Inspection Report on

1st Grade Care (Cardiff Branch)

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

Date Inspection Completed

08 October 2020

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About 1st Grade Care (Cardiff Branch)

Type of care provided	Domiciliary Support Service
Registered Provider	1st Grade Care Ltd
Registered places	N/A
Language of the service	English
Previous Care Inspectorate Wales inspection	20 November 2019
Does this service provide the Welsh Language active offer?	This is a service that does not provide an 'Active Offer' of the Welsh language because it does not intend to become a bilingual service.

Summary

1st Grade Care (Cardiff Branch) is a domiciliary support service that operates in the Cardiff and the Vale region. The agency provides care for people over the age of 18, including: older people, people with physical disabilities, people with sensory loss/impairment, people with mental health problems, and for the elderly with memory loss.

1st Grade Care Ltd is the name of the company that owns the service. The Responsible Individual (RI) for the service is Lucy Thomas. This means they have responsibility for the strategic operations of the service. There are two managers in post with day-to-day responsibility for the operations of the service.

Most people are happy with the service they receive and speak highly of the care workers who support them. Care is provided in a dignified way, but isn’t always quality care. Poor care documentation; call time allocation and schedule time; all impact adversely on people’s care and wellbeing outcomes. In order to ensure the service meets all of its regulatory requirements, significant improvement, in a number of core areas, is needed to fully meet people’s care and support needs.

Well-being

People's well-being isn't always promoted by a good standard of care and support. We received mixed feedback from individuals using the service and representatives we spoke with. People's needs are not always met because care workers don't have enough time to spend with them, although some people told us they mostly felt well supported. Care is not always provided in the way people want or need.

Personal plans don't always say how best to support the behaviour and communication of people, particularly when the person lives with dementia or poor mental ill health. A lack of guidance in personal plans for people with dementia and/or mental health issues meant that staff were not delivering care appropriate to people's needs. We further found that staff training in dementia was basic and not adequate to give staff skill to support people with memory problems. A family member told us that their relative had lost significant weight recently. Care records demonstrated that care workers were accepting of people's responses that they had eaten or washed with no evidence of checking that this was the case. It is, therefore possible that some people will deteriorate without care workers taking steps to help the person further. This is of particular concern when the person may have a memory problem or cannot physically help themselves. There was little evidence that encouragement or prompting was given with very short call lengths being delivered. Infrequently we saw some care workers were able to encourage people appropriately and noted the full call time being delivered on occasion. Daily recordings did not provide a narrative of the person's well-being. We have previously found the provider lacking in this area and have not seen the expected improvements.

People told us they are treated with dignity and respect. Staff are said to be kind, considerate and always respectful. Staff told us that they feel skilled and sufficiently trained to do their job correctly, but do not always have enough time to chat with people or to travel to get from one call to another. Staff rotas and call monitoring logs showed that calls are not always taking place at the agreed time and calls are often cut short. The checks needed to make sure that calls happen when they are supposed to and for the duration they are needed, were not in place. Auditing of care delivery was not robust we could not find evidence that anyone had identified and was taking action to identify short fallings, such as people consistently refusing personal care, medication or saying they had eaten. This exposes people to the risk of harm including weight loss, neglect and mismanagement of their medication leading to impact on their physical and mental health and wellbeing. The provider is failing to identify and address the systemic issues affecting the service as this was raised at the previous inspection.

A system is in place for reviewing the quality of care, but it needs improving to demonstrate that identified issues are being addressed. There is evidence the RI visits the service regularly and monitors some of the managerial oversight. Further work is needed to ensure areas like call duration, recording interventions is more robust. There were some improvements made since the last inspection, but these were not sufficient to demonstrate full progress. The RI ensures that quality assurance monitoring takes place every three

months, the service has a complaints policy in place and safeguarding concerns are taken seriously and dealt with appropriately. There is evidence that the service liaises appropriately with relevant bodies when necessary. There are appropriate policies and procedures in place to protect both staff and people using the service. Turnover of care workers is high, meaning that people are often supported by different people who don't know them as well as regular carers. There had been changes to the management and operational structure during 2020 which, coupled with the pandemic, had reduced the frequency of training, supervision and spot checks of care workers. We recognise that the pandemic has put additional pressure on the services at this time. CIW will aim to work with services, however where non-compliance notices are in place we are still required to test improvement and ensure services are delivered safely

Care and Support

People and their representatives are involved in planning and reviewing their care; but those reviews need to be more frequent and meaningful. People's overall opinion of the service was good, but some people told us that communication could be improved, especially if there are problems with their calls. Relatives of people with memory problems expressed that they felt their relative were not encouraged or prompted enough to eat, drink or accept personal care.

People told us they have received written information about the service and know who to contact if they have a complaint. People told us their needs were assessed before their service started. Written guidance for care workers isn't always sufficient and clear. Risk assessments aren't always present to accompany personal plans and tell care workers how to keep the person safe. We saw an example of this in relation to pressure care. There are instructions for care workers about how to help people with their medication. We saw that these were not always being followed. A medication policy is present and care workers receive medication training. Record keeping about medication completed by care workers is sometimes not completed properly leading to the risk of error. We saw that prescribed creams had not being included within care or medication records.

Care workers are aware of their safeguarding responsibilities and feel confident raising any concerns with their line manager. People told us they felt comfortable with the care workers who provide their support. A system for managing incidents and safeguarding concerns is in place and there is evidence the service liaises appropriately with relevant bodies.

People told us that they feel safe and protected as appropriate PPE is used at all times to minimise the risk of infection transmission. One person told us they remind care workers to change their gloves following personal care and prior to food preparation, as this is not always done. Care workers told us they have sufficient supply of personal protective equipment (PPE). This helps them, and the people they support, stay safe. The service adopts adequate infection control procedures.

People often have several changes of care workers so that not all people have a regular person to help them. Written information about the service is present. People's care calls are planned but calls are sometimes late and shorter than scheduled. Care workers told us there are times when they don't have enough time to assist people with the care they need. They told us they often do not have time to chat with them, or encourage them at a pace which suits them. Care plans did not always accurately reflect risk or identify why calls were double staffed. The lack of behaviour and communication support plan, meant that important information such as triggers and management techniques for communication and behaviours were not present. The service doesn't always identify, understand or meet people's wellbeing needs.

Care workers do not always have sufficient time for travel between visits. This has not been helped by the pandemic.

Leadership and Management

Care workers told us they felt trained and supported and were happy in their work. Training records evidenced staff undertook training in core areas case. We noted as in previous inspection a lack of specialist, in-depth training in important areas such as dementia and mental health. Only a small number of care workers had a recognised qualification in care. Not all care workers had completed medication administration or manual handling competence testing. Staff files showed that most recruitment documents were in place. We saw that there were some gaps in recruitment processes but these were in line interim changes to regulations, in order to allow care services more flexibility to meet staff demand during pandemic.
Supervision and annual appraisal completion had improved since the last inspection. The service provider has not made sufficient progress in this area since the last inspection. The RI advised us that the time in between last inspection and the current pandemic had affected the services ability to address a number of outstanding issues. There is a recognition that some services have had to prioritise other areas during the pandemic and therefore we were unable to fully test out this area of non-compliance. We will follow up staff training and recruitment at a next inspection

Care workers commented positively on the support they receive from their direct line manager yet expressed the managers were over stretched; have too much to do and are pressured. Managers were covering out of hours permanently. Care workers said that travel time between calls were short in places which caused time pressures and resulted in them being hurried to make up time. Concerns were also expressed about the support given via the out of hour's system. We saw within manager's supervision records that issues were being raised and did not appear to be addressed by the provider. There have been frequent changes to management; key roles such as office planners are vacant and the service does not employ any senior carers or field supervisors. These positions would support the managers in their roles. At time of inspection we were informed that the manager of the vale services was leaving. The provider must ensure that the staff structure supports the safe running of the service.

Quality monitoring arrangements need some improving. We saw completed RI visits included an action plan. We could not see that the RI checked to make sure areas for changing or improving had been put right at their following visits, such as schedule plans not matching call times. Checks of care documentation, by managers and others, are not undertaken soon enough to identify any issue with care delivery. Completed feedback questionnaires from people and staff were read to identify areas that needed improvement by the RI. A six monthly quality of care report had not been completed since the service registered under RISCA. Policies and procedures are in place. Some would benefit from further review. The provider has responded to incidents appropriately, telling other professionals of events they need to know about. Adult safeguarding procedures are followed, and referrals made to the safeguarding team when necessary. These referrals

were stored appropriately but outcomes of investigations were not always recorded. There are systems in place to record and store complaints.

Areas for improvement and action at the previous inspection		
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.	Regulation 21 (1)	**Not Achieved**
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.	Regulation 36(2) (d) & (e)	**Not Achieved**
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.	Regulation 17(b)	**Achieved**
Provision of care and support (Regulation 21(2)): The service provider is required to ensure that care and support is provided to individuals in accordance with their personal plan. We found that not all individuals had consistently received care and support at the times and for the durations planned for.	Regulation 21(2)	**Not Achieved**
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	Regulations 41(3)(a)-(b)	**Not Achieved**

travel in between visits having regard to the matters specified under Regulations 41(3)(a) and 41(3)(b). There was insufficient travel time provided between some calls in the visit schedules.		
Medication administration (Regulation 58(2)(c)): The service provider is required to have arrangements in place to regularly audit the administration of medicines, to ensure risks to people's health and safety are identified and minimised as far as possible. There was insufficient evidence that regular audits had been carried out to oversee medication administration.	Regulation 58(2)(c)	**Not Achieved**
Oversight of adequacy of resources (Regulations 74(1) and 74(2): The RI is required to report to the service provider on the adequacy of resources available to provide the service on a quarterly basis. There was insufficient evidence to demonstrate the required oversight.	Regulations 74(1) and 74(2)	**Achieved**

Where providers fail to improve and take action we may escalate the matter by issuing a priority action (non-compliance) notice.

Areas where immediate action is required	
Requirements in relation to the provision of the service 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.	6
Provision of care and support Regulation 21(1) – the service provider did not ensure that care and support was provided in a way that protects, promotes and maintains the safety and well-being of individuals.	21 (1)
Provision of care and support Regulation 21(2) - We found that not all individuals had consistently received care and support at the times and for the durations planned for.	21(2)
Delineation of travel time Regulations 41(3)(a)-(b) - There was	

insufficient travel time provided between some calls in the visit schedules. Medication Administration Regulation 58(1) - The service provider must ensure there are arrangements in place for the safe management of medications.	41(1) 58(1)

We found poor outcomes for people, and / or risk to people's wellbeing**,** which is likely to continue if no action is taken. Therefore, we have issued a priority action (non-compliance) notice and expect the provider to take immediate steps to address this and make improvements.

Areas where improvement is required	
A quality of care report is to be produced every six months	Regulation 80

Date Published 09/03/2021

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 our website
www.careinspectorate.wales

1st Grade Care (Cardiff Branch)

Cardiff

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<table>
<tr><th colspan="2">Care and Support</th><th>Our Ref: NONCO-00009737-SJPP</th></tr>
<tr><td colspan="3">Non-compliance identified at this inspection</td></tr>
<tr><td colspan="2">Timescale for completion</td><td>02/02/21</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="2">Description of non-compliance/Action to be taken</td><td>Regulation number</td></tr>
<tr><td colspan="2">Medication Administration : Regulation 58(1) The service provider must ensure there are arrangements in place for the safe management of medications.</td><td>58(1)</td></tr>
<tr><td colspan="3">Evidence</td></tr>
<tr><td colspan="3">The service provider is not compliant with regulation 58. This is because, although some improvements had been made since the last inspection, further improvements were needed and medication policies and procedures were not always being followed.

The evidence:
This is because, at the last inspection, we found that:
• Personal plans were not always clear who had responsibility for administering medication. On some occasions, staff were administering medication and families at other times.
• We saw gaps in Medication Administration Record’s (MAR’s). It was not always clear if people had been given medication as there were frequent gaps on all the MAR sheets we viewed.
• We saw topical creams had been applied however; this had not been recorded within charts.
• We requested sight of internal audits of medication charts. Information provided within internal medication audits 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.

At this inspection, suitable arrangements were not being followed to promote the safe management of medicines. We considered a sample of documentation including medication administration records (MAR), personal plans, daily notes, internal medication audits, the organisations medication policy and staff training records. We found that :

• We saw gaps in Medication Administration Record’s (MAR’s). It was not always clear if people had been given medication as there were frequent gaps on all the MAR charts we viewed. There is a statement on the MAR’s that any gaps must be reported immediately.
• We saw codes being used within Medication Administration Record’s (MAR’s), such as ‘O’ for other. Staff had not completed the explanation sheet to indicate the meaning/reason.</td></tr>
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- We noted that medication administered outside of the person’s blister pack had not been sufficiently recorded on the MAR’s chart. It was not possible to determine the dosage/strength of the medication or the frequency of its administration such as regularly each day or PRN (as and when).
- We saw medication had been missed on two occasions within daily recordings of a person with dementia. Care workers had left medication for them to take themselves later which they had forgotten. There was no evidence to indicate that this had been reported to the office in a timely manner.
- We saw topical and prescribed creams had been applied from daily recordings. This had not been recorded within a cream or MAR’s chart to indicate the frequency, location and specific cream to be applied. The organisations medication policy 17.0 refers to the application of Creams, Lotions or Ointment.
- The internal medication audit process did not identify missed medications or evidence of administration in a timely way. Audits did not provide detail of follow-up, such as, contact with health professionals when medication had been missed.

The impact on people using the service is they are potentially at risk because safe systems for managing their medicines are not always being followed.

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<tr><th colspan="2">Leadership and Management</th><th>Our Ref: NONCO-00009740-PLGK</th></tr>
<tr><td colspan="3">Non-compliance identified at this inspection</td></tr>
<tr><td colspan="2">Timescale for completion</td><td>02/02/21</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="2">Description of non-compliance/Action to be taken</td><td>Regulation number</td></tr>
<tr><td colspan="2">Delineation of travel time Regulations 41(3)(a)-(b) - There was insufficient travel time provided between some calls in the visit schedules.</td><td>41(1)
41(3)(a)
41(3)(b)</td></tr>
<tr><td colspan="3">Evidence</td></tr>
<tr><td colspan="3">The registered person is not compliant with Regulation 41(3) travel time must be sufficient regarding (a) the distance between visits and (b) allow for other factors eg traffic congestion, parking etc;
• This is because the service does not allow and account for travel time and other factors eg traffic, between service users.
• The evidence:
Staff schedules provided evidenced many instances of 5 minutes being allocated for travel time. For those who living within the City individuals call monitoring reports indicated that carers were not always arriving on time to their call. Staff members who completed a ‘walking route’ told us they had sufficient time to get to the next call. Carers who drove indicated insufficient travel times between calls.
• The impact on people using the service is: Some people spoke about care workers arriving with them very late and are rushed/leave early to go to next call. For people with dementia this meant that they were not being sufficient encouragement or prompting with medication, personal care and meals.</td></tr>
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Leadership and Management	Our Ref: NONCO-00009742-LKWV

Non-compliance identified at this inspection	
Timescale for completion	**02/02/21**
Description of non-compliance/Action to be taken	**Regulation number**
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.	

Evidence

The registered person is not compliant with 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

This is because:

- Processes to ensure care is delivered consistently and reliable were not being accomplished.
- Safe staffing arrangements, underpinned by professional development, to met the care and support needs of the individuals using the service was not being attained.
- Quality and audit systems to review progress and inform service development was not adequately being implemented.
- The systems for assessment, care planning, monitoring and review which supports evidence –based practice and supports individuals to achieve their personal outcomes was not sufficiently executed.

The evidence:

- Daily recordings need to provide a narrative of a person's wellbeing, particularly those people who may be experiencing mental ill health
- Quality monitoring report now includes action plan - – but no evidence to show followed up on next visit
- Concerns raised by people (but not complaints) should be monitored and addressed – i.e. call too late for T** etc.
- Reporting of incidents by staff needs to be improved, - reporting back to office in timely manner i.e. missed medication, refusing personal care over a number of days, saying they have eaten
- Audit matrix showed significant gaps in medication and daily recording adulting - when audits had been completed no follow up re. gaps, or when people said they felt unwell, no evidence of contact to inform the office
- Review of care plans and risk assessment doesn't always match that of the assessment i.e. medication/mental health needs. Skin risk assessments – application of creams - no behaviour care plans/risk assessment highlighting triggers etc. no communication care plan
- People not getting their allotted call length or times,
- Call monitoring system being better used - however is it fit for purpose as doesn't highlight/flag up on the day when a call is late/missed, report has to be run which may not be done for a significant time.

- Only 3 staff have obtained recognised qualification in care. Only 8 staff registered with SCW.
- Staff files – gaps in employment histories, 4 DBS returned after start date, employer reference needs to be from the most recent employer, need to check the reason for leaving last care job
- Significant gaps in medication and manual handling competencies for staff
- Gaps in staff supervisions although did see an improvement since last inspection

The impact for people using the service is that they have been exposed to the risk of harm in relation to their physical and mental health wellbeing. The provider has failed to identify and address the systemic issues affecting the service.