High Level Care Limited

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Inspection report

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Date of inspection visit: 7 and 13 April 2015
Date of publication: 07/07/2015

Overall summary

This inspection was unannounced and carried out on 7 April 2015. A second, announced inspection took place on 13 April 2015. The service had registered with the Care Quality Commission (CQC) in December 2014, and this was the first inspection.

High Level Care Limited is a domiciliary care agency which provides care and support to people in their own homes and in the community. Care is provided for people with physical or mental health needs. At the time of our inspection the service provided care for two people.

A registered manager had been in place and our records showed she had registered with the Care Quality Commission (CQC) in December 2014. However the provider told us that she had left the company approximately one month before our inspection. 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.

Staff had not received training in how to identify and respond to potential abuse. One member of staff told us about their concerns for a person using the service. We found this information had not been shared with the local authority safeguarding team which meant the provider's protocol had not been followed. The acting manager of the service, and the provider told us they had not undertaken any safeguarding alerter training, about what to do if staff came to them with concerns, but said would arrange this training after our inspection.

Risks had not been properly assessed. We saw incorrect information had been recorded on some risk assessments and there were no assessments in place for risks associated with the activities people were supported to take part in.

People we spoke with told us the service was reliable and there were enough staff to meet their needs. However, robust recruitment processes had not been followed and staff had started working for the service, providing care to people, before checks had been carried out to determine if they were suitable to work in a caring role.

Staff had not completed any training whilst they had been working for the service. They had been provided with DVDs to watch and then expected to complete a questionnaire testing their knowledge on the training. None of these questionnaires had been completed at the time of our visit and the provider was unable to tell us how they ensured staff were competent to deliver care.

Staff had not received any supervision sessions. The acting manager told us these would be arranged for every three months, but that none of the staff had been in their

Summary of findings

roles for three months at the time of our inspection. Staff told us the organisation was supportive and they could contact the acting manager or provider with any concerns.

Staff, the acting manager and provider of the service had an awareness of the Mental Capacity Act 2005 (MCA) and were able to tell us about the way they followed the requirements of this law. Staff told us people had capacity to make all of their own decisions, including the right to refuse care if they wished. The person we spoke with confirmed that staff respected their wishes.

A range of assessments had been carried out to determine people's needs. However, we saw when people's needs changed these had not always been updated which meant they were not accurate.

The care delivered did not always match the care that had been planned. We saw staff did not follow a moving and handling assessment provided by an occupational therapist which meant people may have been at risk of receiving unsafe care.

The records we viewed as part of this inspection were not completed to a high standard. Care records were unnamed or undated. The acting manager and provider were unable to provide us with records or information during our inspection. They told us they had not recorded information.

Risks to staff had not been assessed and mitigating actions to reduce risks had not been put into place.

We found four breaches of regulations. These related to; Safe care and treatment, Safeguarding, Good governance and Fit and proper persons employed. You can see what action we told the provider to take at the back of the full version of the report.

Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

Summary of findings

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 safe.

People were not protected against the risk of abuse, as staff had not been trained in how to identify potential abuse and the provider had not followed the local authority safeguarding protocol.

Risks had not been assessed and accidents had not been properly recorded.

There were enough staff to support people; however, recruitment processes had not been followed. Checks had not been carried out to determine if there was any reason staff should not be working with vulnerable people.

Is the service effective?
The service was not effective.

Staff had not received training in how to deliver aspects of care and the provider had not ensured staff were competent to provide care for people.

Staff had an awareness of the Mental Capacity Act 2005 and described to us how this impacted on their work.

Staff supported people with preparing meals. The relative we spoke with told us staff were aware of people's preferences and the food they prepared was of a good standard.

Is the service caring?
The service was caring.

The person we spoke with told us they had a very good relationship with staff.

We saw from care records, and from speaking with a care manager, that people's independence was promoted.

The person we spoke with told us they had been involved in planning their care.

Is the service responsive?
The service was not responsive.

Care needs had been assessed, but these assessments were not always up to date.

Care was not always delivered as planned, which left people at risk of receiving unsafe care.

Care records were personalised and detailed.

Is the service well-led?
The service was not well-led.

There was no registered manager working at the service

Record keeping was of a poor standard with care records missing information such as names and dates. The provider was unable to provide us with some information as records had not been kept.

No formal arrangements were in place to monitor the quality of the service, although the provider told us they were regularly in contact with people and staff to ensure people were being cared for properly.

High Level Care Limited

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. Because of the limited size of the service we have not awarded a rating in this instance.

This inspection took place on 7 April 2015 and was unannounced. We returned on 13 April 2015 for a second day to complete our inspection. We had received information about concerns in relation to the service, and as a result we brought the date of this planned inspection forward. The inspection was carried out by two inspectors.

Before the inspection we reviewed all of the information we held about the service and the service provider, in particular any of the notifications that had been sent to us. Notifications are sent to CQC to inform us of any legally notifiable events, such as accidents or safeguarding matters.

Prior to the inspection we contacted North Tyneside Council safeguarding team and North Tyneside Council contracts team to discuss their views of the service. We did not receive any information of concern from these teams.

During our inspection we spoke with one person who was supported by the service, one relative, and a care manager. We visited the main office for the service and looked at two people's care records, seven staff personnel files and records relating to the management of the service. We spoke with the provider, the acting manager and four members of care staff. With their permission, we visited one person who used the service to discuss their views of the care provided and look at the records kept at their home.

Is the service safe?

Our findings

People were not protected from potential abuse as the service did not have effective systems in place to ensure staff were competent in identifying and reporting issues of concern. Staff told us that since joining the company they had not completed any training in safeguarding people. We asked the provider about the training provided for staff in recognising and responding to abuse. The provider said, "Staff have been given DVDs which include safeguarding. They are getting on with that now." The training provided by the company required staff to watch a DVD on safeguarding and complete a questionnaire which would be sent to the training provider to be marked. The provider confirmed that at the time of our inspection, none of the staff had completed the questionnaire.

A member of staff told us about a situation where they had concerns for a person they supported. The situation they described met the criteria for a referral to the local authority safeguarding team. We spoke with the provider about this situation. They told us they were aware of the staff members concerns and that they had worked closely with the person's care manager. They said they had not spoken with, or made a referral to, the local authority safeguarding team, as they did not know they needed to do this. The provider and the acting manager told us they had not undertaken any safeguarding 'alerter' training. When asked about how they would respond to any allegations of potential abuse, the provider described investigating and speaking with care managers. They did not mention a referral to the local authority safeguarding team. This meant people could be at risk of abuse because appropriate action had not been taken and an alert not made to the local safeguarding team.

We spoke with the care manager of one person who used the service who said, "The service have always shared their concerns with me, they are really good at keeping in touch. I don't think they know the proper processes, but they will share information, perhaps just not in the right way."

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks had not been identified and action had not been taken to minimise risks people were subject to. We saw from care records that some risks had been assessed; however, incorrect information had been used in assessments. We saw one person had been assessed to determine the risk of them falling. Their risk assessment stated there was no risk of them falling as they had mobility aids in place. However, staff told us this person had fallen on a number of occasions. These falls had not been reflected in the risk assessment. This meant the risk assessment was not accurate, as the risk had not been identified and actions had not been taken to reduce the risk.

There was no record of an assessment of the risks people were exposed to when they were supported by staff to take part in activities, such as swimming or cooking. Staff were able to tell us about some of the ways risks were mitigated, such as having two members of staff to accompany the person when they went swimming. However, in discussions with the provider they acknowledged these risks had not been properly assessed and told us they would now assess the risks associated with the activities people were involved in.

We reviewed the accidents and incidents records for the service and saw no entries had been made. The provider told us there had been no accidents or incidents whilst staff had been delivering care. However, care records and staff discussions indicated there had been accidents. For example, a member of staff told us about when they helped a person off the floor after they had fallen. As this information had not been recorded as an accident, it meant it could not be monitored to determine any trends or any actions which could be taken to reduce the likelihood of accidents happening again.

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

Staff supported people to take their medicines. We were told medicines were prepared by the pharmacist into a dosette box, which is a container where people's regular medicines are stored to help people to take them at the right time. We saw from records, and from speaking to one person who used the service that staff also gave people other medicines which weren't stored in the dosette box. Staff told us they had undertaken safe handling of medicines training when they had worked with other companies. However, they told us, and records showed they had not completed any similar training with this provider. The provider had not completed any competency assessments to ensure staff were competent to administer medicines.

Is the service safe?

There were enough staff to meet people's needs. At the time of our inspection there were six staff working with two people who used the service. We spoke with one person, who told us the service was reliable and staff arrived for all of their visits on time. They said, "The staff come when they say that they will. I've never had any problems where they haven't turned up. I've dealt with a lot of services and this one is one of the best." A relative told us, "They are reliable now. We had some issues in the past, but they've changed the staff team now and it's a lot better."

Recruitment procedures were not robust and checks had not been undertaken to determine if staff employed were suitable to work with vulnerable people. We looked at seven staff recruitment files. We saw five staff had started providing care and support to people before the service had received information from the Disclosure and Barring Service (DBS) to determine if there were any reasons that may prevent them from working with vulnerable people.

The acting manager had told us the recruitment procedure included gaining two references about the staff member's character. We were told one of these references needed to come from a previous employer. We saw from the seven staff files that the service had not received any references for five of the members of staff. The provider told us they had contacted some previous employers over the phone to gain a telephone reference, but had made no record of these references. They also told us they had become short staffed following one staff member leaving, meaning they quickly needed to employ more staff. They said, "We had to make sure that everyone (the service users) was covered." They continued, "We had to think on our feet a bit to cover the situation we were left in and try and get people's DBS checks and references requested as soon as we could." This meant staff provided care to people before sufficient checks had been carried out.

One member of staff had declared a conviction on their application form. The service had a policy in place which detailed the process which would be followed when employing staff in these circumstances. This would include an assessment of the circumstances of the conviction to determine if the person was suitable to work with vulnerable people. However, there was no record of this assessment, and no information had been recorded as to what the conviction was. The provider told us they had discussed the conviction during the interview and considered that it did not raise any issues in relation to the staff member providing care and support to people. However, they did acknowledge they had not formally assessed the risks, or put in place any monitoring of the staff member.

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

Is the service effective?

Our findings

Staff had not completed any training. The acting manager told us all staff had been issued with DVDs to watch on key areas of training, such as moving and handling, safe handling of medicines, and health and safety. Once staff had watched the DVDs, in order to receive their certificates, they needed to complete a questionnaire which tested their knowledge. This would be marked by the training provider and if they met the pass mark the certificate would be issued.

At the time of our visit, none of the staff had received any certificates. We saw one member of staff had completed one questionnaire. However, this had not yet been sent to the training provider and none of the other staff had handed in any of their questionnaires.

We asked the acting manager what training people had received before they started to provide care to people. They told us all staff had attended an induction meeting, where they had discussed key policies and were issued with the training DVDs. The acting manager told us the training DVDs needed to be completed within 12 weeks of staff beginning work. The provider was unable to tell us how they had ensured staff were competent to deliver care to people at an appropriate standard.

The acting manager told us plans were in place to arrange to meet with staff once every three months in supervision sessions to discuss their role and performance. However, at the time of our visit none of these supervision sessions had been held. The acting manager said this was because most of the staff had only recently been employed by the service.

Staff we spoke with told us the service was supportive and that they could contact the provider if they had any concerns or issues. One staff member said, "I speak with [name of the provider] or [name of the acting manager] regularly; they are always in touch. They seem like lovely people to work for."

The person who was using the service who we spoke with said, "The staff are very good at their jobs. I've never had any problems with them at all. It does what it says on the tin; it is a high level of care". The care manager we spoke with said, "[name of the person receiving service] is getting what they need. The agency is a good service." A relative we spoke with said, "The two staff who visit now definitely meet his needs."

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and followed the requirements of the law. The MCA protects and supports people who may not be able to make decisions for themselves. Staff told us people they supported had capacity to make all of their own decisions and told us about how they supported people to do this. For example, one member of staff told us how the person they supported decided what activities they were going to take part in that day.

We discussed the MCA with the acting manager and provider, who were able to describe to us the actions they would take if they provided care to someone who did not have capacity to make decisions. They were able to tell us about the principles of MCA, but acknowledged they, along with their staff, required specific training in MCA and told us this was something they would arrange.

Staff told us they gained people's consent for all of the care they provided and the person who we spoke with also confirmed this. They said, "They listen to me. They'll say, 'Are you happy with this…? Do you want us to do that…?' They chat to me the whole time, checking that they are doing what I want." The person we spoke with told us they had read through the care plans and were happy with what had been included. They told us a copy of the care records were stored in their home, so they could look at them whenever they wanted to.

Staff prepared food for one of the people they supported. We saw information about what the person liked to eat had been recorded in their records. We spoke with a relative who told us the food staff prepared was of a good quality. They said, "I do the shopping anyway, so there is lots of stuff in the cupboards to make. The staff that are in there now, they do a good job. [Name of the person receiving care] gets his food when he likes and they know what he will and won't eat."

Is the service caring?

Our findings

The person we spoke with told us they had a very good relationship with staff. They said, "I've used lots of home care services and this one really doesn't compare to others. It's excellent. They arrive on time, they respect your home. With another company, when two carers came in they would be talking over my head like I wasn't there. That's never happened with High Level Care, the staff are like my friends now. They are all lovely. It's half the battle if you like the staff."

The relative we spoke with told us staff were kind. They said, "He has a better relationship with [name of staff member]. They always have the music channel on, the one that he likes, and they'll sing along. They brought a karaoke machine round as they know he loves to sing and they'll put it on the odd night or daytime if they aren't going out. Nine times out of ten [name of staff member] will stay behind after the end of their shift to finish playing a game on the iPad, [name of person receiving service] likes that."

The person we spoke with told us they had been fully involved in planning their care. They said, "I was involved from the off. They came around and asked me how I wanted everything done. They really listened as well, as I've been happy with everything." We saw throughout care records that people's preferences had been recorded.

The acting manager of the service provided us with a service user guide when we asked to see one, but the person we spoke with told us they had not received written information about the service, apart from their care records. The service user guide contained information about what people should expect from the service and contained telephone numbers for the office, including the emergency contact number for the service. Whilst the person we spoke with told us they had contact numbers for all of the staff, they did not have access to this important information. We fed this back to the acting manager who told us they would provide all of the people who used the service with service user guides.

We saw from care records people were supported to be as independent as they could be. Information for staff included details on how they should support people to do as much as they could for themselves. We saw the service was supporting one person to maintain and develop their skills in cooking and shopping. We spoke to one person's care manager who said, "Since the very start of this company being on board they have been involved in how to promote [name of person receiving the care]'s independence, by helping with activities and going out. I have been very impressed with what they want to achieve. The service is really good with [name of person receiving the care]; they do lots of things outside the box with him. He's come on leaps and bounds since they've been providing care."

Is the service responsive?

Our findings

We saw a range of assessments had been carried out to determine people's needs. Plans of care had been written with information for staff about how to care for the person to meet their needs. However, we saw care records were not always updated when people's needs changed. For example when one person started receiving care they managed their own medicines. However whilst receiving care their needs changed and staff started to support them with this. Their assessments were outdated as they did not include any information about staff supporting the person with their medicines.

Care was delivered in a way that did not always reflect the information in people's care plans. For example, one person had mobility needs, which meant they needed support from staff to transfer from their wheelchair to bed. An assessment had been provided by an occupational therapist describing how staff should use mobility aids to help the person to transfer out of their wheelchair. Staff told us the person did not like to use the mobility aids and asked staff to help them to move without using the aids. The person who used the service told us, and records confirmed that staff did help this person to transfer without using the mobility aids. This meant staff were not following the assessment provided by the occupational therapist about the safest way to support the person.

Staff had not received moving and handling training from the service. The acting manager told us if the person fell out of their wheelchair staff needed to contact another care agency to safely help the person up from the floor. However, we spoke with the person who told us staff had helped them when they had fallen. The acting manager confirmed a staff member had assisted the person to get up after a fall, when they had not realised that it wasn't safe to do so. As staff had not been trained in moving and handling they could have put the person at risk by helping them up. The acting manager told us she would arrange the training as soon as possible.

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

Plans of care were specific and detailed to individuals. They included people's preferences about their care delivery, as well as information about their needs. The person we spoke with told us they felt their care was individual to them, they said, "They have made it clear that I decide how things go. They've been very open to what I've said, checking if I'm happy or want any changes. They said, 'This is your care, so it should be about you.'"

In addition to caring for people in their home, we saw one person was supported to take part in activities and to access their local community. We saw they went swimming regularly and visited shops and cafes.

The person who received care and the relative we spoke with both told us they had not received any information on how they could make a complaint. Both told us that they would not hesitate to make a complaint, if they needed to, and they would contact the acting manager or provider. We fed back to provider that people did not have access to a complaints policy and they told us they would ensure these were issued immediately. The acting manager told us no complaints had been made.

Is the service well-led?

Our findings

During our visit we noted the quality of record keeping was poor. We saw within people's care records some documents were unnamed or undated. The acting manager was unable to provide us with records of staff rotas for the month before our visit and could not tell us which member of staff carried out a visit to a person receiving a service on two specific dates. There was no diary or communications book for the agency office. This meant the provider was unable to tell us dates telephone references had been requested for new staff or which member of staff had replaced another when they had been unable to work their planned shift. Staff personnel files were missing information, such as what dates staff had been interviewed and the dates they started working for the company.

The provider was unable to show us how they had assessed and mitigated the risks to staff from working within the service. One person who used the service smoked and staff told us they were conscious of this impacting their health. The provider did tell us they had asked the person not to smoke an hour before their visit was planned, but this had not been documented in an agreement. There were no risk assessments in place relating to the risks staff may be exposed to by carrying out their role.

The provider was unable to show us how they had assessed and mitigated some of the risks to people who used the service. The provider told us she had taken a volunteer into the home of one person, to discuss their condition as the volunteer had experience in that area. The provider told us they had not carried out any background checks on the volunteer. The service did not have a policy related to taking volunteers into people's homes. The provider could not show us any evidence they had assessed or mitigated any potential risks to people in respect of the use of volunteers.

The provider told us they did not carry out any formal quality assurance checks or audits. When asked how the provider was assured staff arrived on time, were reliable and were making good quality records of their visits, they told us this was monitored informally. The provider told us that as there were only two people who used the service they were able to speak with them regularly, to check they were happy with the service, and to speak with staff to make sure they were fully aware of people's needs. The provider told us a new computer system was being implemented, within a week of our visit, which would monitor people's visits. This would provide the office staff with information about the time staff arrived for visits and how long they stayed. Following our discussion the provider also told us they would implement formal care and medicine records audits.

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

At the time of our inspection a registered manager was not in place. The registered manager had left the service approximately one month before our visit. The provider told us they had placed an advert for the role in a newspaper and they were planning to interview shortlisted candidates within a fortnight.

The provider told us that she and the acting manager were based in the agency office every working day and available for staff over the telephone 24 hours a day. Staff we spoke with told us they could reach the provider, acting manager or business manager whenever they needed to.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse because systems were not in place to investigate allegations or prevent abuse. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Appropriate systems were not in place to monitor and improve the quality and safety of the service. Systems were not in place to ensure accurate, complete and contemporaneous records were maintained for each service user. Regulation 17 (1)(2)(a)(b)(c)(d)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not have appropriate procedures in place to ensure people employed were of good character. Regulation 19(2)(a)**

The enforcement action we took:
We have issued a warning notice to High Level Care Limited with regards to this regulation.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have in place systems to ensure care and treatment was provided in a safe manner. Regulation 12(1)(2)(a)(b)(c)**

The enforcement action we took:
We have issued a warning notice to High Level Care Limited with regards to this regulation.