# Inspection Report on

**Spectrum Healthcare**

**Social Care Training Centre**
**St Georges Court**
**Tredegar**
**NP22 4NE**

## 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) looking at issues around care and support 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, with the result there have been negative outcomes for people receiving support.  Complaints are not being recorded or responded to consistently or appropriately, resulting in a failure to protect people and contrary to the Statement of purpose. Improvements are needed with regard to infection control training procedures.  People's personal plans do not always contain the correct information and are not reviewed in line with regulatory requirements.

## Well-being

The service sets out to promote people's wellbeing but this is not always achieved. Some people feel they are given choice in all aspects of their care and we were given a written statement complimenting the support they receive; however, other people told us they have limited control over the care they receive. People told us they sometimes had unfamiliar carers, or call times were changed without consultation.

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

## 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. Some people told us care was of a good standard, care staff always came in twos when double handed calls were required and staff were generally punctual. Others spoke of varying standards between different care staff. We found a number of care staff have recently left the service and this is impacting negatively on both the time and reliability of calls. Staff told us they felt they had insufficient time to travel from call to call, and felt they had insufficient reimbursement. Since the inspection, the provider has informed us that this is not the case. We recommend the workforce are assisted, by the provider, to understand their rights and the service's practices in relation to reimbursement arrangements and travelling expectations. We identified instances where office staff were called upon to leave the office to deliver care due to staff shortages; while all staff have received the basic necessary training to deliver care, we are not confident that office staff would have the same level of confidence and experience as dedicated care staff. We found one instance where this had resulted in a negative outcome for a service user. We have shared the relevant feedback with the local authority.

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, others told us they do not feel valued. Some staff told us they feel vulnerable due to the current pandemic and told us they have not received sufficient training in use of personal protective equipment (PPE). Some people were positive about care staff's use of PPE but others told us that 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 requested, but were unable, to look at detailed induction training information for all staff but we looked at a number of staff files which indicated initial training and shadowing was provided prior to people providing support. This initial training is condensed into three to four days. We did not see documentation for any training specifically related to the current pandemic; however, the provider has assured us that all staff have received training in all necessary areas.

## Leadership and Management

The responsible individual (RI) maintains oversight of the service and completes regular quality reports for the service. The RI also plays an active role in the daily management of the service. 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. While some issues are reported, other notifiable events should are not always promptly reported to CIW. We also found relevant information about the service is not being openly shared with CIW. We found improvements are needed to ensure people's personal plans are audited as we identified examples where these contain incorrect information and are not consistently reviewed in line with regulatory requirements.

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 necessarily showed any actions taken as a result. People told us they felt their concerns were not acknowledged. We identified that an action agreed at a recent safeguarding meeting had not been implemented by the RI and manager. We advised the RI immediate action is required to address this.

There is a need for further improvements 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. Staffing levels are currently not at an optimum level and we saw there have been a number of staff leaving, both from the management team, office team and care workers. 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. We found one occasion where this had resulted in unnecessary risk to a service user.

## 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 are being supervised at appropriate intervals. | Regulation 36(2)(c) | **Not Achieved** |
| CIW are not being informed of all reportable incidents. | Regulation 60 | **Not Achieved** |
| Not having sufficiently robust staff recruitment arrangements in place. | 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)** |
| There have been insufficient improvements in notifications being made to CIW. | **Regulation 60 (1)** |

| Areas where improvement is required | |
|---|---|
| Relevant information about the service should be routinely 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-00010221-MWHV |
| --- | --- |
| **Non-compliance identified at this inspection** | |

| **Timescale for completion** | **03/05/2021** |
| --- | --- |
| | |
| **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.<br><br>Evidence: The service provider has failed to make adequate arrangements to provide care in line with people's personal planscare (Regulation 22) and low staffing numbers have resulted in some care staff having to deliver care to people with whose needs they are unfamiliar. There have also been occasions when lack of resources have meant that office staff and members of the management team have been called upon to deliver care and support in the community, and have not had appropriate specialist knowledge or experience of individuals' care and support needs,<br><br>It was identified that due to time constraints staff have been leaving messages for other staff with service users or representatives, thus breaking confidentiality.<br><br>There have been reports of staff incorrectly utilising or disposing of PPE.<br><br>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. 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.<br><br>Impact:<br>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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**Tredegar**
**NP22 3EA**

Date of publication: 22/02/2021

| Leadership and Management | Our Ref: NONCO-00010222-MMPD |
|---|---|
| **Non-compliance identified at this inspection** | |
| **Timescale for completion** | **03/05/2021** |
| | |

| Description of non-compliance/Action to be taken | Regulation number |
|---|---|
| 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. | 26 |
| **Evidence** | |
| Evidence:<br>The virtual inspection commenced on 07/01/21 found evidence of an incident where a service user had been visited by a member of care staff accompanied by a member of the office staff who was unfamiliar with the individual. The service user told the visiting staff they did not wish to mobilise but was encouraged to do so; this eventually resulted in a fall and subsequent hospital admission with a serious injury. It was identified a safeguarding meeting had been informed a staff member was suspended; however, it was found the staff member had been allowed to return to restricted duties without informing the people involved in the safeguarding investigation. It was also identified that one of the members of staff had previously been the subject of a complaint in relation to manual handling the previous year but there was no evidence of additional training being provided following the earlier complaint.<br><br>Impact:<br>There were negative outcomes for the individual in question. | |

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**Tredegar**
**NP22 3EA**

Date of publication: 22/02/2021

| Leadership and Management | Our Ref: NONCO-00010223-MFBW |
| --- | --- |
| **Non-compliance identified at this inspection** | |
| **Timescale for completion** | **03/05/2021** |
| | |
| **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 now handed back care hours to the local authority as they recognise they are unable to meet these going forward; however there have been negative outcomes for service users as a result of the insufficient travel time. Care Co-ordinators described covering two 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 out of area 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.

Impact:

There is a negative impact upon retention of staff. Subsequently individuals are not regularly receiving 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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**NP22 3EA**
Date of publication: 22/02/2021

| Leadership and Management | Our Ref: NONCO-00007252-QBTB |
|---|---|
| **Non-compliance identified at this inspection** | |
| **Timescale for completion** | **03/05/2021** |
| | |
| **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** | |
| Evidence:<br><br>The inspection undertaken on 21/01/2019 identified notifications were not being made to CIW, particularly relating to alleged or actual misconduct of staff. At the virtual inspection commenced on 7/1/21 it was identified there had not been any improvements in this area, with further examples of alleged misconduct being identified that had not been reported to CIW, and insufficient action had been taken to rectify the issue.<br><br>Impact:<br><br>The lack of improvement presents a potential risk to individuals using the service. | |