Ms Katrine Price

Quality Home Care

Inspection report

Lower Pendrill Court
Ermine Street North, Papworth Everard
Cambridge
Cambridgeshire
CB23 3UY

Tel: 01480839911
Website: www.carecambridge.com

Date of inspection visit:
08 July 2016
11 July 2016

Date of publication:
25 August 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Quality Home Care is registered to provide personal care to people who live in their own homes in the St Neots, St Ives, Huntingdon and Papworth areas. At the time of our inspection 74 people were receiving personal care from the service and there were 28 care staff employed.

This announced inspection took place on 8 and 11 July 2016.

The service had a registered manager in place. 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.

People were not always safe because risk assessments had not been completed to assess and minimise individual risks to people.

The provider's policy on administration and recording of medicines had not been followed, which meant that people may not receive their prescribed medicines. There had been no audits that would have identified issues with medicines management.

Staff had not reported incidents that affected people's health and welfare in line with the provider's policy.

People had their needs assessed and reviewed so that staff knew how to support them to maintain their independence. People's care plans contained person focussed information, but this information was not always sufficient, up to date or correct. This meant people could be at risk of inappropriate care.

There was a sufficient number of staff available to ensure people's needs were met safely. The risk of harm for people was reduced because staff knew how to recognise and report abuse. Staff were aware of the procedures for reporting concerns and systems and policies were followed.

The recruitment process to complete comprehensive and satisfactory pre-employment checks had not always been followed to ensure that only suitable staff were employed to work with people in their own homes. Staff were well supported by the registered manager and area manager through supervisions and staff meetings.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and report on what we find. We found that staff were trained in the principles of the Mental Capacity Act 2005 (MCA) and could describe how people were supported to make decisions.

People received care and support from staff who were kind, caring and respectful to them. Staff treated people with dignity and respected their privacy.

People knew how to make a complaint. The provider investigated any complaints and as a result made changes to improve the service for people.

The registered manager was supported by a staff team that included a regional manager, a care manager, two care co-ordinators and care workers. The service had an effective quality assurance system in place. People and relatives were encouraged to provide feedback on the service and their views were listened to and acted on.

We found one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was in relation to providing safe care and treatment as risk assessments were not always in place and medicines were not always managed in line with guidance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's safety and welfare were not assessed or managed.

Staff were not following safe practices when they administered or recorded medicines, which meant people may not receive their medicines as prescribed. Audits of the medicine administration process had not been undertaken.

The recruitment process had not always been followed to ensure that only suitable staff were employed to work with people in their own homes.

People were protected from harm because staff had an understanding of what might constitute harm and what procedure they should follow.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not reported incidents to the registered manager to ensure people's health and wellbeing were maintained.

Staff understood the Mental Capacity Act 2005 so that people's rights to make decisions about their care were respected.

People received care from staff who were trained and supported to provide safe and appropriate care. Staff knew the people they cared for well and understood, and met their needs.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were kind, caring and respectful.

People were involved in the decisions about their care.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in the assessment and reviews of their care. Care records had not always been updated when changes had occurred to people's health and wellbeing.

People and their relatives knew who they could speak with if they had a concern or complaint. A complaints procedure was in place and the registered manager investigated and actioned any concerns or complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager was not supported by the provider to undertake their role and responsibilities.

There was a lack of application of effective systems to monitor the ongoing quality of the service. This meant that any shortfalls in the service provided to people were not always identified and acted upon.

Quality Home Care

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 was planned to check 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 8 and 11 July 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection was undertaken by one inspector.

Before the inspection we looked at all of the information that we held about the service including notifications, which provide information about events that happen in the service that the provider is required to inform us about by law.

During the inspection we visited with four people who received the service. We spoke with the registered manager, the area manager and the external trainer. We also spoke with five members of care staff.

As part of this inspection we looked at records in relation to keeping people safe from harm and medication administration records. We also checked the care plans and risk assessments for nine people. We looked at records in relation to the management of the service including satisfaction surveys, complaints and meeting minutes.

We also contacted the local authority safeguarding team and local authority contracts department.

Requires Improvement

Is the service safe?

Our findings

The levels of risks to people were not managed effectively. The registered manager stated that there were no individualised risk assessments in place for people, even where there were risks that had been identified in the person's care plan. For example we saw one person had swallowing issues that would indicate a risk of choking. There was nothing in the person's file to indicate what staff should do if the person choked. In another person's file we saw that the relative who had administered medication to them had recently died. There had been no assessment of risk for the person who was now administering their own medication.

We could not be confident people received their medication as prescribed. The provider's policy in recording the administering of medicines and creams had not always been followed by staff. Gaps in medication administration records (MAR) had not been referred to the registered manager for investigation and she was not aware of these omissions. One person's medication was prescribed for evening administration but it was actually administered much earlier in the day. The registered manager said she had not contacted the person's GP to check if the medication could be administered so early in the day. The registered manager said that there had been no audits completed and therefore issues we saw during the inspection had not been identified or actioned.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had staff recruitment procedures in place but these were not always followed. Staff confirmed that checks that had been completed prior to their employment with the service. For example, a satisfactory employment history, Disclosure and Barring Service (DBS) check, (this check was to ensure that staff were suitable to work with people who used this service) and proof of previous employment. We saw that other identity documents including recent photographic identity and a declaration of their health status had been provided.

However, we found that one member of staff had worked on their own in the service before their DBS had been checked. The area manager was unable to find evidence that a previous DBS had been completed. We saw that in one member of staff's file that they had previously worked in social care with vulnerable people. However there were no references requested or satisfactory verification recorded in the interview to show why the member of staff's employment had ended.

People we visited managed their own medication. Staff told us they had training in medication administration and competency checks were completed by senior staff. The registered manager told us that staff competency in medication administration was checked when spot checks were completed in people's homes. We saw evidence in staff files that showed that medication administration was part of the spot checks. One member of staff said, "I've done my medication level 3 and I have [training] updates this week or next [in relation to medication administration]."

People told us they felt safe. One person said, "I feel safe. If they [staff] move me they are always very careful.

They [staff] tell me what they are going to do and explain it to me." We saw that, where necessary, people had their lifeline pendant to call for help in emergencies round their neck.

The area manager stated that all staff had up to date training in safeguarding people from harm because they were either completing a National Vocational Qualification (NVQ) in Care or had one prior to being employed by the service. The independent trainer confirmed that refresher training in safeguarding people from harm was available and showed us the new information that staff were being provided with.

Staff were able to explain the process to be followed if incidents of harm occurred. One member of staff said, "I completed safeguarding training in my induction. I would always report [any incidents of harm] if there were marks on people or if they seemed frightened. I would report in to the office [registered manager] and they would take it to social services [safeguarding team in the local authority]." Another member of staff said, "Safeguarding is if a client was in danger or there was physical or mental abuse. I would document in the log [daily notes], detail on a body map [of any injury] and pass the information on to [staff in] the office. The [staff in the office] would report it."

The area manager said, and records showed, that the service did not investigate safeguarding issues but referred them to the multi-agency safeguarding hub (MASH). The area manager had received information about one safeguarding concern from the local authority. This safeguarding investigation had been concluded and the area manager had taken action to ensure people were safeguarded from harm.

Staff were aware of the whistleblowing policy in the service and where to find all the necessary telephone numbers. One staff member said, "Whistle blowing is where I can pass on any concerns about staff. I know how to do that and who to go to. We all have the [phone] numbers [of people they can raise concerns with]."

People were satisfied overall with the level of care staff and told us there had been calls from the office staff if care staff were going to be late. One family member said, "They [staff] are usually on time and if they are running late they [office staff] usually let me know." One person said, "The regular carers [staff] are excellent, but it all falls apart if they go on holiday or go sick." Another person said, "Some of the carers [staff] come very late." The daily notes for one person showed staff were usually one hour later than the time expected and recorded on the care plan. According to the person this was because they (staff) believed the time of the call was different to that recorded on the care plan. People told us they used to receive a weekly rota which showed the name of the member of staff who would be providing their care. This was not currently being sent and people said things such as, "I've had ad hoc carers [staff]," "I don't know who's coming [to provide care]", and "At the moment I have regular carers." The area manager said that a new system will be in place soon so that people can have the information they want about who will provide their care.

Staff said they covered the care calls for people when staff were sick or on annual leave. The registered manager said she covered any care calls that staff were unable to pick up. This meant there were arrangements in place to ensure that people had their assessed needs met.

People told us staff used personal protection equipment (PPE) such as gloves and aprons when providing personal care. We saw that PPE equipment was available in the office and staff were able to come in so that they had sufficient to provide personal care to people safely. One person said, "They [staff] put gloves and aprons on [when assisting with personal care]."

Requires Improvement

Is the service effective?

Our findings

People told us they or their relatives usually made the necessary appointments for things such as GP visits, chiropody, eye tests and hearing tests. Staff told us that they would ring the emergency services when required and then inform the office staff (registered manager). One member of staff said, "I would dial 999 [where applicable] and only then would I phone the office." There was evidence in some people's daily notes that a GP or district nurse had been called. However staff had not reported any healthcare concerns or issues, which they dealt with in people's homes, to the registered manager. This meant that any changes in people's health were not monitored and referrals were not made when necessary.

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.

The registered manager and staff had an understanding of the MCA. The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests and in the least restrictive manner. All the people we visited or spoke with were able to make their own decisions. The area manager and registered manager said there was no-one who was not able to make decisions about their care needs or who would require a specific assessment under the MCA in relation to best interest decisions. However from evidence in one person's file we saw they had been confused. Staff had not reported it to the registered manager for her to check about any necessary changes in the person's care plan or to refer the person to the appropriate health professionals. The registered manager said she would take any action necessary.

We saw that staff understood people's needs well. This was by ensuring that the care provided was only with the person's consent, and the people we spoke with agreed that was the case. A member of staff told us that the MCA was, "in the service user's best interests of what they want. [By knowing a person] if they aren't able to tell you, you have a good idea of what they want and the choices they would make."

Staff who were new to caring told us about the five day induction training programme, which provided all the mandatory training expected by the provider. Staff who had care experience and had at least an NVQ Level 2 in care completed a one day induction which covered areas specific to the service. Staff confirmed that following their induction (whether it was five days or one day) they were supported with shadow visits (working with a more experienced member of staff). This continued until the registered manager was confident the staff member was able to do their job independently.

People were supported by staff who had the necessary skills and who knew the people they cared for well. Staff confirmed that their competency was assessed through observations in areas such as medication administration and moving and repositioning people. The external trainer for the service said training for

current staff was up to date. They also confirmed that new training in areas such as medication administration, safeguarding people from harm and moving and transferring people, would be through face to face training, completion of a workbook and competency checks of staff. One staff member told us, "I am due for my refreshers [updates of mandatory training] but am up to date. [Some of the subjects for refresher training are] in infection control, moving and handling [transferring], medication and safeguarding." There was evidence in records seen of the courses and training staff had undertaken.

People told us they felt the staff had the skills to be able to provide their care. One person said, "The new carers [staff] sometimes come with another carer [member of staff] or [name of registered manager] who knows what to do. The regular carers [staff] know what I need." The person went on to say that the staff had been trained how to use the equipment needed to provide safe care.

Staff told us that they received regular supervision and a yearly appraisal. One staff member told us, "I get supervision and have had one recently." The service had access to private rooms so that supervision and appraisals could be discussed in private.

People told us they were supported with their meals if needed and they were able to choose what they ate and drank. One person said, "Yes, they [staff] ask me what I want to eat and then cook it for me. It's frozen meals. They make sure I've got some drinks [available]."

Good

Is the service caring?

Our findings

People told us that the staff were caring and kind. People said things such as, "They're [staff] wonderful." Another person said, "My new carer is marvellous." The person went on to explain that the staff member had gone out of their way to provide an early call when the person had a hospital appointment that meant they had to leave their house very early.

People told us that they had a good relationship with the regular staff who provided their care. One person told us, "I know they [staff] focus on me and they always ask if there is anything else I need." However, people said that when their regular carer was on holiday or off sick they felt the care was "slapdash" and "we have to show them [different staff to the regular staff member] where everything is and what to do". One staff member said, "All the staff are really close to the service users [people] and we have a chat [if there is time]. We don't just do what we need to do."

People were able to express themselves and state how they wished to be cared for. People were also supported by their relative who would speak up for them where necessary. The registered manager said that, if necessary, an independent advocate would be sought to help anyone if they wanted it. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

People told us staff treated them with dignity and respect. One person said, "Yes they [staff] do [treat me with dignity and respect] by covering me with a towel to cover me and keep me respectable."

Staff told us how they ensured people's privacy and dignity by closing the curtains, keeping doors closed and covering people when providing personal care. They told us how they involved people in their everyday decisions about their care and how they provided choices to them. One person said, "They [staff] know what to do [to maintain dignity and respect]." People told us they had not been asked if they preferred a male or female member of staff to provide their personal care. The area manager said if people requested a specific gender the service would try to meet their request. One person said they had not been asked about male or female staff members but were happy with male staff providing their care. They did however, comment that that they should have been asked before sending male staff to provide personal care to females.

People told us they were encouraged to be as independent as possible. One person said, "[Name of staff member] has encouraged me to the point I am now confident to get into the shower on my own."

Requires Improvement

Is the service responsive?

Our findings

People told us that an assessment of their needs had been carried out before the service started. Care plans had been produced from the assessment, which had been discussed and agreed with them. One person, with their relative, said, "They [staff] asked us what we wanted." However, we saw that there was not always sufficient detail in a person's care plan. For example there was no information that showed how much the person could do for themselves.

Three people said that they or their relative had been involved in developing and reviewing their care. We went through the care files with people and they confirmed that the care plan information was correct. However, we saw information that was not always current. Information in one person's file had not been updated about their main family carer, which had an impact on their care. Staff told us they reported any changes when they provided care, but that was not what we found. However, staff were able to tell us about the people they were caring for and how they supported those people in their own homes. One member of staff said, "I always ask people what they want me to do." Information in the staff meetings records showed that people's care and support was discussed so that staff were kept up to date. Care plans we checked in the office showed that there was no documented evidence that people or their relative had been involved in reviews.

Staff were very clear that people made choices about all elements of their care. One staff member said, "We ask them [people] the food they want us to prepare, what they want to wear and we always check with them." One person said, "They [staff] help me [with areas of care] if I need it." A relative told us that staff always asked their family member about every element of their care so that they [family member] could make their own choices. These were examples such as what to wear or when to be supported with personal care.

There was a complaints procedure in place so that investigations and action taken could improve the service. There was information on how to make a complaint about the service found in people's homes. This included telephone numbers of agencies that people could contact outside the service such as the local ombudsman or CQC. The area manager said that people could complete on line complaints if they wished. There were details of the telephone numbers including the out of hour's number when the office was closed. People we spoke with were aware that they could complain and to whom, such as the registered manager. One person told us that they had complained about a member of staff that they did not get on with very well. They said the company listened to them and replaced the staff. The person said, "I never saw [staff member] again". Another person said, "Oh yes I do [know how to make a complaint], but I haven't needed to."

We saw that the registered manager had not followed the providers' policy for logging issues of complaint. However, there had been investigations made by the registered manager and actions put in place where necessary. Where necessary there was evidence that staff had received written or verbal warnings or had been dismissed. Concerns raised by the local authority had been discussed and action taken where appropriate.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led. There was a registered manager in post at the time of the inspection. Although the registered manager understood their responsibilities they did not have the support systems in place to enable them to demonstrate good management or leadership within the service. The area manager said that a new deputy and senior had been advertised to enable the registered manager to undertake all the necessary processes and tasks in relation to their role.

Staff said they could always talk to the registered manager when she was available. One member of staff said, "[Name of registered manager] is fine and fair. She is very approachable and helps where she can." Another member of staff said, "The [registered] manager is really nice. I love the whole team. We can pop into the office at any time." Another said, "[Name of registered manager] is fantastic. She's got time for everyone. It doesn't matter if the issue is outside of work. She's always out working [providing care to people in their own homes]." However, the boundaries between the staff and registered manager were blurred because of the level of time the registered manager spends providing personal care to people.

People and their relatives said they were comfortable to telephone the staff in the office but some commented that there had been times when the telephone had not been answered. The registered manager said there was an out of hour's system with on call staff and that people had all the telephone numbers available. However, one relative said, "I have rung but there was no reply. I'm not sure if they have an answer machine but when I phoned I couldn't leave a message. Although another person said, "If the carer [staff] is late I get worried and I phone the office. I can always get hold of them." The area manager said that the on call system automatically diverted calls to the on call manager if the office was not manned. During the day we found that the telephones have an answer machine, which we tested after the inspection dates.

There was a system for monitoring the quality and safety of the service people received. However the system was not robust and this meant that there was a risk that areas for improvement would not be effectively identified and actioned.

The registered manager said there had been no audits completed and this meant they had failed to identify a number of issues in the service. For example reports of information about incidents had not been recorded and had therefore not been referred to the appropriate authorities to keep people safe. We saw that there were no audits for medicines administration, care plans or care reviews. This also limited the provider's ability to respond to situations as effectively as they could have.

The registered manager told us that there was a system of spot checks to observe the care provided by staff every three months or when required. Staff confirmed this to be the case. People could not remember having had a visit to discuss the quality of their care but said they did not have any issues about the service or the care staff.

The area manager said every person in the service was sent a questionnaire in January 2016 to check the

quality of the care being provided by the service. One person said they were not aware of the outcome even though they had completed the questionnaire. A report had been written and we saw that one action to be taken was that telephone surveys would be introduced for the next quality check. This was because so many people stated they were never contacted about their care. However there was little information about specific areas surveyed or the impact on people. From the information in the report the 'surveys are analysed and presented at the relevant company meeting' but there were no actions or comments from people or what they said about the service.

People told us they knew how to contact the service if they needed to speak with someone. All staff said they would feel confident about reporting any concerns about poor practice to the registered manager or area manager and that action would be taken where necessary.

All staff told us there were regular staff meetings. Minutes from the meetings showed that information to improve the service, new documentation to be completed, updates on individual people being cared for and new policies were provided. One staff member said they attended the staff meetings and they felt they were useful and used to discuss areas, provide information on changes to people as well as any training that could be suggested. Staff also said they were listened to and responded to about the care they provided and this helped them to improve people's care. One staff member said, "Everyone [all staff] has got something to add to the service." They told us they had made a suggestion, which was immediately taken on board.

Although there had been no notifications from the service, in our discussions with the registered manager she was aware of when to inform the Care Quality Commission (CQC) if required. A notification is information about important events that the provider is required by law to notify us about. This showed that the registered manager had an understanding of their role and responsibilities.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. People's risks of choking, falls and moving and transferring were not properly assessed and managed. Care and treatment was not provided in a safe way. People's risks of choking, falls and moving and transferring were not properly assessed and managed. Although there were policies and procedures in relation to the management, administration and recording of medication, staff had not followed them. Regulation 12 (1)(2)(a)(b)(g)