Short Notice Care Services Limited

Short Notice Care Services

Inspection report

The Hollies
Chester Road
Whitchurch
Shropshire
SY13 1LZ

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Short Notice Care Services is a domiciliary care agency providing personal care to people in their own homes. The service was supporting 34 people with personal care in their own homes at the time of our inspection.

People's experience of using this service and what we found
We found widespread shortfalls in the way the service was monitored at a provider level. Unpaid bills meant that services such as the rental of phones and printers had been withdrawn. This had negatively impacted upon the service provided.

The lack of governance and audits meant the provider did not know if staff met people's needs or delivered safe and effective care. The registered manager had left the service in December 2020 and the provider had not implemented management support for the service in a timely manner. This meant there was a period of time where the service was not monitored and this had impacted upon the quality of the service provided, despite staffs' best efforts.

Some people were supported by staff to take their medicines and although overall they did this safely there were occasions when people ran out of medicines and this was not immediately resolved. This placed people at risk of harm. Staff did not have all the information they required to ensure people's medicines were administered safely and there was a lack of monitoring to ensure processes were followed and were safe. Following the inspection visit we raised a safeguarding after identifying a lack of medication monitoring could have negatively impacted upon one person's wellbeing.

People told us they felt safe while being supported with their personal care and all commented that staff knew them well and 'went the extra mile' to ensure their calls happened and their needs were met.

Risks relating to people's safe care and support had been considered by staff and the majority were documented. Not all information had been recorded to direct staff how to safely manage issues identified. For example, staff had no written direction for how to monitor pressure areas when a person was at risk of their skin breaking down. There was no evidence that the lack of recording had impacted on the quality of care provided.

Staff were safely recruited however documentation did not always reflect that required checks had been carried out, or documented, to reflect safe practice. These shortfalls had been identified by staff who were taking action to update records.

We have taken action to address issues identified.

Rating at last inspection

The last rating for this service was good. The inspection took place in April 2019.

Why we inspected
We had received concerns from social care professionals that suggested there were issues with the financial viability of the service, and this would potentially have an impact on the service provided. Our findings reflected the concerns shared with us.

We reviewed the information we held about the service. We did not inspect the key questions of effective, caring and responsive which were previously rated as good.

The overall rating for this service has changed from good to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Short Notice Home Care on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and in the governance of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe	**Inadequate**
Is the service well-led? The service was not well led	**Inadequate**

Short Notice Care Services

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service did not have a registered manager. This meant the provider alone is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure there would be service representative in the office to support the inspection.

Inspection activity started on 24 March 2021 and ended on 31 March 2021. We visited the office location on 25 March 2021.

What we did before the inspection.
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who worked with the service. We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took

this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service and five people's relatives about their experience of the care provided. We spoke with seven support staff, three staff who worked in a supervisory role, the deputy manager and the manager.

We reviewed a range of records. These included three people's care records and two staff files in relation to recruitment and staff supervision. We also looked at variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with the nominated individual (a person nominated by the provider to be accountable for the service provision).

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This service was previously rated as requires improvement in this outcome area. We found it has now deteriorated to inadequate. People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely

- At the time of the last inspection we identified concerns in the recording of the administration of medicines. Staff had required further guidance on how to administer 'as and when' required medication such as prescribed creams. During this inspection we found these areas of concern had not been acted upon meaning people continued to be at risk of harm. For example, one person required a topical cream when their skin became sore. The provider had failed to provide staff with information about when they should apply this cream. This meant the medicine may not be administered appropriately, possibly leading to harm.
- People did not receive their medicine when they needed it. One person's medicines could not always be given as prescribed as care visits were carried out before or after the four-hour gap required between doses. Staff recorded 'not enough time' to administer regularly but this was not reviewed or followed up due to the lack of monitoring.
- One person required a medicine to treat an identified medical condition. This person did not receive this medicine for a week as there was none at their house. Following the inspection, we raised a safeguarding concern to the local authority to review this omission. Staff were responsible for ordering this medicine, yet the omission had not been followed up and this could impact of the person's health in the meantime. Staff completed medicine administration records (MAR) as 'none here' being the reason for not administering.
- Following the inspection, the care supervisor told us they have now changed their ordering system to ensure this does not happen again.
- One person was prescribed a three-day medicine patch. Their medicine record did not state which side it should be administered. The provider had not ensured a protocol was in place to support staff as to how best to administer this prescribed medicine and as a result it may not be effective.

Assessing risk, safety monitoring and management

- When risks had been identified there was not always actions documented to show how staff should mitigate these risks. For example, in relation to supporting people with pressure areas. Staff told us they had had supported a person whose skin had broken down and had needed input from a health professional. The provider had not updated this person's care plan to reflect this change or detail how to monitor the person to prevent a reoccurrence. This meant the risk of reoccurrence had not been reduced.
- One person had been identified as being at risk of falls however the safeguards put in place to keep the person safe meant the staff were restricting this person's freedom of movement. Staff were removing the person's walking aid to deter them from getting up. Staff told us this was an agreed course of action however ,there was no documentation that was the least restrictive action to take to keep the person safe.

This was a breach of regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● During the outbreak of COVID-19 in the community the provider failed to supply all required personal protective equipment for staff use. For example, aprons. This meant that the provider had not ensured staffs' safety, placing them, and people who used the service, at risk of harm. Staff had acted independently to keep people who used the service safe by purchasing additional items themselves.

● Upon arrival at the office (on the day of the inspection site visit) we were not asked to follow infection control measures to ensure the risks of spreading coronavirus were minimised. The manager advised they were aware of this shortfall and since the inspection we were told by the nominated individual that this was immediately rectified meaning safe practice is now followed to keep visitors and staff safe.

This was a breach of regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Moving and handling care plans were in place to help staff move people safely and staff told us that care plans and risk assessments were helpful and supported safe practice.

● The deputy manager told us they had worked with the local authority infection control team when local community had an outbreak of COVID-19, which affected some staff and service users, in order to keep people safe and reduce the spread of the infection. They had managed to do this successfully, minimising the impact of the virus to people's health and safety.

Systems and processes to safeguard people from the risk of abuse

●The provider had placed people at risk of harm by not effectively monitoring the administration, receipt and recording of medicines. This meant people were at risk of missing medicines or having the wrong dose.

● People were safeguarded from the risk of abuse because the senior staff team knew how to report concerns of alleged abuse to external agencies and work with them to investigate.

● Staff told us they were aware of signs of abuse and that allegations of abuse would be reported immediately. People who used the service told us they always felt safe while receiving care and support.

Staffing and recruitment

● Of the two staff files we looked at we saw there was essential information missing from one. One staff member had no record of a check with the Disclosure and Barring Service (DBS). The DBS helps employers make safe recruitment decisions. The new manager had already identified that records relating to some checks made were not available. As a result, they had initiated a review to ensure all paperwork was available. The deputy manager and senior office staff were confident all staff had demonstrated they were fit for the role they were appointed to, and staff confirmed this in discussions with them. This meant that there had been a recording issue in relation to demonstrating staff fitness to work and this was being addressed.

● Some staff were not up to date with their mandatory training and the new manager had begun to implement online training to plug the gaps until face to face training could be delivered again.

● Senior staff had accessed training to enable them to become 'trainers' and this meant they could work alongside staff to support them to meet the identified needs of the people they supported.

● People who used the service were positive about the consistency of their staff team who they had formed close bonds with. One person who used the service said, "We could not be more pleased with the reliable service offered".

● People said staff stayed the required amount of time and carried out all required tasks. (Staff told us they

had time to carry out their calls although on occasions records reflected, they were unable to complete tasks due to time constraints. Senior staff and the staff team were working very hard to ensure all calls happened. Often staff worked well over and above their designated hours. One staff member told us, "Yes I feel there is enough time for care calls and on travel time as well. If we feel like we need more time we talk to the office staff and they help us and will deal with that".

Learning lessons when things go wrong

● Senior staff told us they learned lessons when things went wrong to improve the service provided. For example, one senior staff member told us that one person's personal safety alarm had failed to operate. As a result, staff checked everyone's pendants and smoke detectors to make sure such an incident was less likely to happen in the future. This would mean people would be better protected.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This outcome area was previously rated as good. We have now rated this service as inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● We had not been formally notified of the changes to the management of the service. The previous manager had not formally 'deregistered' with us and the provider had not notified us.

This is a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009

● We carried out this inspection after financial concerns were shared with us by the local authority. We had also been advised of issues affecting the payment of staff. Some staff had not been paid their full entitlement and had left the service.

● Staff were unsure of their roles and who was managing the service at the time of the inspection. We sought clarification about this following the inspection and the nominated individual advised us of arrangements. They told us the acting manager would become the registered manager and the staff member who had been previously acting in a management role would become the deputy manager. These arrangements were not clear within the staff team meaning individual roles and responsibilities were not clear. This meant tasks may not get done and this could impact on the quality and safety of the service.

● The provider did not have oversight of the service provided and they could not guarantee people were being effectively or safely supported. They did not have systems in place to identify shortfalls and make improvements. For example, the omission of medicines had been documented but had not been identified at a management level to enable prompter action to be taken. The nominated individual confirmed to us they had not carried out any audits or checks and this reflected our findings.

● The provider had not acted to ensure improvements required at the time of our last inspection had been actioned. They therefore could not ensure people's ongoing safety, and so the risk of harm remained.

● The provider was not aware of the day to day running issues affecting the service. For example, the nominated individual was not aware that the staff team had had to manage an outbreak of Covid-19 that affected staff and people who used the service.

● The provider had failed to support their staff. One staff member said, "I do not feel this company is well-led." This feedback was reflected by every member of staff we liaised with. Staff did, however, feel supported at a local level by their peers and office staff. One staff member told us, "The office staff and all fellow members of staff are very supportive with everything."

● The provider had failed to provide effective out of hours systems. Staff told us on call systems were not effective and the deputy manager was required to keep manually checking records as they did not have the technology available to them to do it electronically. This meant that monitoring was time consuming and

issues may be missed. Staff told us that on one occasion the on call phones did not work at all and this left people vulnerable of they needed urgent support.

This is a breach of Regulation 17(1) good governance, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There had been no complaints or concerns about the quality of the service, and no accidents reported. However, the provider was not monitoring the service so could not demonstrate staff were following a culture of openness and transparency. The provider was not communicating with the staff team to demonstrate effective leadership. This lack of communication does not reflect the culture that encourages candour.

This is a breach of Regulation 20, Duty of Candour, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

● People told us that they were more than satisfied with the support they received and felt their individual needs were met. This happened because the senior and core staff team had worked together to make sure people received their support calls. This was achieved without the support from the provider, and records reflected that some omissions to people's care had occurred. For example, some people had missed prescribed medicines because they had not been available to administer. The staff team culture was totally focussed on the people they supported and reflected the staff's commitment and passion for their work. Oversights were not identified by the provider to ensure changes could be made to improve service delivery.

● Care plans contained details of people's preferences as well as their needs. Staff knew people very well and a high number of staff had worked for the service for several years. People reflected very positively about how well people met their individualised needs.

Continuous learning and improving care

● There was no evidence that learning from events had taken place at a provider level. For example, there were still outstanding requirements from our previous inspections.

● Staff told us how they responded effectively to people's changing needs meaning they could offer a better service to people.

Working in partnership with others

● Office staff told us they received excellent support from the local authority infection control team during a recent COVID-19 outbreak. They felt this support meant they could safely manage the outbreak effectively and keep people safe.

● Staff felt health professionals worked effectively with them meaning they could offer consistent support based on people's medical needs. One staff member told us, "I feel we have a very good, strong relationship with the healthcare professional in this area, our district nurses are very supportive and communicate with us regularly regarding client care. The doctors are also very helpful and responsive to our needs and have been very supportive throughout this pandemic". Another told us, "I have a really good relationship with district nurses and doctors in the local area, and work alongside them in the best interests of the service users".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Despite the provider's failings, people told us the agency had a good reputation locally and staff told us how they worked with community groups to help out during the pandemic. This impacted positively on people who used the service and raised the profile of the agency. A relative told us, "We would not hesitate to carry on using Short Notice Care and indeed would recommend them to other parties".

● People we spoke with said staff did everything they wanted them to do in their assessments 'and more'. One relative told us they had been consulted in developing their family member's care plan and worked with staff closely to monitor the person's wellbeing. This meant people's individual characteristics could be identified and supported and individual needs met.

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 20 HSCA RA Regulations 2014 Duty of candour Thee provider was not monitoring the service thus could not demonstrate that staff were following a culture of openness and transparency. The provider was not communicating with the staff team to demonstrate openness. This lack of communication does not reflect the culture that encourages candour.

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 15 Registration Regulations 2009 Notifications – notices of change The provider had not formally notified us of changes to the management of the service.

The enforcement action we took:

We are imposing conditions to the providers registration and making requirements within the report

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving their medicines and errors and omissions were not being followed up. Risks were not always documented to demonstrate people received safe support and the provider did not support safe working practices but not supplying personal protective equipment when required

The enforcement action we took:

We are imposing conditions to the providers registration and making requirements within the report

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have oversight of the service provided and they could not guarantee people were being effectively or safely supported. They did not have systems in place to identify shortfalls and make improvements.

The enforcement action we took:

We are imposing conditions to the providers registration and making requirements within the report