Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

1st Grade Care (Cardiff Branch)

Alexandra Gate Business Centre Ltd
2 Alexandra Gate
Ffordd Pengam
Cardiff
CF24 2SA

Date Inspection Completed

20th to 22nd of November 2019

Description of the service

1st Grade Care Ltd is registered with Care Inspectorate Wales (CIW) to provide a domiciliary support service (1st Grade Care Cardiff and the Vale) to people over the age of 18 years within the Cardiff and Vale regional partnership area.

The registered service provider (1st Grade Care Ltd) has nominated a person as the Responsible Individual (RI), who has responsibility to oversee the strategic operation of the service. The application to be RI is yet to be approved by CIW. At time of inspection, the service had a manager who was registered with Social Care Wales (SCW), which is the workforce regulator. However, following the inspection, we were informed that they had left. CIW regulates the care and support that a domiciliary support service provides to people, however, this does not include the accommodation they live in. At the time of this inspection, this domiciliary support service was delivering between 500 and 1000 weekly hours.

What type of inspection was carried out?

We carried out an unannounced focused inspection in relation to a concern we had received around staff competency and poor practices at the agency. We focused on the operations at the Cardiff offices and care being delivered to people who live in the Cardiff area , although there are also offices located in Barry that deliver care to people who live in The Vale of Glamorgan this was not a focus of our inspection activity.

Summary of our findings

1. **Overall assessment**

   People were mostly complimentary about the direct support they received from care staff at the service. People mostly had a consistent team of carers who they knew well and had built relationships with however there were instances where staff had not received the correct training to enable them to carry out their duties safely. People did not always feel their concerns were listened to and acted upon by the agency management. People have not benefitted from a well-managed service. The service provider is not meeting legal requirements in several areas, as outlined in the body of this report, which indicates a lack of governance and oversight.

2. **Improvements**

   This inspection was in response to a concern about the service, and was focused on care delivered in the Cardiff area.

3. **Requirements and recommendations**

   Section five of this report sets out recommendations to improve the service and areas where the registered provider is not meeting legal requirements. These include; service provider oversight, staff supervision, reporting of significant incidents, medication management, staff training and ensuring the Statement of purpose (SOP) meets requirements

1. Well-being

Our findings

The care delivered by staff at 1st Grade generally demonstrates respect and regard for people's welfare. People using the service and relatives mostly reported positive experiences about care staff commitment and attitude to their role Comments included.
"*lovely staff no complaints"*
"carers great"
" I very rarely have a carer turning up I don't know"
"all my carers are good"
One person we spoke to reported that they had a very different experience and had not felt carers were equipped to manage the needs of their relative who had a diagnosis of dementia. Personal plans were in place; however, on some instances particularly where a person had dementia needs, they had not always captured people's needs and risks in order to guide staff in the delivery of care and support. We conclude people receive care from staff who promote their dignity, physical, emotional and social well-being. Although, as detailed above, training to support staff in their role, is not always adequate.

People receiving a service from 1st Grade Care in Cardiff have not always been adequately protected from abuse and neglect. We found that staff did not always have the sufficient training in place that enabled them to deliver care safely.
The oversight of some people's care needs had not been adequately monitored meaning they were potentially put at risk. Staff did not always have up to date training in key areas such as medication and safeguarding. There was further a lack of current training for staff in moving and handling practices. We found an instance where a person had been placed at risk due to staff not following process. From this, we concluded that the service was not meeting its legal requirements to provide a workforce that can deliver care safely to people receiving a service.

Mostly people's physical wellbeing is monitored by the service and people are supported to access healthcare in a timely and responsive way. We saw in daily recordings that changes in people's physical health were recognised by staff who visited them. We saw a number of occasions where this had prompted the service to contact the GP and request support for the individual. One person told us *" the carers are fantastic, when my mobility changed the carers pushed to get me the right equipment as quickly as possible".*
However, this was not always the case in the monitoring of people's mental wellbeing. We saw a lack of monitoring in place for those service users who had mental health needs which meant that people were not always being supported to remain as healthy as they could. We concluded that whilst people's physical health is managed well by the service there is a lack of understanding within the service around caring for and promoting the wellbeing of people with mental health needs.

Process and practice does not always promote positive outcomes for people receiving the service and staff delivering the service. At time of inspection, a new manager was in post and they had begun work to rectify areas where the service required improvement such as supervision of staff and the promotion of competency and training. We found that

organisational processes did not adequately support the manager in their role. For example, managers not having access to staff training records and there being no safe call monitoring system in place. This meant it was very difficult for the manager to run the service safely as they did not have oversight of staff skills or the delivery of calls in the community. Based on the information available to us people do not always get the right care and support because there are a lack of systems in place to support the manager with oversight of the service.

2. Care and Support

Our findings

The approach and conduct of care staff mostly supports people's needs. However, people cannot be confident they will always receive the right care at the right time. This has the potential to directly impact on their well-being. We considered the care records of a sample of people in receipt of a service, including their personal plans. Plans viewed were generally an accurate reflection of people's needs, However, we found that where people had a dementia care need, there was a lack of detail and analysis around understanding the person's mental health and associated behaviours. The plan did not provide staff with guidance of how they should work with that person. Daily care records, in most instances, were clear and gave descriptive account of care tasks undertaken; they did not provide much of a narrative around people's mood and presentation, which is particularly important for those whom have a mental health need. Some recordings were difficult to understand due to quality of writing, and language. We were told care was mainly provided from a core group of staff who had regular runs, records of staff visiting supported this, people were mostly happy with the core group of staff but people were of the opinion that weekends could be problematic in this area. People told us "*weekends care can be late*" and "*weekends can sometimes be a bit of a problem* ". We were told people had not experienced any missed calls, but call times were sometimes variable or likely to change, It was not possible to have an accurate report of call timings because there was not a reliable call monitoring system in place.We conclude that although care staff try to promote people's well-being, they are not always supported by the agency's processes.

Arrangements are not in place to promote the safe management of medicines. We considered a small sample of documentation including medication administration records (MAR), personal plans and daily notes and staff training records. Personal plans were not always clear who had responsibility for administering medication. We saw gaps in MARs. We saw topical creams had been applied however; this had not been recorded within charts. We saw, on some occasions, staff were administering medication and families at other times.It was not always clear if people had been given medication as there were frequent gaps on all the MAR sheets we viewed. We requested sight of internal audits of medication charts. Information provided was disorganised and did not support the service provider in driving improvement within this area of care and support. We viewed staff training in this area and found that a number of staff did not have in date training. We were told by the manager that training was in an e-learning format and there was not a process in place for testing the competency of staff in practice. Based on the information viewed, we conclude the service does not have measures in place to help minimise risks associated with medication.

3. Environment

Our findings

This theme does not currently form part of the inspection remit of domiciliary support services in Wales. We noted the service had designated premises and a satellite office. We considered there were appropriate arrangements for entry and securely storing confidential information.

4. Leadership and Management

Our findings

Staff are safely recruited, and vetted but are not given the required training and support in order for them to carry out their duties safely. There have been instances where a lack of adequate training and monitoring has resulted in poor care for people receiving a service. As a result non-compliance notices have been issued to the provider. We considered the recruitment information for a sample of staff. We saw all legally required information was in place prior to people working directly with vulnerable adults. We saw references, DBS checks and employment. A full work history was completed as per legal requirement. This means people can be confident staff have been vetted appropriately for their role. Records examined, demonstrated staff did not always receive supervision from their line manager, in line with legal requirements. Additionally, annual appraisals were not up to date.

We were advised all newly employed staff completed an induction, staff completed in-house training in areas including the role of the care worker, manual handling, medication handling, safeguarding, food safety and hygiene. Apart from manual handling; all training was online. We saw annual refresher training was undertaken by some staff but found there were many staff who had not received refresher training in key areas. We did not see completion of any specialist training. The statement of purpose states "*Each care worker undergoes continuous training and development that ensures the agency can deliver the highest quality services. This training is delivered in line with Social Care Wales*." Also "*Additional training is provided, specifically relating to the care needs of individual service users, should this be required*." We did not see this evidenced in the quality and quantity of training provided.

Although there are quality assurance systems in place, these could be improved to provide people with confidence that their views will be obtained and used, for the continued improvement of the service. We saw evidence the RI had consulted with people or staff on a quarterly basis. We were provided with information from the RI in order to evidence the quality of the service had been reviewed in recent months We did not see any evidence that following, the quality of care review, an action plan was implemented by the RI. We conclude the service provider has some oversight of the service but in order to drive improvement further work is needed around improvement plans following on from the findings of the quality review.

Information about the service and a selection of policies are in place. We looked at the statement of purpose, which should contain specific information to help individuals have a clear understanding of the culture of the service, how it will be provided and what they can expect to receive. We advised the service provider that amendments should be made, to ensure information is up to date and reflective of the needs this service can meet. We concluded that information about the service needs to be updated to reflect the skill level of staff and the areas the service can support.

Oversight by the provider and a designated manager is not always robust enough to support the operation of the service. The service provider had not ensured that there was a stable management structure in place and managers at the service lacked access to systems such as oversight of calls, staff training needs and supervisions. When we inspected, a manager had been newly appointed and had begun to address some of the issues. However, we were informed after the inspection that the manager had left. We found there were deficits in arrangements for monitoring the service in line with legal requirements. We did not see sufficient internal systems and processes to oversee medication practices, staff supervision and appraisal, support and developmental needs of staff and the monitoring of staff. The statement of purpose provided people with information about the type of service delivered, but needed updating to reflect the type of support staff have skills to provide. We conclude people do not benefit from a well-managed service and there is a lack of systems and oversight to ensure vulnerable people are safeguarded.

5. Improvements required and recommended following this inspection

5.1 Areas of non-compliance from previous inspections

1.*The personal plan (Regulation 17(b)):* The service provider is required to give a copy of the personal plan and any revised plan to the individual, or any representative, where appropriate.

2. *Provision of care and support (Regulation 21(2)):* The service provider is required to ensure that care and support is provided to all individuals in accordance with their personal plan.

3. *Maintaining relationships with individuals and staff (Regulation 21(3)(a)):* The service provider must ensure that good and professional relationships are maintained at all times with people.

4. *Supervising staff (Regulation 36(2)(c):* The registered provider is required to ensure that all staff employed to work for the service receive appropriate supervision.

5. *Delineation of travel time (Regulations 41(3)(a)-(b):* The service provider must prepare a schedule of visits for care workers with sufficient time allocated for travel in between visits having regard to the matters specified under Regulations 41(3)(a) and 41(3)(b).

6. *Medication administration (Regulation 58(2)(c):* The service provider is required to have arrangements in place to regularly audit the administration of medicines.

7. *Oversight of service performance and adequacy of resources (Regulations 73(2), 73(3*), 74(1) and 74(2): The RI is required to meet with individuals and staff to monitor service performance, as well as reporting on the adequacy of resources available to provide a service in accordance with Parts 3 – 15 of the regulations, at least quarterly.

Non-compliance notices were not issued

5.2 Areas of non-compliance identified at this inspection

Improvement is needed to satisfy the following requirements of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017:

During this inspection, we identified areas where 1st Grade Care (Cardiff and Vale) is not meeting legal requirements and this is resulting in potential risk and poor outcomes for people using the service. Therefore we have issued a non-compliance notice in relation to the following:

- Regulation 21(1). This was because the provider has not ensured that care and support is provided in a way that protects, promotes and maintains the safety and well-being of individuals

- Regulation 36(2) (d) and (e).The provider has not ensured that people working at the service receive core training appropriate to the work to be performed

Details of the actions required are set out in the non-compliance report attached.

We have also advised 1st Grade care that improvement is needed in relation to:

- Staff supervision (Regulation 36(2) (c): The service provider has not always ensured that any person working at the service receives appropriate supervision and appraisal.

- Medication management (Regulation 58 (1): The service provider has not always ensured there are arrangements in place to ensure medication is administered safely

- *Delineation of travel time (Regulations 41(3)(a)-(b):* The service provider must prepare a schedule of visits for care workers with sufficient time allocated for travel in between visits having regard to the matters specified under Regulations 41(3)(a) and 41(3)(b).

    - Regulation 6. The service provider has not ensured the service is always provided with sufficient care, competence and skill, having regard to the statement of purpose.

5.3 Recommendations for improvement

We made the following recommendations to promote quality outcomes for people receiving the service:

- To update the statement of purpose, to ensure the document sets out accurately the training staff will receive in regards to specialist areas
- Weekly rotas outlining the care times and named care workers should be offered to all service users.
- Quality monitoring report should be followed by an action plan to address issues identified
- A monitoring system should be in place that enables the manager of the service to oversee the calls being delivered
- Managers require access to systems that oversee the training, and developmental needs of staff
- Concerns raised by people (but not complaints) should be monitored and addressed
- Daily recordings need to provide a narrative of a person's wellbeing, particularly those people who may be experiencing mental ill health.
- Reporting of incidents by staff needs to be improved,

We expect the service provider to take immediate action to rectify the above matters. This will be followed up at the next inspection.

6. How we undertook this inspection

This was a focused inspection undertaken as the result of a concern. We made un-announced visits to the domiciliary support service's registered address and we visited people in their own homes between 20th to 22nd of November.

The following regulations were considered as part of this inspection:

- The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017

The following methods were used :

- Information we already held about the service, such as re-registration information and notifications of significant events.
- Discussions with the RI/manager.
- Feedback from people receiving a service, their relatives and staff within the organisation.
- Examination of care records for a sample of individuals. This included care planning documentation, daily care records and medication charts.
- A sample of staff rotas and records.
- Supervision records of staff.
- Statement of purpose.
- A range of auditing information, which the service provider was utilising to measure the quality of the service.
- Training matrix for staff, Induction programme.

Further information about what we do can be found on our website: www.careinspectorate.wales

About the service

Type of care provided	**Domiciliary Support Service**
Service Provider	**1st Grade Care Ltd**
Responsible Individual (proposed)	**Lucy Thomas**
Date of previous Care Inspectorate Wales inspection	**25th and 26th February 2019**
Dates of this Inspection visit(s)	**20th to 22nd November 2019**
Operating Language of the service	**English**
Does this service provide the Welsh Language active offer?	
Additional Information:	

Date Published 06/10/2020

Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Non Compliance Notice

Domiciliary Support Service

This notice sets out where your service is not compliant with the regulations. You, as the registered person, are required to take action to ensure compliance is achieved in the timescales specified.

The issuing of this notice is a serious matter. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with its enforcement policy.

Further advice and information is available on CSSIW's website
www.careinspectorate.wales

1st Grade Care (Cardiff Branch)

Cardiff

Date Published 06/10/2020

Well-being	Our Ref: NONCO-00009195-JJVQ
Non-compliance identified at this inspection	
Timescale for completion	**02/03/20**
Description of non-compliance/Action to be taken	**Regulation number**
The service is non-compliant with Regulation 21(1) of the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017. This was because the provider (registered person) did not ensure that care and support was provided in a way that protects, promotes and maintains the safety and well-being of individuals. The evidence to support this is as follows:	
Evidence	

The service is non-compliant with Regulation 21(1) of the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017. This was because the provider (registered person) did not ensure that care and support was provided in a way that protects, promotes and maintains the safety and well-being of individuals. The evidence to support this is as follows:

1. We saw in one person's daily recordings that a care worker had found the person on the floor and had assisted the person up with the help of a neighbour. This fall had not been reported nor any medical attention sought for the individual. We were told by the person's relative that this person had gone on to fall again during the night. The opportunity to possibly prevent the second fall had been missed.

2. We saw that one person had developed a pressure area that had not been recorded by staff who were commissioned to provide personal care. Carers were frequently noting that care was being declined, but we did not see any actions taken by the service to risk manage this situation.

3. Personal plans (in relation to people with dementia care needs) were basic and did not represent an understanding of how to support people with care and support in this area. We saw no evidence of instruction to staff to; identify possible relapse signatures and triggers to escalating distressed behaviour, advise staff how best to support people who become mentally unwell, instruct staff to identify at what point further advice and support is required from health professionals and to review and revise properly agreed strategies to manage adverse risks and associated behaviour.

4. Daily recordings also lacked detail to properly reflect people's emotional or mental wellbeing and were simply descriptive of tasks and people's daily routines. We visited one person who was often declined personal care. We found that staff were not recording any detail about the person's mood, interventions they had tried to engage the person or what actions were being taken as a result of declining care.

5. On review of staff training records, we saw there were care workers on the ‘doubles ‘team (this refers to two carers working together to provide support to people who require the use of equipment to mobilise), who did not have up to date training in moving people safely.

6. We saw in one person’s daily recordings, occasions where medications from blister packs containing tablets had been found on the floor.

7. Training records of staff indicated that a high number of workers did not have up to date training in essential areas such as; safeguarding people, safe medication practices and moving and handling. We saw no evidence that staff had any in depth training about meeting the needs of people with Dementia.

8. The provider has not ensured that there are systems in place to support the safe delivery of care. There is not a reliable call monitoring system in place, to monitor the calls. Managers at the service don’t have access to pertinent information such as staff training records, in order to inform them of staff skill and suitability to attend calls

The impact for some people receiving a service from 1st Grade Care is that they have been exposed to the risk of harm in relation to their physical and mental health and wellbeing.

Care and Support	Our Ref: NONCO-00009197-GDTB
Non-compliance identified at this inspection	
Timescale for completion	**02/03/20**
Description of non-compliance/Action to be taken	**Regulation number**
The service is non-compliant with Regulation 36(2) (d) and (e) of the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.The service provider must ensure that any person working at the service receives core training appropriate to the work to be performed.	

Evidence

The service is non-compliant with Regulation 36(2) (d) and (e) of the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017. The service provider must ensure that any person working at the service receives core training appropriate to the work to be performed. Our evidence is as follows:-

9. The manager of the service was unable to clarify if staff delivering care had training in pertinent areas such as medication, moving and handling and safeguarding. This was because a Human Resources person was managing the oversight of staff training needs. The manager was not given access to this information and, therefore, did not know if staff they were providing to attend these calls were sufficiently skilled and competent to deliver the care that people needed. Potentially this could put people receiving a service at risk

10. When we accessed the training information, we found that some staff were delivering calls without up to date training. We found that two carers who were part of the doubles team (doubles refers to calls where two staff members are required to use equipment to help people mobilise). One had not received any training in this area since March 2016 and another since February 2015. This meant that the safety of people was being compromised.

11. We found that Medication training across staff was significantly out of date. Adult safeguarding training was out of date. We saw instances where staff had not received training in these areas since 2015. The service did not have any systems in place to effectively audit the safe administration of medication by the staff. We saw no evidence that staff underwent any competency testing.

Staff 1
Medication training May 2017, safeguarding May 2017

Staff 2
Medication training February 2015, safeguarding April 2017

Staff 3
Medication training February 2015, safeguarding February 2015

Staff 4
Medication training May 2017, safeguarding training May 2017

12. The statement of purpose states “the organisation provides support to its workforce by way of learning, development and opportunities that enables further development of knowledge and skill”. And “each care worker undergoes continuous training and development that ensures the agency deliver the highest quality “. We did not find this to be the case, as evidenced above the agency did not keep staff up to date with basic training required to undertake the caring role.

13. We saw that staff had some basic dementia care awareness training as part of their induction. However there was no further or more in depth training to equip staff to support people with dementia care needs despite the service’s statement of purpose advising that they are able to meet the needs of people with Dementia.

Impact
Care is not delivered by staff who have sufficient training to undertake their role. There is potential risk that vulnerable people who receive care and support are not being safeguarded from harm.