering people a blanket or making sure the heating was switched on. One person said, "I have great faith in them."

People were supported at the end of their life with sensitivity and compassion. A health care professional told us, "I've worked with Windrush Care with a few patients, but one palliative case in particular sticks with me. The lady in question was a very challenging individual to look after for a number of reasons, but they did a great job where I suspect other companies would have walked away. We managed to keep her at home to die which was her wish although this required a huge effort from all involved. I did witness their carers

treating the patient with dignity including after death." The manager shared with us reflections about another person who they supported at the end of their life. The person was very attached to the staff and when discharged from hospital only wanted Windrush Care to support them. Staff worked closely with health care professionals and the manager provided cover to ensure they had breaks or were supported by their presence. When family visited the manager said they had prepared a meal for them. Staff attended the funeral and were requested by the family to continue to provide support to their remaining relative.

Good

Is the service responsive?

Our findings

People's care was personalised and reflected their individual needs and preferences. Their needs had been assessed to make sure Windrush Care was able to provide a service to them. The manager described circumstances when they had been unable to meet people's needs and had said they were unable to provide a service. This could either have been due to the complexity of the person's needs or availability of staff. People's needs were reviewed with them to make sure any changes had been highlighted and their care records reflected these. The manager said they also visited people to make sure the care and support continued to reflect their needs and wishes. If adjustments were needed these were attended to. For example, a person was unable to walk up the stairs and so equipment they needed had been brought downstairs for them.

People were encouraged to maintain their independence. Their care records clearly identified what they were able to do for themselves and what they needed help with. Daily records confirmed people were as independent as they could be. This took into account people's general health and well-being and any day to day changes. The nominated individual described how they had successfully helped people to rehabilitate after discharge from hospital and they were now able to care for themselves independently. One person told us, "I would use them again, if I needed to."

People were helped to access social activities or events if this was part of the service they wished to receive. Staff said it helped to work in blocks of over one hour and up to three hours at a time, so they could take people shopping, to church or out for a coffee if they wished.

People knew how to raise a complaint and said they had no concerns. A complaints procedure was in place and a copy had been provided to each person. No complaints had been received by the service. People told us they would speak with staff, the manager and the nominated individual if they had any issues. They said, "I would ring them up and speak with them" and "I have no concerns but I would chat with [Name]." A relative said they would give the manager a call if there were any issues or concerns but they had none. Another relative commented if they had any concerns they would speak with the manager. A health care professional told us, "I had no cause to feedback anything negative so can't comment on how they would respond to this."

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems had not ensured improvement in some areas of the service. Although quality assurance processes were in place to identify and assess actions to improve the service they had not been as effective as they could be. We found shortfalls in the recruitment process which could potentially impact on the quality of service provided. The manager had highlighted to the provider they had been unable to schedule or complete support for all staff through individual support meetings and assessment of their competency through observations of practice and spot checks. Plans had been put in place to address this but schedules were still to be developed. Medicines administration did not take account of one person who had creams administered by staff. The appropriate medicines records were not in place. This was addressed during the inspection. The manager had trained as a trainer and was delivering training to staff. Evidence of this qualification was not available to verify their accreditation and competency to provide this training.

A business plan was in place which identified key steps to develop the agency and support growth at a pace which was sustainable. This included increasing the number of staff and people receiving a service, expanding internal training and auditing care records. The management team planned to meet each week to discuss the service, for example "client issues, carer issues and new clients". A quality assurance activity schedule was in place which identified key areas for improvement, actions to be taken and the timescales for completion. As part of these improvements a new electronic management system had been introduced to collate information about staff and the business.

People had the opportunity to provide feedback about their care and support in a variety of ways. The manager visited them in their homes and any verbal feedback was recorded. People's views and opinions were recorded as part of the review of their care. There were plans in place to send out questionnaires to people and staff during 2017 as part of the quality assurance process seeking their views about the standards of care and support. Compliments had been paid to Windrush Care by people and their relatives as the service being provided came to an end. These included, "It has been terrifically helpful", "Girls are amazing" and "Well organised."

There was a manager in place who had applied to become registered with the Care Quality Commission. They were supported by the nominated individual, a care co-ordinator and senior carer. People said the manager was "very obliging" and "[Name] is on top of everything". Staff told us, "Management are so friendly, they welcome you in", "They talk about what's good, they give praise and feedback" and "They are always happy to listen on the phone and office help in any way they can".

The visions and values of Windrush Care were described as offering "excellent support" by "trained professional carers" so people can "remain happily at home in comfort and safety, bringing reassurance for the individual and peace of mind for family and friends". Staff confirmed, "They appoint new staff who have the heart for this work; it's all about the person" and "We provide brilliant care." The nominated individual and manager recognised the challenges to be recruitment and retention of staff. The manager had been invited to give a lecture for an open study college which resulted in students applying to Windrush Care for care positions. They recognised the value of this opportunity and had been invited to provide another

lecture at a different venue.

The nominated individual and manager kept up to date with best practice and changes in legislation. They liaised closely with other care at home services as well as a national home care association. The nominated individual explained they were part of a working group committee for this association as well as attending the national conference. The manager had attended a registered manager's course with this association. The nominated individual described how they were developing partnerships with other providers and commissioners to help develop the service.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person was not operating effective recruitment procedures. They did not ensure all the required information was obtained before appointing new staff. Regulation 19 (2)