

Homebased Care (UK) Limited

Homebased Care (UK) Ltd- Erdington

Inspection report

79 Marsh Lane
Birmingham
West Midlands
B23 6HY

Tel: 01213733633

Date of inspection visit:
31 March 2017
03 May 2017

Date of publication:
16 June 2017

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 31 March and 03 May 2017 and was announced. This was the first inspection since this location was registered with us.

Homebased Care (UK) Limited is registered to provide personal care services to people in their own home. At the time of our inspection 139 people were receiving a service.

There was a registered manager in post at the time of our inspection but they were not available to assist during the inspection and people were not aware of who the registered manager was. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not fulfilling the requirements of their registration to ensure all the required notifications were sent to CQC (Care Quality Commission) to enable them to monitor that people were protected. You can see what action we told the provider to take at the back of the full version of the report.

The quality assurance systems were not sufficient to monitor, identify shortfalls and make the necessary improvements to the service to ensure people were receiving the service as required.

People knew how to raise concerns they had but not everyone felt they were listened to, their concerns taken seriously and that the response from the provider was not always timely. People felt that communication with them could be improved regarding calls, carers who were supporting them and the managers responsible for the service.

People were mostly happy with their regular carers but some people had concerns about the service provided at weekends and periods of staff sickness and holidays. Some people were unhappy that they had not always received a service at the time they had requested or for the length of time they had requested.

People were supported by staff that had the skills and knowledge to identify the risk of abuse and to raise concerns if needed. Safeguarding concerns were raised with the local authority but notifications were not always sent to CQC (Care Quality Commission) so that we could monitor the service and ensure people were protected.

People were protected by a staff team who understood how to manage hazards in order to reduce the risk of harm and had access to care plans and risk assessments to support them. People were supported to take their medicines, receive support with personal care and felt involved in their care. People felt generally staff had the skills to support them appropriately.

People were supported by staff that were kind and caring towards them and with whom they had built good

relationships and who respected people's privacy and dignity. Staff supported people to make choices and give consent to care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were protected by a staff team who understood how to reduce the risk of incidents related to their care and support, and were able to recognise and escalate safeguarding concerns.

People were happy with the support they received with their medicines.

People were supported by staff who had been recruited safely.

Is the service effective?

Good ●

The service was effective.

People felt staff had the skills to support them appropriately with their needs and to ensure their rights were upheld. People were involved in their care making choices where possible.

People were confident staff would ensure that they were supported to access health professionals if needed.

Is the service caring?

Good ●

The service was caring.

People were supported by staff they had developed a good relationship with and who were caring and kind.

People's privacy, dignity and independence was promoted by staff.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People were happy with the care provided by staff but were not always happy that it was at the time they wanted. People did not always feel that their concerns were taken seriously and responded to appropriately.

There were some systems in place to gather people's views about the service they received.

Is the service well-led?

The service was consistently well led.

Whilst there were some systems in place to monitor the quality of service provided they were not sufficient in identifying shortfalls in the service. This included: call times, ensuring that complaints were responded to appropriately and ensuring that notifications were sent to CQC as soon as possible after the incident.

People did not feel they were kept informed about the changes in the management of the service.

Requires Improvement 

Homebased Care (UK) Ltd- Erdington

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 March and 03 May 2017 and was announced.

The provider was given 48 hours' notice on the first day of our inspection because the location provides a domiciliary care service and we wanted them to have information ready for us. The provider was given 24 hours' notice before our second day of our inspection. The inspection was carried out by two inspectors.

In preparation for our inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We looked at any information shared with us by local authorities including safeguarding investigations. We also reviewed the information that had been sent to us by the public. We used this information to help us plan our inspection.

During our inspection we spoke with 12 people who received a service on the telephone and visited seven people in their home. We spoke with six care staff, the compliance manager and the deputy manager. We looked at five people's care records; this included medication records, care plans and risk assessments. The daily records for eight people and records relating to the management of the service including recruitment records for two staff, complaints, incidents/accidents and quality assurance records.

Is the service safe?

Our findings

People told us that they felt safe with the staff that came to support them on a regular basis and if they were not appropriate actions were taken when they reported this to senior staff. One person said they had been unhappy with the way one staff member treated them but they [staff member] never returned after the person raised this with the office. Other people told us that they had developed good relationships with their regular care staff. One person told us, "I have never felt uncomfortable [with staff]. They are lovely." Staff spoken with told us they had received training in how to protect people from harm and were able to tell us what they had learnt in their training. This included how to recognise the signs of different types of abuse. Staff were also aware of whom to report their concerns to and how to escalate these to external organisation if they felt actions needed to keep people safe were not taken.

Some people told us that they did not always receive their calls at the times they expected when their regular care staff were not available. We were aware that there had been some missed and late calls but staff and the compliance manager told us that they had sufficient numbers of staff available. Staff told us they were occasionally asked to cover calls when other staff were not available and this could mean that they needed to adjust the calls times to carry out the additional calls. The compliance manager told us that they had become aware that some staff had made private arrangements with some people to carry out their calls at a different time but people had expressed dissatisfaction when other staff were unable to attend at those times. We were told by the compliance manager that staff were working in teams in geographical areas so that travel times did not affect their ability to attend calls on time and that drivers had been employed to enable staff without cars to be taken to calls so that they could attend calls at the required times.

Staff told us that references and Disclosure and Barring Service checks (DBS) were carried out before they started work. DBS are checks that are undertaken to ensure that staff do not have any relevant criminal offences that would prevent them from providing care and support to people that use services. Staff files we looked at showed that the appropriate employment checks were carried out before staff were employed. This showed that the provider ensured that only suitable staff were employed. The compliance manager told us that recruitment was ongoing to ensure the organisation were able to replace staff that were leaving and to ensure that they continued to have sufficient staff to cover the calls they needed to make to people.

The risk of harm to people whilst providing personal care was reduced and managed because there were procedures in place to help staff to manage risks. People told us that they felt the staff that supported them had the necessary skills to ensure risks were managed. One relative told us, "They talk to me about any safety issues, for example they once found the door open and they discussed this with me to ensure dad was safe." Staff told us that risk assessments and risk management plans were available to support them in caring for people safely. Records looked at confirmed this. Staff spoken with knew the risks associated with people's care and told us how they talked to people about any risks identified and ensured that new risks were reported, so that the care could be reviewed to ensure people were cared for safely. This ensured any risks to people's care was managed appropriately.

People were confident that staff would contact the relevant people if there was an emergency situation. Staff told us what they would do in a medical emergency to ensure people were safe and records we looked at confirmed this. This included calling the emergency services and reporting issues about people's welfare to the office and people's family members. Staff told us that there was an on call system and there was always a senior member of staff available for advice and support. This meant staff had access to guidance and support in an emergency situation

People were supported with their medicines. Most people we spoke with told us they were able to take their own medicines but some people were supported by staff who passed them their medicines. Records looked at showed that there were details about the medicines people were taking and staff completed medication records to show people had been prompted or supported to take their medicines.

Is the service effective?

Our findings

People's needs were assessed before they started to receive a service. One person told us, "They came and chatted to me. Asked about getting up the stairs, washing, equipment and medicines." This person went on to tell us that they were asked by staff what they needed to be done. Another person told us, "They talked to me about care, I can't walk but I can do some things." The person told us that they were happy with the service they received. Staff spoken with told us they had the information they needed to provide support to people and were knowledgeable about the people they supported. Staff told us that they received training before they started work and also ongoing updates and refreshers to update their knowledge and skills. Staff told us and records showed that they [staff] received supervision and were able to speak with a senior member of staff when needed so that any concerns they had could be discussed and advice received.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People spoken with told us that they were always asked about the help they wanted and involved in the care they received. We saw that systems were in place to ensure that people's ability to make decisions for themselves was assessed. One staff member told us, "If person has no capacity I will speak with the manager and they will decide what is best for the client. It has to be team work and will include the family so that they can make the best interest decisions as a team. We always look at the point of view of the person." Staff told us and training records confirmed that they received training in the principles of the MCA.

People told us that where they needed support with preparing meals they received this support and staff always asked them what they wanted and prepared food according to their wishes. Staff said they would monitor and record people's food and fluid intake, if this was part of their care plan and inform the office staff or family members if people were not eating. This ensured people were supported where needed with maintaining their food and fluid intake.

People told us that they were confident that if they needed support to access a doctor or nurse the staff would support them to do this. Staff told us that they would contact the GP or district nurses if needed and tell the office staff and family members if people were unwell. We saw that emergency services were contacted if necessary and we saw that some people had pendants that they could use to summon emergency services in an emergency. This showed that people were able to get medical support if needed.

Is the service caring?

Our findings

People told us that they had built up good relationships with the staff that supported them. One person told us, "They [staff] are lovely, definitely respectful." Another person told us, "I have had no trouble; they [staff] call me [person's name]. I like that. They are respectful." A third person told us, "She [staff] is always on time, she is like a friend." People told us that the care staff always helped them to make choices about their daily care and felt a part of the care they received.

People and their relatives were involved in discussing and agreeing their care and support needs. Relatives told us that staff provided the care that their relatives wanted and did so with their agreement and ensured their privacy and dignity. People and relatives told us that staff were respectful and treated their family members with respect and dignity. During our visits to people in their homes we saw that staff called out to let people know they were entering their home. Staff were able to tell us how they ensured people's privacy and dignity was maintained. This included using people's preferred name, telling people what they were going to do, keeping people covered and asking them to do their private areas if they could.

People told us that their independence was promoted by staff. People told us they were supported to take their own medicines and make choices about the food they ate. One person told us that staff took out clothes for them to wear but would change them if they said they didn't want to wear them.

People told us that their individual needs and preferences were promoted. One person told us that they had been asked if they had a preference of male or female staff to support them. A member of staff told us that they were matched with people whose first language was not English so that they could communicate well and provide culturally appropriate care.

Is the service responsive?

Our findings

People and their relatives told us they knew how to raise concerns but were not always confident that their concerns would be responded to. Some people felt that the office staff were not always responsive to the concerns they raised. One person told us, "It's a waste of time complaining to the office. They [staff] still come when they want to come." A relative told us, "It hasn't been 100% due to missed calls. They [staff] used to not turn up or very late. It only got resolved because others got involved. Usually they pass the buck, I was making a complaint as [person] was waiting at 11am for a morning call and I was told, "What do you want me to do about it". They never responded to any complaints." Prior to our inspection a relative raised concerns with us about not receiving a response to their complaint and their request for a copy of the complaint procedure. We discussed this with the compliance manager who had acknowledged the complaint at the time of the second day of our inspection but was not able to explain why there had been a delay in responding to the individual. We saw that the complaints record showed that the recorded complaints had been investigated and there was a record of the findings and outcome. The complaints record did not record complaints about all the missed calls that people told us they had made. This means that the complaints log was not an accurate record of all the concerns raised by people and the actions taken in response to the concerns

We saw that there were some other ways the organisation was able to get the views of people using the service. These included having a service user group, questionnaires and telephone surveys. People's views were also gathered during reviews and spot checks on staff.

People spoken with were mostly happy with the support they received. One person told us, "They [staff] come once a day. They come about 7am. They cream my legs and wash me. I am able to get dressed. Can do my own medicines. I have had no trouble." Another person said, "She [staff] is always on time. She's like a friend and I have a life." However, some people were not happy with the times that they received support and the length of time staff spent with them. Prior to our inspection we had received some concerns from people telling us that they were not happy with the service because their calls were late or missed and that when their regular carers were not available at weekends or on leave they [person] did not know who would be attending the calls. For example, one person told us, "Today a carer came at 9am but others come at 10.30 [in the morning]. That's not too late. Tea can be anytime between 4 and 6pm. I've got used to it now. The only thing that niggles is like on Sunday the carer didn't come until 2pm. Something seems to happen at the weekends or Sundays. You think no-one's coming." A relative told us that they were not happy with the support and said, "Not very good. Never on time, they don't do their job." They went on to tell us that one staff member came at the time they requested but "When she is off it is chaos." This showed that the service did not always meet people's needs in a responsive way to provide care and support consistently in terms of times and; keeping people informed about which staff would be supporting them; particularly when their regular staff were not available.

People and their relatives were involved in agreeing and deciding their care needs. Relatives told us that someone from the service came out to talk to them and the person using the service, about what care was needed. One relative said, "They came out and met dad and me. They have done an assessment and care

plan and it's all in a folder. People told us that they had been spoken with by someone from the office regarding the support they needed. This showed that care was planned based on the information received from people.

The needs assessments seen were detailed and enabled the provider to plan a personalised service for each person, based on their diverse needs and wishes. Staff spoken with said that the care plans gave them clear instructions about how to provide individualised care for each person. A member of staff told us, "If needs change we would report it. They [senior staff] would ensure a review was carried out." We saw that where possible people's cultural and linguistic needs were matched with the staff that supported them. This ensured staff had clear information about the needs of each person and had the skills needed to enable them to provide a service that met people's needs.

Is the service well-led?

Our findings

During our preparation we saw that although safeguarding notifications were sent to the local authority for investigation we [CQC] were not always notified. During our inspection we further identified that some incidents should have been notified but had not been. After the first day of our inspection these were sent to us. On the second day of our inspection we were told about a incident that had been sent to us following a complaint from a relative however this particular incident had happened two months previous to our inspection and we had not been notified. This showed that the provider did not always notify us of accidents or incidents as soon as possible after they occurred to enable us to monitor and follow up issues if needed to ensure that actions had been taken to keep people safe. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents.

We saw that the systems in place to monitor the quality of the service did not effectively identify shortfalls in the service and enable actions to be taken to improve the service and sustain any improvements made. For example, people told us about missed and late calls. There was no system we were shown during the inspection that was effective at monitoring that calls were carried out at the times agreed with people and that enabled actions to be taken in a timely manner. Although there was an electronic monitoring system in place this was not working efficiently. On the first day of our inspection we were told that approximately 20% of staff were using the system. By the time of our second inspection this had been increased to over 40%. This showed that the way the system was being operated prior to and at the time of our inspection was not effective in identifying and following up on staff if a call had not been attended to.

During our visits to people the records we looked at showed staff did not always attend at the planned times and stay for the length of time requested and agreed with the individual. We looked at some staff rotas and noted that there were occasions when staff were rostered to be supporting more than one person at the same time. One person told us, "Some weeks ago, on a Sunday – we had to chase [call the office], they [staff] didn't come. Carers said there were not enough staff. She had calls for three people at 10am." We discussed this issue with the compliance manager who told us they were aware that this occurred sometimes with the electronic system they used for planning calls but staff were told which order they were to carry out the calls in. However, this showed that actions taken to ensure that staff were not booked to attend multiple calls at the same time.

We were told by the compliance manager that the daily records of care provided to people were audited to ensure they received care as planned. Some of the daily records we checked showed that the records did not reflect the actions required in the care plan. For example, one person was required to have daily skin inspections to prevent skin damage developing. The daily records we looked at stated that the person was turned regularly but nothing about the condition of the skin. The individual developed skin damage but the records did not reflect that the staff had recognised this or raised this issue with senior staff. We saw evidence in a safeguarding concern that the issue had been raised with other professionals however; we also saw that the senior staff were not aware of the issues until the safeguarding concern was raised. Other daily records showed that there were differences in times attended by staff but these had not been identified. This showed that the auditing of the daily records was not sufficiently robust to identify that they

didn't reflect the care provided or that calls were not at the times required. There were some spot checks on staff to check that they attended calls and they did on occasion identify when staff had not attended a call and we saw that follow up actions with the individual staff were undertaken.

We saw that there were systems in place to record accidents and incidents that had occurred. We looked at the incident log held by the provider and saw that although some incidents had been appropriately followed up and actioned we saw that one had not been fully investigated. This could lead to the required actions not being taken to prevent reoccurrence. For example, the records we looked at showed that the incident records were inaccurate as the wrong date had been recorded for the incident. We saw that on the day of the incident the records stated that the staff had attended for the tea call. However, the daily log recording showed that only two calls had been carried out that day and neither were the tea call. We saw that the morning call which should have been at 9am was not carried out until 11.10am and the lunch call that should have been carried out at 1pm was not carried out until 2.10pm. Although the provider was aware of the incident they were not aware of the discrepancies and had not followed up why the calls had not been at the appropriate times. This meant that shortfalls identified were not always followed up and addressed preventing reoccurrence.

There were mixed comments from people about how well the service was managed. Some people were happy with the service they received whilst others felt there were no issues with the care staff but the office staff were not responsive to their calls. There was a registered manager in post at the time of our inspection but people we spoke with were not able to identify the registered manager. One person told us that they were never told when a manager left or another was employed. People told us they were not always happy with the responses they received from the office staff and their calls were not always responded to. Some professionals had also commented that they found the service slow to respond to their requests for information. Staff spoken with told us that they felt that communication with them [the provider] had improved. However, the evidence showed that improvements were needed in the way people and other professionals were communicated with.

There was a registered manager in post at the time of our inspection but they were not available during the inspection. If a registered manager is away from work for a period of 28 days or more, or when the provider becomes aware that the registered manager will be absent for 28 days or more, the provider is required to notify CQC of the absence and how the service is to be managed in the interim. The compliance manager told us that they were aware that they needed to notify us of this absence and that at the time of our second visit on 3 May 2017 the 28 day period had been reached. At the time of writing this report we had not received this notification. However, an application to register a new manager had been submitted and received by the CQC registration inspectors before our inspection. This suggested that the provider was aware that the registered manager was no longer responsible for the day to day management of the service and had failed to notify us accordingly.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met. Notifications were not always sent as required and in a timely manner.