Care service inspection report

Mears Care - Bellshill

Housing Support Service

Evans Easyspace
Suite 20
Bellshill Industrial Estate
Bellgrave Road
Bellshill
ML4 3ND

Inspected by: Beth Lynagh

Arlene Woods
Ann Marie Hawthorne

Type of inspection: Unannounced

Inspection completed on: 23 August 2012

Contents

Service provided by:

Mears Care (Scotland) Limited

Service provider number:

SP2009010680

Care service number:

CS2010250092

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Summary

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change after this inspection following other regulatory activity. For example, if we have to take enforcement action to make the service improve, or if we investigate and agree with a complaint someone makes about the service.

We gave the service these grades

Quality of Care and Support	1	Unsatisfactory
Quality of Staffing	2	Weak
Quality of Management and Leadership	2	Weak

What the service does well

Relatives and service users told us that regular staff, who attended to them, were all very professional and pleasant.
There were some examples where training undertaken by staff had been organised specifically to meet the needs of service users.

What the service could do better

The service must address the areas for development highlighted within this report, the most significant of which have been identified under Quality Statement 1.3 - Health and Wellbeing.
The service must actively improve standards in order to improve the current unsatisfactory grade.
Poor grades have also been awarded for Quality Theme 3 - Quality of Staffing and Quality Theme 4 - Quality of Management and Leadership.
This service will be monitored as the action plan to meet these outstanding requirements is being carried out.

What the service has done since the last inspection

Since the last inspection the service had actioned one of the four requirements made and four recommendations out of eight which had been made.

Conclusion

We were advised during feedback of the developments which the service had already put in place to address the deficiencies identified through both our inspection and the provider's internal audit. This internal audit had taken place during and following our inspection. The provider had also imposed an embargo on admissions to the service until such times as standards had improved.
The new Operations Manager, who attended the feedback session, assured us that significant changes for improvement were being planned and introduced within the service in relation to management practices.
A three month timescale for implementation of the action plan developed, to meet the requirements and recommendations from the inspection process, was agreed as acceptable between the providers and Care Inspectorate.

Who did this inspection

Beth Lynagh
Arlene Woods
Ann Marie Hawthorne

1 About the service we inspected

Mears Care has been registered since 14 August 2010; however the service was formerly known as Supporta Care and had been registered since 2008. The service was also registered as Community Careline Services prior to this and had been registered since 2004.
The service provides a Care at Home and Housing Support service to people living within their own homes. The service operates in North Lanarkshire and has an office base in Bellshill.
The aims and objectives of the service are to:
'provide personal and domestic assistance to enable people to remain in their own homes for as long as they wish and to provide such support as the service user requests in accordance with the care plan'.

Based on the findings of this inspection this service has been awarded the following grades:

Quality of Care and Support - Grade 1 - Unsatisfactory
Quality of Staffing - Grade 2 - Weak
Quality of Management and Leadership - Grade 2 - Weak

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change following other regulatory activity. You can find the most up-to-date grades for this service by visiting our website www.careinspectorate.com or by calling us on 0845 600 9527 or visiting one of our offices.

2 How we inspected this service

The level of inspection we carried out

In this service we carried out a high intensity inspection. We carry out these inspections where we have assessed the service may need a more intense inspection.

What we did during the inspection

In this service we carried out a high intensity inspection. We carry out these inspections where we have assessed that the service may need a higher level of intensity of inspection.

The inspection was carried out on 23 July 2012 between 10.00 am and 3.45 24 July between 9.45 am and 3.00 pm. Interviews were carried out with service users, relatives and staff over 2 and 3 August 2012. Feedback was given to two Operations Managers on 23 August 2012.

During the inspection evidence was gathered from a number of sources.
We looked at a range of policies, procedures and other documentation including the following:

* evidence from the service's most recent self assessment
* the action plan from the last inspection
* service user questionnaire
* staff performance appraisals
* service users newsletter
* Minutes of meetings
* Sample of care plans (Support plans)
* Accident and incident records
* Complaints record sheet
* Staff files
* Public liability insurance certificate
* Registration certificate

and we spoke with the following people:

* 6 people who use the service (service users)
* 5 carers/friends (relatives)
* the Manager
* 6 staff members

Observation of care practice was also undertaken.

All of the above information was taken into account during the inspection process and was reported on.

Grading the service against quality themes and statements

We inspect and grade elements of care that we call 'quality themes'. For example, one of the quality themes we might look at is 'Quality of care and support'. Under each quality theme are 'quality statements' which describe what a service should be doing well for that theme. We grade how the service performs against the quality themes and statements.

Details of what we found are in Section 3: The inspection

Inspection Focus Areas (IFAs)

In any year we may decide on specific aspects of care to focus on during our inspections. These are extra checks we make on top of all the normal ones we make during inspection. We do this to gather information about the quality of these aspects of care on a national basis. Where we have examined an inspection focus area we will clearly identify it under the relevant quality statement.

Fire safety issues

We do not regulate fire safety. Local fire and rescue services are responsible for checking services. However, where significant fire safety issues become apparent, we will alert the relevant fire and rescue services so they may consider what action to take. You can find out more about care services' responsibilities for fire safety at www.firelawscotland.org

What the service has done to meet any requirements we made at our last inspection

The requirement

The provider must make suitable arrangements to ensure staff are suitably skilled in carrying out risk and other assessments which determine how the service will meet service users' health and welfare needs.

What the service did to meet the requirement

Progress: We could not see that staff had received training specifically on risk assessment. We also noted that there were still a number of concerns relating to the completion of risk assessments for service users. A complaint was also upheld by the Care Inspectorate in relation to the assessment made on the amount of staff required to deliver care to a service user. This requirement is repeated.
(See requirement 1, Quality Statement 3.3)

The requirement is: Not Met

The requirement

The provider must ensure that care review minutes are developed to clearly record full people present, discussions, comments and decisions made. This is in order to comply with SSI 2011/210 Regulation 5(2)(b) - Personal Plans Timescale for implementation: on receipt of this report.

What the service did to meet the requirement

Progress: Although reviews were seen to be taking place, records did not reflect who was present at the review therefore there was no evidence that family were involved in the discussions. Sections were not well completed and consisted at times of one word entries, instead of having full and descriptive entries.
(See requirement 1, Quality Statement 1.1)

The requirement is: Not Met

The requirement

The provider must ensure that staff receive appraisals minimally on an annual basis to ensure that their work practice is monitored, performance is reviewed and staff are supported in their role. This is in order to comply with SSI 2011/210 Regulation 9 - Fitness of employees Timescale for implementation: within 3 months of receipt of this report.

What the service did to meet the requirement

Progress: We saw evidence that permanent staff had received annual appraisals and staff whom we spoke with told us that this happened.

The requirement is: Met

What the service has done to meet any recommendations we made at our last inspection

1. The new complaints log records should be fully introduced and used to clearly record information relating to the issue raised; this should also clearly indicate whether the issue is a concern, informal complaint or a formal complaint. In doing so, the complaints policy should be reviewed to take into account any changes required.
PROGRESS: We saw issues raised through questionnaires which had not been transferred over to the complaints log. We also were told by service users of issues that they had raised - again we saw no records of these within the complaints log.
(See Quality Statement 1.1, recommendation 2)
NOT MET

2. The service users'/relatives' questionnaire headings should be reviewed to make sure it is user friendly in the layout and more compact in the content.

Progress: We saw that the layout of the questionnaire had not been developed.
(See recommendation 3, Quality Statement 1.1)
NOT MET

3. The service should make sure that service users and their relatives are made more aware that they can access Care Inspectorate reports.
Progress: This information had been put into the service newsletter. Some relatives and service users whom we spoke with told us that they were aware they could access Care Inspectorate reports.
MET

4. All sections within the service users' care plans should be fully completed including:
* Whether the service user is able to sign the documents themselves.
* Whether they agree to have documents left in their home.
* Dates when records are signed by service users.

Progress: Some of the sections within the service users' care plans had not been completed; these specifically related to whether the service user was able to sign the documents themselves and the section about the service users agreeing to have documents left in their home.
Not all records within care plans which had been signed by service users had the dates recorded when these had been signed.
(See recommendation 7, Quality Statement 1.1)
NOT MET

5. The service should ensure that new staff have an appropriate level of support and guidance when they take up their post in order to be able to meet the needs the service users in a confident and competent manner.

Progress: We saw evidence that new staff had undertaken shadowing shifts with more experienced staff. Staff also told us that they shadowed for a week before they carried out any duties themselves. They also told us that they could contact other staff and senior staff if they had any concerns or queries.
MET

6. The provider should develop personal plans that clearly details individual needs and preferences and sets out how these will be met in a way that is acceptable to the service user and/or their representative.
Progress: we saw that there were still a number of issues relating to the contents of the care plans.
(See recommendation 1, Quality Statement 1.3)

7. The service should consider developing communication with staff during staff meetings and include any matters arising from the previous meetings for discussion.
Progress: We saw that minutes of meetings had been developed to include matters arising and there had been active discussions with staff.
MET

8. Staff supervision sessions should be developed in order to address individual needs of the staff and these should be appropriately recorded
Progress: We saw that although the service had started to develop supervision sessions, they had not taken place with the frequency with which is highlighted within the company policy. This included new staff who were required to have a supervision session within 6 months of recruitment. While this recommendation has been met, a recommendation has been made in relation to the frequency with which staff supervision sessions are carried out.
(See recommendation 3, Quality Statement 3.2)
MET

The annual return

Every year all care services must complete an 'annual return' form to make sure the information we hold is up to date. We also use annual returns to decide how we will inspect the service.

Annual Return Received: Yes - Electronic

Comments on Self Assessment

Every year all care services must complete a 'self assessment' form telling us how their service is performing. We check to make sure this assessment is accurate.

A self assessment document had been submitted by the service prior to the closure for refurbishment. This was completed to a satisfactory standard and gave relevant information for each of the Quality Themes and Statements. The service identified its strengths and some areas for future development.

Taking the views of people using the care service into account

We spoke with 6 service users. Comments included:

'My carer arrived at 11.30pm last week instead of 9-9.30pm. This has happened several times'

'Staff are nice - spot on'

'I've raised issues with the office countless times, and nothing ever gets done'

Taking carers' views into account

We spoke with 5 relatives/carers/friends
. Comments included:

'I don't get a list of staff that are going to attend to mum. The impact is that there are different faces that don't how to deal with her'

'They get the job done, but nothing else'

'I feel that a half hour slot is far too rushed'

3 The inspection

We looked at how the service performs against the following quality themes and statements. Here are the details of what we found.

Quality Theme 1: Quality of Care and Support

Grade awarded for this theme: 1 - Unsatisfactory

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Service strengths

Service users, relatives and visitors to the service could put forward ideas and suggestions through suggestion boxes which were publicly displayed in the reception area of the service's office.

Service users and relatives had access to the service complaints policy. All people whom we spoke with said that they were aware of this policy. An electronic recording system was in place which could be used to record and track any complaints made.

We saw some participation from service users and their carers in the development of the care plan.

The service users' guide, advised service users and relatives about the aims and objectives of the service. This was available in different formats and gave readers information about:
* How they would receive 6 monthly or more frequently reviews on their support package.
* Their right to ask for a worker to be assigned to them who was the same gender as themselves.
* Care plans and risk assessment

The Care Inspectorate details were at the back of the service users' guide which enabled people to contact us if required.

We saw that service users' care reviews were happening within the minimum frequency of every six months. Where service users were unable to sign, we saw instances where staff had signed on their behalf.
Service users and their relatives told us that they were aware of their care plan and their 6 monthly care reviews.

Newsletters which had been sent out had some useful information within them for service users and their relatives.

The manager had an open door policy which meant that people did not need to make an appointment if they wished to talk with her during office hours.
Most people told us they could usually contact the office easily if they had any issues or queries.

Service questionnaires had been developed and sent out for people to complete. Some people whom we spoke with told us that they had completed the questionnaires and returned them. Some comments were positive and included:

* Excellent service - some staff are wonderful and some are satisfactory.
* Overall care is good - some is excellent

Communication books were kept in service users' houses. These could be used by family if there was any information which they wished to pass onto staff.

Some relatives and service users whom we spoke with told us that they were aware they could access Care Inspectorate reports.

Areas for improvement

Although reviews were seen to be taking place, records did not reflect who was present at the review therefore there was no evidence that family were involved in the discussions. Sections were not well completed and consisted at times of one word entries, instead of having full and descriptive entries.
(See requirement 1)

We were provided with a complaints folder which contained no complaints or concerns raised by service users and/or relatives with the service. On speaking with service users and relatives/carers, we were made aware of complaints as well as other concerns which had been raised with the service. There were no formal records of these.
(See requirement 2)

Care plans had a 'permission for relative to sign record' section. This meant that service users could name their next of kin or person of choice to sign records on their behalf. Despite records indicating who was to sign on the service users' behalf, they were not always being followed and some contracts had been left unsigned.
(See requirement 3)

The complaints policy which was in the service users' guide made reference to the regulatory body in England who, it stated, did not investigate complaints. There was no reference to The Care Inspectorate or their responsibility for investigating

complaints in Scotland.
(See requirement 4)

The questionnaires which the service had sent out to service users and relatives had not been collated at the time of the inspection. From looking at these, we saw where there had been specific issues and concerns raised, however these had not been recorded as informal complaints. E.g. 47 questionnaires had been returned and 9 indicated that they didn't know what the out of hours service number was; 14 service users indicated that they were sometimes or never informed about the changes to the workers scheduled to attend to them; we were informed that some carers arrived at 7.30pm for night time tuck in and this was not agreed in the individual care plan.
(See recommendation 1)

Although we were told that questionnaires had been sent out in May 2012, they had not been stamped on return or dated when issued.
(See recommendation 2)

We saw that the service users' / relatives' questionnaire had the headings missing on some of the pages. This meant that it was not easy for people to answer the questions unless they continually used the front page as a reference. This is a repeat recommendation.
(See recommendation 3)

The comments forms which had been completed by service users about staff, had asked specific questions, which resembled a complaints investigation about staff conduct. It was very limited in its content of questions asked about staff.
(See recommendation 4)

No further service users' forums had taken place since our visit in March.
The one scheduled for May 2012 had been cancelled and we could see no further dates arranged.
(See recommendation 5)

We saw no evidence that questionnaires were available in any other format than standard. This meant that service users with sensory or cognitive impairment or learning disabilities may be limited to participating in the completion of these.
(See recommendation 6)

Some of the sections within the service users' care plans had not been completed; these specifically related to whether the service user was able to sign the documents themselves and the section about the service users agreeing to have documents left in their home.
Not all records within care plans which had been signed by service users had the dates recorded when these had been signed.
(See recommendation 7)

Development of a manager's surgery which was discussed at the last inspection had still not been developed.
(See recommendation 8)

Grade awarded for this statement: 2 - Weak

Number of requirements: 4

Number of recommendations: 8

Requirements

1. The provider must ensure that care review minutes are developed to clearly record fully, the people present, discussions, comments and decisions made. This is a repeat requirement.
   This is in order to comply with SSI 2011/210 Regulation 5(2) (b) - Personal Plans
   Timescale for implementation: Within three months of receipt of this report.
2. The provider must ensure that any complaint made under the complaints procedure is fully investigated.
   This is in order to comply with SSI 2011/210 Regulation 18 - Complaints
   Timescale for implementation: Within one month of receipt of this report.
3. The provider must ensure that there are appropriately signed contracts of agreements between the service users and the service.
   This is in order to comply with SSI 2011/210 Regulation 5 - Personal Plans
   Timescale for implementation: Within one month of receipt of this report.
4. The provider must amend the complaints policy to make reference to the regulatory body for Scotland and outline their responsibility to investigate complaints.
   This is in order to comply with SSI 2011/210 Regulation 18 - Complaints
   Timescale for implementation: Within one month of receipt of this report.

Recommendations

1. The new complaints log records should be fully introduced and used to clearly record information relating to the issue raised; this should also clearly indicate whether the issue is a concern, informal complaint or a formal complaint. In doing so, the complaints policy should be reviewed to take into account any changes required. This is a repeat recommendation.
   National Care Standards: Care at Home - Standard 11: Expressing your views, National Care Standards: Housing Support Services - Standard 8: Expressing your views
2. The provider should be able to demonstrate when they send out any questionnaires and when they receive them back in order to demonstrate how people's opinions influence change. The provider should also record on the

questionnaire where service users had been assisted to complete the form.
National Care Standards: Care at Home - Standard 11: Expressing your views, National Care Standards: Housing Support Services - Standard 8: Expressing your views

3. The service users' / relatives' questionnaire headings should be reviewed to make sure it is user friendly in the layout and more compact in the content. This is a repeat recommendation
National Care Standards: Care at Home - Standard 11: Expressing your views, National Care Standards: Housing Support Services - Standard 8: Expressing your views

4. The service users' comments forms should be reviewed in relation to the content of questions asked about staff.
National Care Standards: Care at Home - Standard 11: Expressing your views, National Care Standards: Housing Support Services - Standard 8: Expressing your views

5. A clear schedule of service users forum dates should be developed and given to service users and relatives to give them a structured and planned option to attend.
National Care Standards: Care at Home - Standard 11: Expressing your views, National Care Standards: Housing Support Services - Standard 8: Expressing your views

6
Questionnaires should be developed further e.g. the font should be made available in a larger font in order to make the notices easier to read, particularly for people with sensory impairments. It should also be in a more pictorial format to help service users with communication needs to understand the questionnaire better.
National Care Standards: Care at Home - Standard 11: Expressing your views, National Care Standards: Housing Support Services - Standard 8: Expressing your views

7
All sections within the service users' care plans should be fully completed including:
* Whether the service user is able to sign the documents themselves.
* Whether they agree to have documents left in their home.
* Dates when records are signed by service users.
This is a repeat recommendation
National Care Standards: Care at Home - Standard 11: Expressing your views, National Care Standards: Housing Support Services - Standard 8: Expressing your views

8

A manager's surgery should be developed. This would let relatives and service users come along and talk about things that were important to them with the Service Manager.
National Care Standards: Care at Home - Standard 11: Expressing your views, National Care Standards: Housing Support Services - Standard 8: Expressing your views

Statement 3

We ensure that service users' health and wellbeing needs are met.

Service strengths

The service had an accident and incident reporting system in place.

We looked at a sample of service users' care plans. In some instances, health needs had been assessed and planned.

Some specialist equipment to meet service users' needs was also available within people's homes such as manual handling equipment.

Staff were observed throughout the inspection as interacting with service users in a person centred manner.

We saw some examples where information was recorded in a person centred way within care plans.
Service users were supported in some aspects of being part of their local community such as development in money skills. Some service users were also encouraged to complete household tasks.

Training was available for staff in order to help meet the specific health and wellbeing needs of service users such as training on Epilepsy and Multiple Sclerosis. .

Service users and their relatives told us that they were happy that the regular staff knew their needs and preferences well and spoke mostly positively about the level of care delivered by the staff.

Areas for improvement

Although the social work and police had been notified about an adult support and protection incident which had occurred, the service had failed to notify the Care Inspectorate about this.
(See requirement 1)

Some of the care plans we looked at had an insufficient level of information about the care, needs and abilities of service users e.g. health assessments showed where some service users e.g. had poor speech, were hearing impaired - but there were no related care plans. This meant that staff did not have clear directions as to how to deliver

care and meet the needs of service users.
Relevant information and details such as contacts etc was both inaccurate and incomplete within some of the care plans that we reviewed

Medical conditions were not always recorded clearly and many sections of the care plans had been left blank.
One service user's care plan had another service user's Medication Administration Authorisation sheet which the first service user had signed in error.
Service users were given a copy of their care plan. At times this was not legible as information had not pulled through clearly. At times there was writing which had come through from the master copy which was not relevant to the sections.
(See requirement 2)

There was not always appropriate clinical monitoring of service users. E.g. one service user, whose medical condition was exacerbated by weight gain, had no regular weight checks carried out. This had resulted in the service user's weight increasing and the medical condition becoming more prevalent. Another service user had no clinical monitoring of their medical condition, despite assessments showing them as being at a high risk of having a reoccurrence of this condition, if the care plan and treatment wasn't followed.
(See requirement 3)

From reviewing care plans, we saw that service users' relatives who had Power of Attorney (POA) were not always being consulted in decisions and reviews on the care of their family member. At least one service user had reflected in the service's own questionnaire that they and their family had not been fully consulted in their care plan.
(See requirement 4)

One service user, who we visited, had personal information displayed on their notice board in the kitchen. This meant that the service user's frequent visitors would be able to see sensitive information.
In one care plan, we found pieces of paper with statements about the condition of the particular service user when staff had supported them. These had not been signed or dated. The manager was unaware of these or why these had been used.
We were informed that there were laminated instructions within one service user's house about dealing with a sensitive issue. We were also informed that sensitive and confidential information was being recorded on scraps of paper and inappropriately filed. (See requirement 5)

During the inspection, we saw records which showed that the service was unable to cover all the required hours needed to support all service users. This was calculated as 264 hours unallocated for the period between 23rd and 29th July. This had resulted in senior staff requiring to deliver direct care rather than carrying out their substantive duties.

We were told that referrals were accepted based on whether there was space to accommodate the hours, rather than looking at the needs of the service users through suitable and sufficient assessments prior to acceptance.
(See requirement 6)

We found that there was varied accounts of incidences relating to staff not arriving at service users' homes to assist them as per the contracts of care and in line with their care plans (no shows). Service Users and relatives reported that there were many occasions when this had happened. We also collated evidence from a recent complaint investigation and contract monitoring audit by the North Lanarkshire Council. The outcome of these reflected that there was a significant number of times where staff had failed to attend service users as per agreements. The Care Inspectorate had also previously upheld a complaint which included an element of staff not turning up to people's homes.
(See requirement 7)

The records within service users' homes had been incorrectly recorded by staff and failed to reflect when the staff arrived and when they left the service user's home. Six service users had also said within the services' own questionnaire that the staff did not arrive within the half hour of their scheduled time.
Records also showed that times of staff attending did not reflect the time which was planned on their schedule. This meant that some service users were being assisted to get ready for bed in the early evening. One service user commented specifically about their tuck time being too early at 7.30pm.
A relative told us that 'Staff are a bit rushed - they don't get travelling time'
(See requirement 8)

We were told by all of the service users and relatives who spoke with us that staff did not always wear protective aprons and gloves when carrying out personal hygiene tasks.
Staff told us that there were a number of times where there had been no gloves available at the office and they had had to buy their own.
(See requirement 9)

Many service users and relatives whom we spoke with told us that there were an excessive number of different staff who carried out their care and support. Two responses within the service's own questionnaire said that they would like to see more consistent staff.
We were told by service users and relatives that this had resulted in not all staff being aware of how to meet their needs.
The Care Inspectorate had recently upheld a complaint which included an element of excessive numbers of staff attending to service users.
14 service users indicated within the service's own questionnaire that they were sometimes or never informed about the changes to the workers scheduled to attend to them. Service users and relatives we spoke with also told us that this was the case.

(See requirement 10)

The aim of the service is recorded as being "to provide outstanding care and support to our customers, to enable them to live as independently as possible in their own home"
We were told about one example where a service user's request had not been actioned in relation to being provided with a carer who could drive to enable the service user to access the community. This was a reasonable request relating to providing set times of care and skills of staff supporting them during this time. We saw that the service had consistently sent a non-driver. This meant that the service user was unable to access the community.
(See requirement 11)

Updates to care plans had entries that were not always clearly recorded e.g. one service user's 'Changes to Health' section was recorded as 'mobility slightly poorer'. Personal information sheets were poorly completed e.g. one section headed 'links to local area' stated 'family' with no further information. Another section which should have reflected who the service user's family and friends were, was recorded only as 'family and friends'.
(See recommendation 1)

The service had previously carried out spot checks to make sure that appropriate practices were being carried out by staff and were in line with service users' care plans. However, staff who would have carried these spot checks out were also required to backfill time slots for service users and carry out direct service user care and support hours. This meant that there was insufficient time to carry out a full assessment.
(See recommendation 2)

The accident book was not being completed or used appropriately. Forms were not being removed after completion despite instructions in the book which directed staff to do this.

Grade awarded for this statement: 1 - Unsatisfactory

Number of requirements: 10

Number of recommendations: 2

Requirements

1. 1. The provider must notify the Care Inspectorate of any incident that is a serious unplanned event which had the potential to cause harm or loss, physical, financial or material.
   This is in order to comply with SSI 2011/210 Regulation 4(1) (a) (b) (d) - welfare of service users.

Timescale for implementation: Within 24hours of receipt of this report

2. The provider of the care service must ensure that suitable and sufficient care plans are developed in order to meet the needs of the service users. In doing so, the service must ensure that relatives who give consent for treatment or care for their family member provide the legal documents which show that they have the appropriate power to do so, and that this is clearly recorded.
   This is in order to comply with SSI 2011/210 Regulation 5 (1) - a requirement relating to personal plans.
   Timescale for implementation: within 2 weeks of receipt of this report.
3. The provider must closely monitor the health care needs of service users and take appropriate action to access medical attention as and when required.
   This is in order to comply with SSI 2011/210 Regulation 4(1) (a) (b) (d) - welfare of service users.
   Timescale for implementation: Within 24hours of receipt of this report
4. The provider must be able to demonstrate how service users and any representative have been fully consulted in the development and revision of their care plans.
   This is in order to comply with SSI 2011/210 Regulation 5 (2) (d) - Personal plans.
   Timescale for implementation: within 3 months of receipt of this report
5. The provider must ensure that they provide services in a manner which protects the confidentiality and respects the privacy and dignity of service users at all times.
   This is in order to comply with SSI 2011/210 Regulation 4(1) (a) (b) (d) - welfare of service users.
   Timescale for implementation: On receipt of this report
6. The provider must be able to demonstrate that the service is always appropriately staffed to meet the care and support needs of the service user group. They must also be able to demonstrate that they are taking into account the full details of service users needs and requirements prior to accepting referrals.
   This is in order to comply with SSI 2011/210 regulation 15(a) and (b) (ii) - Staffing
   Timescale for implementation: 1 week from receipt of this report
7. The provider must ensure that they provide accurate and transparent information at all times. In this case, this requirement directly relates to information provided to inspectors during the course of the inspection process.
   This is in order to comply with SSI 2011/210 regulation 7 (c) - Fitness of manager.
   Timescale for implementation: on receipt of this report.
8. The provider must ensure that accurate records are kept of when staff carry out interventions with service users. This should include arrival and departure times. In doing so, the service must review travelling time for staff to ensure that they attend to service users when they are scheduled to do so.
   This is in order to comply with SSI 2011/210 Regulation 4(1) (a) (b) (d) - welfare of

service users.
Timescale for implementation: Within 24 hours of receipt of this report.

9. The provider of the care service must ensure that they provide suitable and sufficient equipment with which staff can carry out tasks in line with infection control best practice guidelines.
This is in order to comply with SSI 2011/210 Regulation 4 (1) (a) - a requirement to make proper provision for the health and welfare of people.
Timescale for implementation: within 24hours of receipt of this report.

10. The provider must manage the service appropriately. Suitable arrangements must be made to ensure that the service is provided consistently and that effective means are implemented for monitoring this.
This is in order to comply with: SSI 2011/210 Regulation 4(1) (a) (b) - Welfare of users, 7(2) (c) - Fitness of managers.
Timescale for implementation: within 24hours from receipt of this report

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The provider must provide the service in a manner which promotes quality and safety and respects the independence of service users, and affords them choice in the way in which the service is provided to them. In doing so, the provider must review the way that staff are matched to service users and given the specific training required.
This is in order to comply with: SSI 2011/210 Regulation 3 - Principles
Timescale for implementation: within 24hours from receipt of this report

Recommendations

1. The provider should develop personal plans that clearly details individual needs and preferences and sets out how these will be met in a way that is acceptable to the service user and/or their representative. This is a repeat recommendation.
National Care Standards: Care at Home, Standard 3 - Your Personal Plan

2. The service should ensure systems to monitor staff performance and timekeeping when working in people's homes is carried out. In doing so responsible staff should be enabled and supported to carry out these tasks.
National Care Standards Housing Support Services, Standard 4 - Management and staffing

Quality Theme 3: Quality of Staffing

Grade awarded for this theme: 2 - Weak

Statement 2

We are confident that our staff have been recruited, and inducted, in a safe and robust manner to protect service users and staff.

Service strengths

The provider had a recruitment and selection policy and procedure. Recruitment practice required candidates to undergo a Protection of Vulnerable Groups (PVG) check and provide names of two referees one of which was from the immediate previous employer.

We were advised that there had been 34 new staff started in 2012. During the inspection we looked at a sample of six of these files. The records showed that some safe recruitment practices had been followed e.g. carrying out appropriate checks and obtaining appropriate references

We saw evidence that new staff had undertaken shadowing shifts with more experienced staff. Staff also told us that they shadowed for a week before they carried out any duties themselves. They also told us that they could contact other staff and senior staff if they had any concerns or queries.

New staff undertook a four day induction course prior to commencing employment. Staff we spoke with confirmed that they had attended this. The course covered 'Skills for Care' topics such as adult abuse, fire, health and safety, manual handling, food hygiene, medications and first aid.

Staff also completed a workbook over a 12 week working period following their induction. This helped make sure that they developed their skills and knowledge to undertake their required tasks and identified any areas for improvement.

The induction booklets we looked at also showed that there were some elements of Health and Safety risk assessment training given.

Areas for improvement

Two files we looked at showed that there had been no disclosure undertaken. Some discussion took place with the manager about the staff not requiring these due to the nature of their position. However these staff still came into contact with service users and dealing with their personal matters at times.
Where staff were promoted there was no evidence of PVG's being rechecked or references or interviews.
(See requirement 1)

We saw evidence that demonstrated that references were not being given by an appropriate referee. We also found that where a reference had been unfavourable this had not been pursued and the person was employed without further checks and balances being made to ensure safe recruitment.
(See requirement 2)

The Selection and Recruitment policy stated that a personal development plan would be created for staff at the end of their initial 12 week induction period; however we saw no evidence of this having happened with any staff.
6 monthly appraisals were also identified within the handbook as being required to be undertaken by new staff; however we saw that these had been carried out annually
(See requirement 3)

We saw some concerns surrounding the contents of staff recruitment files namely:
* Interview forms were not all signed or dated or had any entries within comments sections.
* Confidential information was noted to be loosely stored in some of the recruitment files we looked at. Some information contained within the files was irrelevant information.
* We saw that not all interview records had been signed. It was therefore difficult to establish if there were one or two interviewers present. The service policy stated that ideally there should be two interviewers.
* There was a lack of consistency in the content of the staff files e.g. some had copies of training certificates, others did not.
(See recommendation 1)

Entries in staff's 'shadow record sheets' were recorded as the member of staff having 'not met' certain aspects of care delivery. However it was unclear as to whether it meant there was a concern or no opportunity to complete the actual task.
Signatures on shadow records were noted to be missing in some instances.
(See recommendation 2)

Records showed that not all new staff had received supervision within the time frame as stated in the service's own policy.
(See recommendation 3)

The Selection and Recruitment policy did not include any reference to the staff induction period. There were no references to any probationary period or measures that would be taken if staff had unsatisfactorily completed their induction period.
(See recommendation 4)

The Service Users' Guide made reference to English legislation and regulatory bodies as did the Staff Recruitment policy and induction booklet.
(See recommendation 5)

Grade awarded for this statement: 2 - Weak

Number of requirements: 3

Number of recommendations: 5

Requirements

1. The provider must ensure that all staff employed within the organisation have had appropriate fit persons check carried out. Where elements of these have been deemed as not required, then a clear assessment should be recorded to this effect. This is in order to comply with: SSI 2011/210 Regulation 15 (a) Staffing
   Timescale for implementation: Within one week of receipt of this report.
2. The service provider must ensure when appointing new staff into the service, that two appropriate references are obtained in line with safe recruitment practice. Any information received that is unsatisfactory within a reference should be followed up to ensure safe recruitment practises are being carried out.
   This is in order to comply with: SSI 2011/210 Regulation 15 (a) Staffing
   Timescale for implementation: Within one week of receipt of this report.
3. The service provider must ensure that personal development plans and appraisals are undertaken for staff; in line with the frequency identified within the Selection and Recruitment policy
   This is in order to comply with: SSI 2011/210 Regulation 15 (a) Staffing
   Timescale for implementation: Within three months of receipt of this report.

Recommendations

1. Staff recruitment files should be audited to ensure appropriate content, consistency and completion of records.
   National Care Standards Care at Home, Standard 4 Management and Staffing
2. Staff 'shadow record sheets' should be fully and clearly recorded. Where required, there should be appropriate signatures. Where a task is indicated as 'Not Met', there should be a clear record of the reason and/or any actions taken as a result.
   National Care Standards Care at Home, Standard 4 Management and Staffing
3. Staff supervision should be delivered to staff in line with the service's own policy.
   National Care Standards Care at Home, Standard 4 Management and Staffing
4. The Selection and Recruitment policy should be updated to include reference to the staff induction period, any probationary period or measures that would be taken if staff had unsatisfactorily completed their induction period.
   National Care Standards Care at Home, Standard 4 Management and Staffing
5. The Service Users' Guide, Staff Recruitment policy and Induction Booklet should be updated to make sure that references are appropriately made to Scottish legislation and Scottish regulating bodies.
   National Care Standards Care at Home, Standard 4 Management and Staffing

Statement 3

We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Service strengths

We were told that training was delivered to staff depending on the needs of the service users they supported and the skills they needed to do this effectively. We saw that there was a wide and varied training programme for staff in order to address the needs of service users.

Staff told us that they were generally satisfied with the level of training which they had received, and that they were able to meet the needs of service users.

Some staff meetings had taken place. This aimed to allow staff to talk about any issues, concerns or suggestions they had. Staff told us that the meetings happened. Minutes of the meetings showed some evidence where staff had been actively involved in discussions.

We saw that staff interacted well with service users and their relatives throughout the inspection and appeared motivated and professional.

We saw a number of staff related quotes in service users' questionnaires which included:

* the carers try their best
* carers seem to be happy at their work
* staff are very good with us
* so nice and helpful to us

We saw evidence that staff had received annual appraisals and staff whom we spoke with told us that this happened.

Areas for improvement

We saw that a number of service users had not been appropriately assessed through their care plans. A complaint was also upheld by us in relation to the assessment made on the amount of staff required to deliver care to a service user. This requirement is repeated.
(See requirement 1)

We looked at a disciplinary record which we found to be more in keeping with a practice management decision. The main body of the supervision records did not reflect the specific issues relating to the disciplinary issue. There was no evidence provided which showed that there had been any related disciplinary hearing. This was in response to a recent complaint to Social Work, however there was no reference made to this effect. General statements were recorded and gave no clear detail. No

record was made of actual discussions between both parties and no goals were recorded as being addressed or attained. These, according to the performance management sheets, were supposed to happen daily. The record was not signed or dated.
(See requirement 2)

We looked at a sample of 10 individual staff training records and saw that some staff had received a range of mandatory and non mandatory training
However, we were not provided with an overall matrix therefore could not determine how many staff were up to date with their mandatory training. The staff files we looked at showed that those particular staff were overdue on some of the mandatory refresher courses.
We saw that care plans were not written to a satisfactory standard. Not all staff that were involved in developing care plans had received training in this.
(See requirement 3)

Inappropriate terminology had been formally recorded as being used in staff meetings.
(See requirement 11, Quality Statement 1.3)

We saw that instructions in the accident book directing staff to remove any personal details had not been followed.
(See requirement 11, Quality Statement 1.3)

Grade awarded for this statement: 2 - Weak

Number of requirements: 3

Number of recommendations: 0

Requirements

1. The provider must make suitable arrangements to ensure staff are suitably skilled in carrying out risk and other assessments which determine how the service will meet service users' health and welfare needs.
   This is in order to comply with:
   SSI 2011/210 Regulations 4(1) (a) - Welfare of users, 9(2) (b) - Fitness of employees.
   Timescale for implementation: Within three months of receipt of this report.
2. The provider must ensure that staff disciplinaries are fully carried out and recorded to demonstrate investigations undertaken and any actions or monitoring planned to improve staff performance.
   This is in order to comply with: SSI 2011/210 Regulation 15 (a) Staffing
   Timescale for implementation: Within three months of receipt of this report.

3. The Provider must ensure that staff are appropriately trained to carry out the tasks relating to their role. In this instance this relates specifically to mandatory training. This is to comply with SSI 2011/210 Regulation 9(2) (b) - a requirement relating to the fitness of employees.
   Timescale for implementation: within three months of receipt of this report.

Quality Theme 4: Quality of Management and Leadership

Grade awarded for this theme: 2 - Weak

Statement 3

To encourage good quality care, we promote leadership values throughout the workforce.

Service strengths

Records which we looked at showed that some staff supervision had taken place. Some of these records had been appropriately signed by both parties

There had also been some other opportunities for staff to act up into more senior positions e.g. - Some seniors had been promoted to do 'spot checks' on staff practices and staff supervision.

The service had sent out staff questionnaires. This meant that staff could put forward their views and opinions about the service and support which they received.
At the time of the inspection, only two staff questionnaires had been returned.

One carer said that they had previously attended service users' care reviews. This enabled them to be part of a monitoring and decision making process in relation to the service users.

Areas for improvement

We saw that staff promotion did not follow internal procedures in relation to rechecking PVG's, seeking references and carrying out interviews.
(See recommendation 1)

The service had limited ways in which they actively promoted leadership values with staff.
(See recommendation 2)

Staff supervision sessions were not being carried out in line with the frequency indicated in the service policy.
(See recommendation 3, Quality Statement 3.2)

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 2

Recommendations

1. Where staff are internally recruited, company protocols and best practice should be followed in that PVG's should be rechecked, references should be sought and interviews carried out.
   National Care Standards Care at Home, Standard 4 Management and Staffing
2. The service should continue to seek out and develop ways in which they actively promote leadership values with staff.
   National Care Standards Care at Home, Standard 4 Management and Staffing

Statement 4

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide

Service strengths

Relatives could give their views on the service and their family member's care and support though the six monthly care reviews. They could also express their views and make suggestions through questionnaires which the service sent out.

There was an audit in place at head office for accidents and incidents. This identified if there were any traits or reoccurrences.

Complaints were also monitored at head office which ensured they were all recorded and addressed in line with the service's own complaints procedure. This also helped the service identify if there were any patterns indicating an area for development in the service.

Areas for improvement

The Service Users Guide described how staff and services would be monitored regularly however we saw that none of these methods were being used.
Given that there were so many health related and practice issues there is insufficient evidence of audits taking place and monitoring of performance.
Some of the issues in Quality Statement 1.3 could have been avoided such as insufficient care planning, spot check on performance, monitoring of staff training and experience and monitoring of attendance on site and telephone consultations.
There were no monitoring of arrival or departure times by staff. We saw that staff had been visiting one service user in particular an hour early for tuck in and that this had been going on for some time.
There were five senior care staff that were solely responsible for spot checks however; we were told that these staff were being used to cover shifts for that week. Spot checks were not happening. The manager provided us with no evidence that they had ever taken place. This meant that they were not picking up environmental concerns such as laminated information on service users' walls resulting in a breach of their confidentiality, dignity and respect.
(See requirement 1)

Although accidents and incidents and complaints were monitored at Head Office, there was no local analysis undertaken to identify any traits e.g. location, time and/or individual service users or staff involved. It also meant there could be some time between events occurring and identification of any significant patterns. There was also an under-recording of complaints as identified under Quality Statement 1.1
(See recommendation 2)

We were provided with no evidence that 'no shows' of staff were recorded appropriately.
(See recommendation 3)

We could see no further evidence that there had been any quality assurance systems which involved stakeholders to assess the quality of service provided.
(See recommendation 4)

Grade awarded for this statement: 2 - Weak

Number of requirements: 1

Number of recommendations: 4

Requirements

1. The provider must develop quality assurance systems and processes to ensure that the issues and the serious deficiencies identified during this inspection process are prevented and positive outcomes for service users achieved.
   This is in order to comply with SSI 2011/210 Regulation 4 - Welfare of users
   Timescale for implementation: Within 3 months of receipt of this report.

Recommendations

1. The service must ensure that there are suitable and sufficient quality assurance systems in place to ensure that service users health and well being needs are being met. Audit processes which were identified within the Service Users Guide should be carried out.
   National Care Standards: Care at Home, Standard 4 - Management and staffing
2. Local analysis of accidents and audits and complaints should be introduced in order to identify traits or reoccurrences.
   National Care Standards: Care at Home, Standard 4 - Management and staffing
3. Clear and accurate records should be completed to evidence where staff have failed to attend service users' homes as per the agreed schedule.
   National Care Standards: Care at Home, Standard 4 - Management and staffing
4. The provider should consider how the present quality assurance systems and processes can be improved to ensure involvement from stakeholders.
   National Care Standards: Care at Home, Standard 4 - Management and staffing

4 Other information

Complaints

There had been one complaint investigated by the Care Inspectorate since the last inspection. This had been concluded in close proximity to the inspection therefore progress in relation to the actions planned was still being developed. Elements of the complaint which were upheld were taken into consideration as part of the inspection process and reflected in the grades awarded.

Enforcements

We have taken no enforcement action against this care service since the last inspection.

Additional Information

One complaint was investigated and upheld by the placing Local Authority. This was also taken into consideration when grades were awarded.

Action Plan

Failure to submit an appropriate action plan within the required timescale, including any agreed extension, where requirements and recommendations have been made, will result in SCSWIS re-grading the Quality Statement within the Management and Leadership Theme as unsatisfactory (1). This will result in the Quality Theme for Management and Leadership being re-graded as Unsatisfactory (1).

5 Summary of grades

Quality of Care and Support - 1 - Unsatisfactory	
Statement 1	2 - Weak
Statement 3	1 - Unsatisfactory
Quality of Staffing - 2 - Weak	
Statement 2	2 - Weak
Statement 3	2 - Weak
Quality of Management and Leadership - 2 - Weak	
Statement 3	3 - Adequate
Statement 4	2 - Weak

6 Inspection and grading history

Date	Type	Gradings	
7 Mar 2012	Unannounced	Care and support Staffing Management and Leadership	4 - Good Not Assessed 3 - Adequate
25 Nov 2010	Announced	Care and support Staffing Management and Leadership	4 - Good 4 - Good Not Assessed

All inspections and grades before 1 April 2011 are those reported by the former regulator of care services, the Care Commission.

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