St Gregory's Homecare Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this announced focussed inspection on 13 January and 2nd February 2016. Documentation relevant to the inspection was also collected on 18th January 2016. We last inspected this service in July 2015 during which we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

St. Gregory's Homecare Ltd is a domiciliary care agency based in the town of Carnforth. It offers a range of services in people's homes, including care and support for people living with dementia, learning and physical disabilities and people with palliative care needs. Services also provided includes, domestic support, waking and sleep in night services, 24 hour care and respite care. The service covers rural and urban areas of South Cumbria, Lancashire and North Yorkshire.
There was a registered manager employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in July 2015 we asked the provider to take action to make improvements to the following (Regulated Activities) Regulations 2014, safe care and treatment including the proper and safe management of medications and person centred care. This inspection focussed on whether those actions had been met.

During this inspection we found that there was a continuing breach of Regulation 12 Safe care and treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to the assessing of risk to health and safety of people using the service and doing all that is reasonably practicable to mitigate any risks.

Although people told us that they felt safe receiving care and support from this service we found the provider was not identifying all of the risks associated with providing safe care and treatment. Where risks had been identified they had not always been recorded.

The quality and accuracy of care plans and risk assessments recorded were not consistent and some information about some people's current care needs had not always been recorded. Where care plans had been reviewed previous risks identified had not always been included in the reviewed care plans.

Where risks were evident staff had not always relayed them to the senior staff who manage the care plans or identified them in people's care records themselves.

Most people received support from a regular team of staff who they knew and who understood the care and support they required. We saw that people were treated with kindness and respect and people made positive comments about the staff who visited their homes.

During this inspection we found improvements had been made to the management of medications. The provider was still working on systems and processes to continue to improve the safe management of medications.

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?

Inadequate

The service was not always safe.

The records relating to the safe management of medications had improved.

Risks associated with providing safe care were not always identified or recorded.

Where risks were evident staff had not always acted upon them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The consistency of the quality of care planning did not ensure that accurate information was recorded about the needs of people who used the service.

Not all reviews of people's changing needs were accurately recorded.

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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 13 January and 2nd February 2016. Documentation relevant to the inspection was also collected on 18th January 2016. The inspection visits were announced to the agency's head office. Our visits were announced as we visited people who used the service, with their permissions, in their own homes. The inspection was carried out by two adult social care inspectors and a pharmacy inspector.

Before the inspection we reviewed the information we held about the service this included an action plan sent to us by the provider following our last inspection in 2015. The inspectors visited the agency office and looked at care records for a total of 15 people and we also looked at the management of medications for those who had them. The inspectors also visited four people and spoke with their relatives if they were present, with their permission, in their own homes.

We asked the provider to complete a Provider Information Return (PIR) before the previous inspection. 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. This had been submitted prior to the last inspection in 2015.

We looked at training records relating to the management of medications for staff. We also looked at records relating to how the provider monitored to check the quality of the service provided. We also spoke with the registered manager of the service, a senior company manager, administration staff and four care staff.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe when receiving their care. One person said, ''Yes, I feel very safe with them they know me well and I have regular carers.'' Another person told us, ''We don't always know who is coming but it doesn't matter, they (care staff) are all good. People told us they received their visits on time and if care workers were running late they were called to inform them.

At the last inspection we found a continuing breach of Regulation 12 (g) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014 relating to the proper and safe management of medicines. We issued a notice requiring the provider to become compliant with the regulation. We also found that some hazards to individuals' safety had been not always assessed and measures had not always been put in place to reduce or manage the risks identified. We were also provided with an action plan from the provider telling us how they would comply with the regulation.

During this inspection whilst we found there had been improvements made in the records for the management of peoples medications we found that some risks associated with the delivery of peoples care had not always been identified.

Where two people had been identified as at being of risk from choking due to swallowing difficulties we found that their current care plans and risks assessments made no reference to it. Where someone living with dementia had recently started to become wandersome this had not been risk assessed or a care plan devised for staff to follow. Assumptions were being made as to the whereabouts this person might be at the time of their scheduled visits. For another person we saw where their medical condition may worsen, leading to hospital admission, the relevant key indicators had not been documented for staff to follow to ensure agreed protocols re hospital admission could be implemented. Where a person had a recognised allergy this had not been identified or a risk management plan put in place.

This was a continued breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to assessing the risks to the health and safety of people using the service.

At this inspection, carried out in January 2016, we looked at six care packages that included support with medication. We found action was being taken to address the issues identified at our previous visit. The medicines policy had been reviewed and medicines were administered by appropriately trained staff. Senior Administrator completed regular checks of the medicines record keeping and any concerns were discussed directly with the care staff involved. Where necessary, further medicines training had been provided. Managers' explained that they had experienced difficulties in obtaining pre-printed medicines administration records for some clients. They described plans they wished to introduce to address this by producing company printed medication administration records. This was to be introduced to promote consistency within records.

Information about the support people needed with their medicines was recorded within their care plans. We saw examples where medicines changes had been clearly recorded and promptly made. However, we also saw one example where notification of an unexpected change in the time of medicines administration had not been clearly logged. This meant it was not clear what action had been taken to ensure the client received their medicines at the right time. Similarly, care staff described how another client on occasion made-up and took one of their own medicines prior to their arrival. However, this was not described within their support plan.

Managers and senior care staff carried out unannounced spot checks on care staff as they worked in people's homes. They told us that checks were made to ensure that people were receiving support safely and that equipment was used as directed.

Requires Improvement

Is the service responsive?

Our findings

People who used the service and relatives we spoke with gave very positive comments about the service. One person told us how during recent bad weather their visit had been completed by care staff walking to them. Another person told us, ''They (care staff) have never let me down, I totally trust them to do anything I need, I only have to ask.''

Records we looked at showed that information for staff about how to support individuals was not always accurate or consistent. Some of the care plans we looked at had been reviewed to make sure they held up to date information for staff to refer to. However we found that even where these records had been reviewed recently information about people's needs was not always accurate. This meant that they did not accurately reflect the support people required. We have dealt with this in the domain of Safe under Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We asked the registered manager what improvements they had made in regards to Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) 2014 since the last inspection. The registered manager said that they felt the service had come along way and they had overhauled every process including care planning and assessment. They felt the care plans were all of a similar standard. However we saw that there were still different formats of care planning in use. The managers were unable to give us a definitive number as to how many people had the new care plan format in place.

Since our last inspection the systems and processes that had been put into place to deal with incidents and concerns has shown to been effective in responding to and quickly identifying actions to prevent reoccurrence of issues where feasible.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Assessing the risks to the health and safety of people using the service was not always completed or recorded.

The enforcement action we took:

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