Inspection Report on

Spectrum Healthcare

Social Care Training Centre
St Georges Court
Tredegar
NP22 3EA

Date Inspection Completed

21/01/2021

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About Spectrum Healthcare

Type of care provided	Domiciliary Support Service
Registered Provider	Spectrum Healthcare Domiciliary Care Limited
Registered places	0
Language of the service	English
Previous Care Inspectorate Wales inspection	
Does this service provide the Welsh Language active offer?	Yes

Summary

This was an unannounced focused virtual inspection by Care Inspectorate Wales (CIW) which specifically looked at care, support, leadership and management of the service. At inspection we found people's satisfaction with the service is varied. We found reduced staffing numbers are impacting upon people's wellbeing and people are not given support in accordance with their personal plans. Complaints are not always recorded or responded to appropriately, resulting in a failure to protect people. Improvements are needed with regard to ensuring robust infection control procedures are maintained. Staff are not receiving the appropriate support to undertake their roles. Some issues are not being reported to CIW.

Well-being

The service sets out to promote people's wellbeing but this is not always consistent. Some people feel they are given choice in all aspects of their care and are happy with the support they receive; however, other people feel they have limited control over the care they receive. People told us they do not always feel they are treated with dignity or respect. Ssome people told us they had unfamiliar carers, or call times were changed without consultation. We saw some people's personal plans differ from the actual care provided and reviews are not always taken in a timely manner.

The service needs to take immediate action to ensure people are safeguarded from harm or abuse. Complaints are not always recorded properly or analysed and we found a number of examples where concerns raised with the agency have not been addressed satisfactorily or fully shared with external agencies in a timely manner.

Care and Support

People have varying experiences of care and support. Some people were positive about the standard of care they receive, complimenting the care staff. One person commented on the "*Nurturing and positivity*" of the service, and others spoke of some care staff being, "*Really good"* and that care staff undertook their calls in line with their personal plans, staying for the duration of their allotted call time.. Other people told us some staff do not stay for the duration of their calls.

Staff do not consistently feel supported to carry out their roles with confidence. People have had different experiences; while some staff told us they enjoy their work and feel able to approach the leadership team if issues arise, other staff we spoke with told us about their perceptions of not being valued. While many staff told us they have the necessary personal protective equipment (PPE) to undertake their role, some staff told us they feel vulnerable due to the current pandemic and told us they feel they have not received sufficient training in use of PPE. Some people also told us that a number of care staff did not dispose of PPE after their call. We discussed this with the manager who assured us all staff have undertaken a workforce risk assessment in respect of Covid-19 and all staff have been offered a vaccination. We found staff are undertaking their own risk assessments and while we saw the dates of these are recorded, we were not provided with the individual assessments for each staff member. We looked at one service user's plan and saw it clearly states the visiting carers should have specialist training to ensure the person's needs were met safely. We did not see documentation to confirm all carers have received this training although we were advised training for staff had taken place. We also saw some staff supervision is not up to date, although we saw some telephone supervision has been provided.

We requested, but were unable, to look at induction training information for all staff but looked at a number of staff files which indicated training and shadowing was provided prior to people providing support.

Leadership and Management

The responsible individual (RI) maintains oversight of the service and completes regular inspections and quality reports for the service. The RI plays an active role in the daily management of the service. The service aims to support the work of statutory agencies. However we identified occasions where reportable incidents were not openly shared with other agencies, including CIW. We also found relevant information about the service is not being openly shared with CIW. The statement of purpose (SOP), a key document outlining the visions and functions of the organisation, should be reviewed regularly and updated in the event of any changes and should reflect the functions of the service. We found that the SOP had not been reviewed and updated for two years.

There are improvements needed to ensure people remain safe at all times. We found there were instances where complaints had been made to the service but these had not been recorded or actioned. People told us they felt their concerns are "*brushed under the carpet*". We found more than one instance where the lack of response to a complaint had resulted in a negative outcome for a person receiving support.   The SOP advises that "*People will not be discriminated against*" when a complaint is made, but some people told us they perceived that, their care was cancelled by the service after they had raised complaints.

Further improvements are required into the day to day oversight of care delivery. People told us staff do not always sign in and out of calls at the correct times. We also found there have been times when people's care notes have not been noted appropriately, We found one instance where this has resulted in a delay in a person receiving the correct medical treatment. We recommend regular spot checks should be undertaken to identify issues which may need remedial action.

Staffing levels are currently at an insufficient level. We saw there have been a number of staff leaving, both from the management team, office team and care workers. The RI has taken proactive and decisive action to ensure people are not put at risk by giving the local authority notice that some calls need to be reallocated. Staff suggested unpaid travelling time and inadequate mileage expenses may be a factor in the numbers of staff who have recently left. The low staff numbers have resulted in rotas being changed which has impacted on people through lack of continuity and care staff needing to cover shifts where they may be unfamiliar with people's support needs.

Environment

Environmental issues were not considered as part of this inspection. We are assured that all files relating to staff and service users are stored securely within the service.

Areas for improvement and action at, or since the previous inspection		
Not all staff were receiving supervision as per regulatory requirements (3 monthly)	Regulation 36 (2)(c)	**Not fully achieved – remains outstanding**
CIW were not told about all reportable incidents.	Regulation 60	**Not Achieved – see below**
More robust staff recruitment processes are required.	Regulation 35(2)(b)	**Not Considered at this inspection**

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	
The service provider has not taken sufficient action to ensure care and support is provided in a way which protects the safety and wellbeing of individuals.	**Regulation 21 (1)**
The service provider has not ensured individuals are safe and protected from neglect.	**Regulation 26**
The service provider does not have a sufficient number of suitably experienced staff to meet the support needs of individuals.	**Regulation 34 (1)**
The service user has not made sufficient arrangements with regard to travel time, to enable care and support to be provided in accordance with people's personal plans.	**Regulation 41 (4)(a)**
There has been insufficient improvements in notifications being made to CIW.	**Regulation 60 (1)**
The service provider does not record and respond appropriately to all complaints	**Regulation 64(2)(d)**

Areas where improvement is required	
The statement of purpose has not been updated to reflect current arrangements.	**Regulation 7 (2)(a)**
Relevant information about the service should be shared with CIW.	**Regulation 13**

Date Published 17/09/2021

Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Non Compliance Notice

Domiciliary Care 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

Spectrum Healthcare

Social Care Training Centre
St Georges Court
Tredegar
NP22 3EA
Date of publication: **22/02/2021**

Care and Support		Our Ref: NONCO-0001224-LPQB
Non-compliance identified at this inspection		
Timescale for completion	**01/05/2021**	
Description of non-compliance/Action to be taken	**Regulation number**	
Standards of care and support- overarching requirements - Regulation 21(1); The service provider must ensure that care and support is provided in a way which protects, promotes and maintains the safety and well-being of individuals.	21 (1)	

Evidence

The virtual inspection which commenced on 07/01/21 identified the service is not proactive in identifying and mitigating risks.

Evidence: The service provider has failed to make adequate arrangements for continuity of care (Regulation 22) and low staffing numbers have resulted in care staff having to travel to deliver care to people with whose needs they are unfamiliar. There have also been occasions when lack of resources have meant that staff may have not had appropriate specialist knowledge or experience of individuals' care and support needs,

It was identified that due to time constraints staff have been leaving messages for other staff with service users or representatives, thus breaking confidentiality.

There have been reports of staff incorrectly utilising or disposing of PPE.

People's care and support is not always delivered in accordance with their personal plans; times have been changed on calls and service users are not always made aware of changes. Calls have also been cut short, resulting in risks to individuals.
Reviews have not been carried out in accordance with regulatory requirements and there is incorrect information in some personal plans which has not been rectified, suggesting a lack of oversight by staff and management.

Impact:
There are ongoing risks for people who use the service. People cannot be confident their care will be delivered by staff who are confident or experienced in the delivery of care.

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Date of publication: 22/02/2021

<table>
<tr><th colspan="2">Leadership and Management</th><th>Our Ref: NONCO-00010215-XYMP</th></tr>
<tr><td colspan="3">Non-compliance identified at this inspection</td></tr>
<tr><td>Timescale for completion</td><td colspan="2">01/05/2021</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Description of non-compliance/Action to be taken</td><td colspan="2">Regulation number</td></tr>
<tr><td>Safeguarding - Regulation 26: The service provider must provide the service in a way which ensures that individuals are safe and are protected from abuse, neglect and improper treatment.</td><td colspan="2">26</td></tr>
<tr><td colspan="3">Evidence</td></tr>
<tr><td colspan="3">Evidence:
The virtual inspection commenced on 07/01/21 found evidence of an incident where a service user had experienced an injury that was not logged in daily notes at the time of the incident and was not reported by the carer/s involved. Subsequently one of the care staff did report the incident retrospectively; however by this time the individual had been in pain for a period of time and this eventually resulted in a hospital admission. The information about the incident was raised as a Duty To Report; however some details were not fully conveyed to the safeguarding team due to the initial delays.

A complaint made to the service contained information which should have been treated as a duty to report but was not passed to the local authority to investigate, nor is there any evidence that the complaint was considered.

Impact:
There has been a delay in a service user receiving timely or appropriate treatment.</td></tr>
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Date of publication: 22/02/2021

Leadership and Management	Our Ref: NONCO-00010216-YCNL
Non-compliance identified at this inspection	
Timescale for completion	**01/05/2021**
Description of non-compliance/Action to be taken	**Regulation number**
Staffing - Regulation 34(1). The service provider must ensure that at all times a sufficient number of suitably qualified, trained, skilled, competent and experienced staff are deployed to work at the service, having regard to the care and support needs of the individuals.	34 (1)
Evidence	
Evidence: The virtual inspection commenced on 7/1/21 identified there were inadequate numbers of staff employed to safely provide a comprehensive service to individuals. There is a high turnover of staff with a number of staff leaving both care and management positions. Staff who have recently left the employment of the service have told us they were working excessive hours each week and were unable to take planned leave due to low staff numbers. Staff have expressed concern to CIW about the lack of travel time and reimbursement for travel costs. Rotas show staff travelling distances between calls. The agency has taken action and now handed back care hours to the local authority as they recognise they are unable to meet these going forward; however there have already been negative outcomes for service users as a result of the insufficient travel time. Care Co-ordinators described covering vast areas due to being short staffed and a lack of drivers. They were required to drive care workers to some of the calls. One person mentioned that there were gaps in the rota so if they were in Powys they had to sit and wait in their cars until the next call time as it was too long to drive back home and then back again but they only got paid for the calls they completed, not the times they were away from home. Please also refer to Regulation 41(4)(a) below. Impact: There is a negative impact upon retention of staff. Subsequently individuals are not receiving consistent care at times specified in their personal plans. Reduced numbers mean there are ongoing risks for people who use the service.	

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Date of publication: 22/02/2021

Leadership and Management		**Our Ref: NONCO-00010217-QOVT**
Non-compliance identified at this inspection		
Timescale for completion	**01/5/2021**	
Description of non-compliance/Action to be taken	**Regulation number**	
Travel time – Regulation 41(4)(a): The time allocated for each visit must be sufficient to enable care and support to be provided to the individual in accordance with their personal plan.	41(4)(a)	
Evidence		
Evidence: The virtual inspection commenced on 07/01/21 concluded that reduced staffing numbers have impacted upon care staff and senior staff. Staff who have recently left the employment of the service have told us they were working excessive hours each week and were unable to take planned leave due to low staff numbers. Staff have expressed concern to CIW about the lack of travel time and reimbursement for travel costs. The agency has taken action and now handed back care hours to the local authority as they recognise they are unable to meet these going forward; however there have already been negative outcomes for service users as a result of the insufficient travel time. Care Co-ordinators described covering larger areas than normal due to being short staffed and a lack of drivers. They were required to drive care workers to some of the calls. One person mentioned that there were gaps in the rota so if they were in Powys they had to sit and wait in their cars until the next call time as it was too long to drive back home and then back again but they only got paid for the calls they completed, not the times they were away from home. Please also refer to Regulation 34(1) above. Impact: There is a negative impact upon retention of staff. Subsequently individuals are not receiving care at times specified in their personal plans.		

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Date of publication: 22/02/2021

Leadership and Management	Our Ref: NONCO-00007241-LDQQ
Non-compliance identified at this inspection	
Timescale for completion	**01/05/2021**
Description of non-compliance/Action to be taken	**Regulation number**
Notifications – Regulation 60 (1): The service provider must notify the service regulator of the events specified in Parts 1 and 2 of Schedule 3.	60(1)
Evidence	
The inspection undertaken in January 2019 identified that notifications were not always reported appropriately to CIW, particularly when this related to alleged or actual misconduct by staff members. We did not issued non-compliance notice on that occasion because there was no immediate or significant impact for people using the service. Evidence; The virtual inspection commenced on 07/01/21 concluded that there have failed to be improvements in this area and as a result immediate action is required to address this matter. CIW has identified at least two occasions where there has been potential misconduct by a staff member but no direct notification has been received. Impact: The lack of action from the provider means that there are ongoing risks for people who use the service.	

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Date of publication: 22/02/2021

Leadership and Management	Our Ref: NONCO-00010218-YGDQ
Non-compliance identified at this inspection	
Timescale for completion	**01/05/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider must have effective arrangements in place for dealing with complaints, including arrangements for keeping records relating to the matters in sub-paragraphs (a) to (c), namely identifying and investigating complaints, giving an appropriate response to a person who makes a complaint, and ensuring appropriate action is taken following investigation.	64 2)(d)
Evidence	
Evidence: The virtual inspection commenced on 07/01/21 and 12/02/20 concluded that a number of complaints had been made to the service. These had not been recorded or actioned and CIW were not made aware of the complaints at inspection. Where complaints had been noted, people were not given satisfactory responses, and in one instance we found a person had their care package withdrawn and passed back to the local authority. Impact: Complaints, particularly of a virtual nature, are not recorded or dealt with in accordance with regulatory requirements or the service's statement of purpose. The lack of consideration of complaints has impacted on people's confidence in the service. The lack of investigation or clear recording puts people at potential risk of harm.	