Surrey Homecare Limited

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Inspection report

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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?	Inadequate

Summary of findings

Overall summary

Surrey Homecare is a domiciliary care agency. It provides personal care and live-in care to people living in their own homes in the community. It provides a service to older and younger people some of whom may have a physical disability. At the time of our inspection the service provided a regulated activity to 100 people.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the previous inspection in February 2018 we found that incidents and accidents were not always analysed and that that the management of medicines was not always safe. We found that training and supervisions were lacking for staff and that staff were not staying for the full length of the call. There was a lack of robust quality assurance in place. At this inspection we found improvements around how incidents were analysed however that had not been sufficient improvements in the other areas. We found that the service continued to breach regulations.

Medicines were not always managed in a safe way, which put people at risk. Medicines audits were always being undertaken and where they were they did not always identify the shortfalls. However, people did say that they received their medicines when needed.

Staff had not all received the training and supervision necessary to carry out their role. Robust recruitment checks had not taken place before staff started work, which put people at risk. There were insufficient levels of staff to support people. Staff were not given travel time between calls which impacted on the amount of time they needed to spend at the call. People fed back that staff were not always spending the full time with them. We have made a recommendation around staff levels and allowing travel time between calls.

The principles of the Mental Capacity Act 2005 were not being followed and staff lacked an understanding of when assessments of capacity needed to take place. Some care plans lacked information on people's backgrounds and interests. We have made a recommendation around this. Other records relating to people's care were person-centred and care plans included detailed guidance for staff to follow.

Quality assurance was not robust and had not identified all of the shortfalls we identified. Audits did not have action plans in place to ensure that any shortfalls they identified were addressed. The provider had not met the warning notice in relation to this from the previous inspection.

People felt that staff understood the care they needed to deliver. Staff worked with healthcare professionals to ensure that people were supported with the healthcare needs. This included being supported with their food and hydration needs.

People told us that they felt safe. Relatives felt that their family members were safe with staff. Staff understood what they needed to do to protect people from the risk of abuse. Risk assessments were in place for people and staff were aware of how to reduce risks. Staff followed good infection control procedures. Accidents and incidents were recorded and analysed to look for trends. In the event of emergency there were plans to in place to ensure that care delivery was not impacted.

A full assessment of people's needs took place before people started using the service. Staff understood people's needs and were effective in communicating changes in people's care. People were supported to access the community.

People and relatives felt that staff were kind and respectful. Staff supported people's independence and included them in any decision-making about their care. People told us that they felt involved in their care. People and relatives developed positive relationships with staff.

People understood how to make a complaint. Complaints were investigated and actions taken to resolve complaints. People and staff provided positive feedback around some aspects of the running of the service. Staff said they felt supported and valued.

The service worked with other relevant agencies such as the Local Authority and health care professionals. The registered manager ensured that notifications were sent to the CQC where necessary.

The overall rating for this service is 'Requires Improvement' however on two consecutive inspections the service has been rated inadequate in Well Led. The service therefore has been placed into 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 consistently safe.

Medicines were not always managed in a safe way. People however did say that they had their medicines when needed. Food and fluid records were not always completed accurately.

There were insufficient numbers of staff to meet people's needs. We have made a recommendation around this.

The provider had not carried out appropriate checks on new staff to ensure they were suitable before they started work.

Care plans were in place to manage risks to people. Where accidents and incidents occurred, staff responded appropriately to reduce further risks. Improvements were needed in relation to the recording of these.

Staff understood how to respond to suspected abuse. People told us that they felt safe. Staff followed best practice with regards to infection control. In the event of an emergency, appropriate plans were in place ensure people continued to receive care.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs and choices were not assessed in line with best practice. Staff did not understand the principles of the Mental Capacity Act. MCA assessments were not always undertaken where needed.

Staff were not always sufficiently trained to carry out their roles. Staff had not always completed their induction and had not had regular one to one meetings with their line managers to discuss their work.

People were supported with their meals in line with their dietary needs and preferences. Staff worked with healthcare professionals to meet people's needs.

Before people started to receive the care a full assessment of their needs took place.

Is the service caring?

Good

The service was caring.

People were treated with care and consideration by staff. Staff treated people with respect and dignity and ensured their independence was maintained.

People had developed good relationships with their care workers

People were able to express their opinions about the service and were involved in the decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not always reflect people's needs and interests. End of life care planning was not always in place. We have made a recommendation around this.

Care needs contained other detailed guidance around the care that needed to be delivered.

There was a complaints policy in place that was accessible to people. Complaints were investigated and responded to.

Is the service well-led?

Inadequate

The service was not well- led.

The provider continued to breach regulations from previous inspections. A warning notice from the previous inspection had not been met.

There was not adequate management and leadership at the service.

Audits were not robust or always used as an opportunity to make improvements.

People and staff felt that there were aspects of the running of the service that were effective.

The staff at the agency worked with organisations outside of the

service to support people's care.

Notifications were sent to the CQC where appropriate.

Surrey Homecare Limited

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 was a comprehensive inspection and was announced. We gave the service 48 hours' notice of the inspection visit because we needed the registered manager to arrange visits for us to people's homes with their permission. We also needed to be sure that the registered manager would be in the office.

The inspection site visit activity started on 29 September 2018 and lasted one day. It included visiting five people living in their homes. We visited the office location to see the registered manager and office staff; and to review care records and policies and procedures.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

In addition to visiting five people in their homes we called and spoke with 15 people and two relatives. At the office we spoke with the registered manager, the Nominated Individual, and three members of staff. We spoke to five members of staff in people's homes. We read aspects of care plans for 10 people, medicines records and the records of accidents and incidents, complaints and safeguarding. We looked at records of audits and surveys.

We looked at records of staff training and supervision. We looked at a selection of policies and procedures and health and safety audits. We also looked at minutes of staff meetings and evidence of partnership working with external organisations.

After the inspection we called and spoke with a further four members of staff.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in February 2018 we identified that accidents and incidents were not always being monitored or analysed for trends. We found on this inspection that this had improved. However, on the previous inspection we also found that the management of medicines was not always safe. This continued to be a concern on this inspection and we found that sufficient improvements had not been made.

People and relatives fed back that they received their medicines when needed. One person said, "If I'm not sure about a tablet he [staff member] can always tell me what it is and what it's for." Another person said, "They help me to take my medicines and they are all written up in a book."

However, despite this feedback we found that medicines were not always managed in a safe way, which put people at risk. Medication administration records (MARs) were not always recorded according to NICE (National Institute for Clinical Excellence) guidelines. If a MAR is handwritten there must be a robust system to check that the MAR is correct before it is used. We found that prescription medication had been hand written on to all of the five MAR charts that required two people to sign that they had checked the information is correct. However, we found no evidence of the happening. There was not always detail regarding how many times medicines should be administered each day. There was no PRN in place for people that were unable to communicate when they were in pain. There were people they may not always be able to indicate when they required pain relief. There was not always information on the MAR of people's allergies or GP details.

Dosage information on how medicines should be administered was not always clear. There were gaps on the MARs and it was not clear if the person had been offered the medicine and refused or not offered it at all. There was no guidance for staff for people that had time critical medicines, for example for people that are living with Parkinson's disease. Staff had not received competency assessments prior to administering medicines and medicines training was out of date for a number of staff. One member of staff told us did not could not remember having a competency assessment to test their knowledge of administering medicines.

People's nutritional and hydration risks were not always managed safely. Where people were having their food intake recorded staff were not always analysing or recording accurate information. For example, we were told by a member of staff that two people were at risk of malnutrition. We reviewed the food and fluid charts for both. Staff were inconsistently recording information on what they had eaten. At times staff were writing the type of food the person was offered but not whether the person had eaten it. Staff had not recorded the amounts of drink and food people had eaten and drunk and at times were just recording 'All' in reference to what they had consumed. This meant that staff were not analysing the information appropriate to ensure that the person had eaten and drunk sufficient amounts.

As medicines continued not to be managed in a safe way and people's nutritional and hydration risks were not always recorded and analysed appropriately this is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a risk to people as the provider had not ensured that all new staff were thoroughly checked to make sure they were suitable to work for the service. The registered manager told us that two references were required from staff before they started work. Of the five files we looked at, three had only one reference in place. One member of staff had been dismissed from their previous employer however no action had been taken to establish why they had been dismissed. There were gaps in the employment for another member of staff that had not been explored by the provider. There was a risk that a member of staff had not divulged all their previous employments.

Other documents that had been obtained included checks with the Disclosure and Barring Service (DBS.) The DBS checks people's criminal history and their suitability to work with vulnerable people. Health questionnaires and proof of identity were provided by staff.

As robust recruitment checks had not taken place before staff started work this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks were managed effectively. Incidents and accidents were recorded and action taken to reduce the risks of incidents reoccurring. Since the last inspection the provider had implemented a central recording of all accidents and incidents. These were colour-coded into geographical areas and gave detail of the incident, the immediate action and on-going action. For example, one person had been supported to clean their face with an anti-bacterial wipe which had led to a skin reaction. As a result, longer handovers between staff had been planned to discuss the person's care and what actions they needed to take to prevent further occurrence.

Risks to people were assessed and measures to enable people to live safely in their homes were recorded. Risk assessments included the risks associated with people's homes and risks to the person using the service including catheter care, moving and handling, falls and skin integrity. For example, one person was at risk of falls. The person's care plan stated that staff should ensure that equipment was checked before use and that two members of staff were always present when transferring the person. We saw that this was in place. Staff understood the risks to people and would update the team leaders if they noted any changes. One member of staff told us, "If I saw someone's mobility going downhill I'll always report it so their risk assessment could be reassessed. Ongoing risk evaluation, really."

We asked people if they felt safe in their homes with the staff from the service. People told us that although they felt safe with staff they did not always know who was going to be attending to their care due to there being a shortage of staff. One person told us, "I'd like a regular person but there are never enough." Another told us, "People [staff] vary and I have my favourites but nobody is unkind."

There were not always sufficient staff to ensure that all aspects of the business were carried out. There were four team leaders working at the service whose primary role was to write and update care plans and risk assessments and assess new clients. In addition, they had to undertake supervisions for staff, spot checks, one to one meetings with staff and create the staff rotas. However due to care staff shortages, partly as a result of annual leave, the team leaders and the registered manager had been providing care to people, which took them away from their primary roles. One member of staff told us, "At the moment 100% I cannot deliver." The registered manager told us, "If I'm not here in the office I'm not able to update policies or sit down with team leaders. The problem is the lack of staff and that's why we're trying to offer the permanent rates." The provider stated they also experienced difficulties with recruitment due to their proximity to London where wages are higher. To mitigate risk, they had taken the decision to offer some staff permanent contracts at competitive rates and move away from zero hours contracts. They confirmed another five staff members were due to start.

The provider advised us that, due to staffing concerns, they had told team leaders not to accept new clients unless, "They could fit them in easily." The meant that staff were not always able to get to people when they were expected. One person told us that they often let their care worker leave early as they knew time was tight for the care worker to get to their next call.

The provider and registered manager acknowledged that there were times when travel time could not be factored into the rotas due to staff shortages. This meant they were knowingly taking time from people's support. We reviewed the times that staff were arriving at and leaving people's homes and found that there were many occasions where staff were not staying for the full length of the call. For example, one person's call was expected to be 45 minutes long. The member of staff stayed for 25 minutes. Another call was expected to be 60 minutes long however the member of staff stayed for 44 minutes. There was nothing in the notes from the member of staff that they had been asked by the person to leave earlier than planned. However, we also noted that no calls had been missed for people needing care.

After the inspection the provider confirmed that all team leaders had been taken off care duties so that they could continue with their supernumerary work. They also confirmed that they would not take on new clients until they had sufficient care staff to meet the person's needs. They said that travel time would also now be incorporated into the care staff rotas. Calls made to staff after the inspection confirmed that this had been implemented. One told us when asked if travel time had been included in their rota, "I'd say in the last couple of weeks. There was not always enough travel time before this." They told us that prior to this they started their working day 15 minutes early to get a head start. They said of the increased travel time, "It's made life a whole lot easier."

We recommend that the provider continues to ensure that there are sufficient staff to meet the needs of people using the service and that people receive the full length of their call.

Staff had a good understanding about safeguarding and the procedures to be followed should they suspect abuse had taken place. Two staff told us what action they would take if they noticed bruising on a person. One member of staff told us, "I would report it and fill in a body map, especially if it was unexplained. If the office didn't do anything I could go to Social Services. "Another member of staff said, "I would write an incident form and write it in the notes." An out of hours number was printed on people's care plans so that they were able to call the service in the event of an emergency.

Staff understood what they needed to do to reduce the risks of spreading infection. Staff wore gloves where needed and people confirmed that staff washed their hands regularly. Staff had access to protective equipment such as hand gels, gloves and aprons when they needed them. We saw a member of staff wearing gloves when supporting the person with their care. One member of staff said, "We use aprons and gloves. I always make sure I have plenty of stock of gloves. I'm constantly washing my hands and use hand gel."

In the event of an emergency the service had measures in place to ensure people were kept safe. If there was inclement weather, staff would prioritise those people that were isolated or did not have any other support. There were electronic systems in place that secured people's records if staff were unable to access records from the office.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in February 2018 we identified that the correct legal procedures in relation to the Mental Capacity Act 2005 (MCA) were not being followed and there was a lack of understanding by staff of the principles of MCA. At the inspection we found that this had not improved.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. Some people who used the service lacked capacity to make decisions in relation to receiving care. There were no MCA capacity assessments in place for these people or any evidence of best interest decisions. Where relatives were signing consent for people there was no evidence that the provider had obtained documentation from the relatives to show that they had authority to consent on their behalf.

At the last inspection we identified that the correct legal process had not been followed where a person had been administered covert medicines (without the person's knowledge). This had still not been addressed appropriately. We were told by the registered manager that staff were still giving the person their evening medicines covertly and that that this was done on the advice of the person's GP, who had stated that the person lacked capacity. There was no evidence of an assessment around this decision or evidence of a best interest meeting. The registered manager told us they were not sure whether the medicine was actually being given covertly as they thought the person may be aware that the medicine was being placed into a drink. The care plan was unclear as to whether the person was in fact having the medicine covertly or if in fact they chose to have the medicine in this way. Appropriate actions had not been taken by the registered manager to ascertain this and there was still a risk that they person's rights under the MCA were being restricted unlawfully.

The failure to follow the correct legal process as outlined in the MCA was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in February 2018 we identified a breach in relation to training not being kept up to date with staff and staff supervisions were not always being done. At this inspection we found continued concerns in these areas.

We found that people were not always supported by staff that had undergone a thorough induction programme which gave them the skills to care for people effectively. The registered manager told us that all staff were expected to undertake an equivalent to the Care Certificate [an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff working in health and social care] unless they already had a similar qualification. They said, "We do the Care Certificate but we do our own version. We've used the standards and record if they've done the training and competence. Team leaders and buddies sign them [staff] off." However, when we reviewed the records we found that this had not been completed for 10 new staff who were providing care to people.

The registered manager told us that the lack of evidence regarding staff completing the equivalent to the Care Certificate was due to staff only having to complete it if they were new to care. They said that if they had a previous qualification they did not need to do it. We checked the files of four new members of staff and none of them contained evidence of previous qualifications. The service policy stated that within the first six weeks of the member of staff starting at the service they needed to have completed a full induction programme. They were not always working to their own policy in relation to this.

Care staff had not always received appropriate support that promoted their professional development and assessed their competencies. The registered manager told us that all staff received spot checks of the care that they were providing. However, these were not always taking place. One member of staff told us that they had worked for the service for over two years and had never had a spot check. Staff were also not having one to one meetings with their manager. One member of staff said, "I was due to have one a couple of months ago but it got cancelled. I don't know the reason why it was cancelled. We're supposed to have them about once a year I think." The team leaders told us that staff should receive four observation supervisions and four spot checks per year and two one to one meetings with their manager. According to the training matrix seven out of 44 staff had not received any spot checks this year and 10 staff had not had a one to one supervision with their manager. Fifteen staff had only had one meeting with their manager this year. This meant that there was a risk that new staff were not providing the most appropriate care as checks were not being undertaken. The team leaders told us that supervisions had been lacking due to them having to undertake care work.

Staff were not always sufficiently qualified, skilled and experienced to meet people's needs. Staff we spoke to were complimentary about the training that they received. One told us, "Fantastic. I did training and shadowing and it was only when I was ready I went out on my own. The first time I was caring for someone who needed hoisting, I asked if I could have refresher training on this and this was organised for me the next day." However, we reviewed the training records and found that staff not always received updated training or, in some cases, relevant training in specific areas. For example, 10 staff had not completed refresher safeguarding training within the last year and two had not received any safeguarding training. Three staff had not completed any medicines training. We found that 11 staff had not completed moving and handling training and there were other staff that not received this training since 2014. There were 17 staff that not received any training around dementia despite their being people with this diagnosis. The registered manager told us, "We are sending two courses out each month to get people up to speed." We asked if staff completed practical training for moving and handling. They told us, "They've [staff] come in to do that. Maybe we should record it."

As staff were not always appropriately trained or supervised in their role this is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff monitored people's health and liaised with relevant healthcare professionals to ensure people received the care and treatment they required. One person told us, "I went to the doctor yesterday. The carers are very good at going between one pharmacy and another to get what I need." Another person said, "I am going downhill and they have to see how well I am on a day and adjust what I need help with. They are very supportive but know when it's a bad day." A third person said, "Twice they [staff] have needed to call the doctor. I tell them I feel unwell and usually it's obvious to them – they know what they are doing."

One member of staff told us, "He [the person] is prone to UTIs [urinary tract infection]. I recognise the signs and will just call the GP straightaway." One person said, "I needed a carer to come to a hospital appointment as I couldn't drive at that time or push a wheelchair. They were able to send someone who was a great help."

Other than the concern identified with the food and fluid charts not being completed accurately, people were supported and encouraged by staff to ensure that they ate and drank sufficient amounts. We observed a member of staff making a person's lunch and ensured that the person had a choice of what they wanted. The member of staff told us that they person had not wanted their usual meals and as a result they made salads or sandwiches for them. One person told us, "They [staff] will sometimes make a sandwich and I always have bottles of water."

People's needs and choices were assessed in line with current best practice. Prior to using the service, detailed assessments took place to ensure staff could meet people's needs. Once a referral had been received from the person or their representatives, team leaders would complete an assessment on the person and on the home environment. They then came back to the office and checked that the times requested could be fitted in prior to accepting the package of care. The registered manager told us, "Team leaders do introductions to staff. New staff go to shadow every person in their area so they never go in blind." We found that this was taking place.

Good

Is the service caring?

Our findings

People and relatives were complimentary about the caring nature of staff. Comments from people included, "They've [staff] all been very good", "I am very happy with my carers and I hope that comes across", "I enjoy our chats" and, "She's [member of staff] so kindly. Am I allowed to say bloody marvellous?" One relative told us, "They [staff] have a wonderful manner. One gives [family member] a peck goodnight as she settles him into bed and that calms him and he always settles well." Another relative said, "We have one principal lady [member of staff] who is excellent and when she's off she says who should stand in. She knows who would suit my wife. They are delightful."

People and relatives valued their relationships with the staff team. One person said, "They [staff] have taken time to get to know me without seeming to be intrusive. That's a skill." Another told us, "My husband is here too and she [member of staff] always includes him. I am amazed that she remembers when he goes to a special interest club and she always asks him if he had a good day. He is part of my equation and that is never forgotten [by staff]." A relative told us, "'I have found that it's not just a job [to the staff]. They make us both feel comfortable about having care as it's all new to us."

During the home visits to people we observed staff to be kind and encouraging to people. For example, we overheard staff talking to a person whilst they were being hoisted. They did this by being clear with the person about what was about to happen saying, "We're going to lift you up now [person]. You can cross your arms or hold on to the straps, whatever you prefer, whatever makes you feel safe." They encouraged the person by saying, "One, two, three, here we go, that's great, well done [person]." We could see the person appreciated this.

Staff knew people really well and clearly had a good relationship with them. They shared conversation, jokes and laughs. One person told us that the staff were, "Marvellous." They said they were happy with the agency because they provided good care workers, which was the most important thing. They said, "It's the niceness of the ladies [staff], that's what it comes down to." We saw in one person's home that a member of staff showed concern when the person told them they had been to the doctor. The member of staff listened intently and showed empathy. There was a very friendly, relaxed relationship between the two of them.

People were treated with respect and dignity. One person told us, ""They (staff) always ask me what I want." Another told us, "They [staff] make a real effort to check that I have understood them and that they are understanding me. It's never been a problem." We saw that staff provided personal care behind closed doors and knocked on people's bedroom doors before entering. One member of staff said, "I treat them the way they would want to be treated. Doors shut, curtains closed and make sure they are covered adequately during personal care. I make sure all of their requests are being met." A relative said, 'It's very important to me that my wife is treated well and they are all great and include my wife in conversations and just generally."

People told us that they felt involved in their care and that staff supported them with their independence. "Carers make meals for me but I can cook myself too." They told us that staff supported them with this.

Another person said, "I choose what to wear or we do it together." A third told us, "[Staff name] takes such care to check that I understand her. She is a lovely, vibrant girl." A third told us, "If there's something they do that I moan about, they say they are helping me to keep my independence. It's a byword of theirs and I might fight it but I do appreciate it." One member of staff said, "If I'm making their lunch I encourage them to join in. Or for example, [person's name] will go one side of the bed and I'll go the other and we'll make the bed together."

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in February 2018 we identified that improvements were required with care planning to ensure that they were person-centred and specific to people's individual needs. We made a recommendation around this. At this inspection we found that there were still improvements required in this area.

Care plans did not always contain specific information on the person they were supporting. For example, the care plan for one person who had seizures did not describe the type of seizures the person had or give clear direction for staff on what they needed to do if a seizure took place
There was limited information on people's backgrounds, such as their work histories, particular interests or hobbies. This information can help provide responsive and personalised care to a person. There was also a lack of planning around people's end of life care in the event that this was needed. At the time of the inspection no person was receiving end of life care. We fed this back to the registered manager who told us that this would be addressed.

We recommend that the provider ensures that care plans are personalised, that end of life care is considered and that detailed guidance is included where a need has been identified.

There was however other detailed guidance in the care plans on the specific care that people required. There was information on how people communicated, their mobility, skin integrity, continence, personal care and nutritional needs. Each care plan detailed what staff needed to ensure when providing people's care and how people's conditions presented themselves. For example, one care plan stated, "My muscles tighten in my hands and arm. Carers to help stretch them as it limits my ability to use my light-writer." There was guidance for staff on how they should do this. We saw from another care plan that a person became anxious at night and there was guidance for staff on how best to reassure the person. If people used wheelchairs, there was information for staff on where to place cushions to reduce the risks of pressure sores. Where people were unable to verbally communicate, there was guidance in place to assist staff in understanding people's gestures.

Staff told us that they were aware of people's needs before they provided care to them. One member of staff told us, "[The team leader] always pre-empts our first visit to someone. She will let us know about the call and what is needed. When I get there, I read the care plan and read all about them. If there are any changes to someone's needs we communicate with each other." Daily notes were recorded electronically and included information on how the person was, what care had been provided.

People's care was adjusted based on how they would prefer their care to be delivered. For example, one person told us that they did not like being taken shopping in the agency's cars and with staff wearing uniforms [the car and the uniforms both bore the company name and logo]. They had mentioned this to the agency who had made sure that staff used their own cars and wore their own clothes when supporting the person to go shopping. One relative said, "I was going out and I needed the carer to give [their family member] his lunch. I needn't have worried as they were very happy to so that I could have some time. It

meant that I was able to relax and not be on edge. They seem to be very adaptable."

Complaints and concerns were investigated and recorded with the actions taken. We asked people and relatives if they knew how to complain and how the agency had responded if they had complained. One person told us, "I have complained about the rotas. They reacted well and are trying to sort things." Another told us they had never needed to complain, but there were telephone numbers on the booklet in the house that they could use. We saw examples of complaints that had been investigated and responded to. For example, one person stated that they preferred a different member of staff due to a personality clash. The member of staff was changed for this person. One member of staff told us, "If someone wanted to complain I would advise them to phone the office."

Inadequate

Is the service well-led?

Our findings

At the previous inspection in December 2016 and February 2018 we identified that there was a lack of robust oversight of the service. Some audits were not being carried out and those that did take place did not always identify concerns effectively. At the inspection in February 2018; as a result of the continued breach of Regulation 17 of the HSCA we issued a warning notice. We found at this inspection that the warning notice had not been met and there continued to be a lack of robust oversight of the service.

After the last inspection in February 2018 the provider sent us an action plan which stated that all of the shortfalls had been addressed by May 2018. The action plan stated that mental capacity assessment forms and best interest forms had been introduced. It stated that people's medicines records would be audited more closely and that staff would be provided with all necessary training in all aspects of care. We found on this inspection that these actions had not all been implemented and that there had been a deterioration in the oversight of care delivery by the registered manager and provider. At this inspection we have identified continued breaches of regulation in relation to the safety of care, staff training and supervision and MCA capacity assessments and a further breach that related to recruitment. Recommendations that were made in February 2018 in relation to travel times and person centred care had not been addressed at this inspection.

The provider's stated objectives were, "To manage and implement a formal programme of staff planning, selection, recruitment, training and personal development to enable service user care needs to be met." The provider was not always meeting this objective. For example, people fed back to us that they did not always know what member of staff was attending the call. One told us, "It irritates me if someone comes who I have never met as I have to show and tell them what to do and that eats into the short time that we have." Another person told us, "They don't stick to the rota, neither times nor person and that's if I get one [a rota]." A third told us, "If there's a change in the rota they should tell you but they don't." A fourth said, "The office call if someone is going to be late but they don't call if there is a change in the rota and that can throw me. I look forward to certain people coming and then am disappointed."

People and their families were asked for their views of the service being provided, however improvements were not always made as a result. When we reviewed the responses of an April and May 2018 survey, we found that comments were made in relation to staff being rushed and not staying for the full length of the call. One person stated, "I understand that you do not provide for travel time between calls. This does not make it easy for carers to be on time." Another stated, "I would like the carer to give an extra 5/10 minutes instead of dashing off quickly to dash off to the next patient." This had still not been resolved when we inspected and there was no action plan to address this concern.

The provider had failed to take steps to ensure there were sufficient numbers of staff to support people before new care packages were taken on. This, combined with staff absence through annual leave and sickness, had impacted on the delivery of care. Team leaders who would ordinarily undertake care work were having to deliver care which was impacting on the work they needed to undertake including observational supervisions with staff and one to one meetings with staff.

The registered manager told us that they had started to use an electronic system to monitor the arrival and departure times of staff. An alert would be sent to team leaders by email if no one arrived for the call. We asked the registered manager how this was checked at the weekend and they told us that team leaders were expected to check their emails when they were off duty. There was no system in place for the emails to be checked when the team leaders were on annual leave. There was also no analysis of the electronic tracking to ensure that staff were staying for the full length of the call. We identified several occasions where staff had not stayed for the full length of the call however people were still being invoiced for the full call time. Staff were also able to log that they had arrived at a call without actually being at the person's home . This meant that there was a risk that the information that staff were at the call may not be accurate.

An analysis of the electronic system showed that there were occasions staff were logging that they had left a person's home and arrived at another call at the same time. This meant that the system was not always accurately reflecting the length of time staff were staying at a call. This had not been picked up by the registered manager or the provider at the time of the inspection.

Staff meeting minutes showed that the registered manager and the provider were not proactive in addressing the current shortfalls with staff shortages. In a meeting on the 19 September 2018 the minutes stated that, "Around November will then advertise for more clients" but went on to state that there were staff shortages and the need to recruit more staff. At the time of the meeting they had not considered the urgency to not take on further clients until they had recruited additional staff. The minutes also stated that the registered manager needed to look into staff having more travel time in between calls yet at our inspection this had still not been addressed until we identified the concerns.

The provider had employed a consultant to undertake audits of the service in April and September 2018. The reports from the audits recommended more detailed outcomes from supervisions with staff, however we found that this was not taking place as supervisions were lacking. Audits within the service were not robust and had not identified the shortfalls that we had found. This including the lack of mental capacity assessments, the lack of training and supervisions for staff and the concerns around the management of medicines.

As systems and processes were not established and operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider sent us an action plan to detail what actions they had taken since the inspection. They advised that they would be looking into the changing the management oversight of the service. They told us that they would not take on any more people until they were assured that they had sufficient staff to meet their needs. They also advised us that team leaders would not be undertaking care calls. This meant that they would have time to undertaken their other duties. They told us that they would ensure that staff completed all training and that supervisions would take place with staff. We will check this at the next inspection.

People did have positive feedback about certain aspects of the how the service was run. One person told us, "I think it's a good agency." They told us that the response from the office when they rang was, "Very good." Another told us, "I have found them to be an excellent agency. They have met all my requirements."

Staff were complimentary about the support they received from their direct line manager. One member of staff told us that when their personal circumstances meant they needed to change their availability, the agency enabled them to work flexibly around their commitments. They said, "They work around you if you give them enough notice." Another member of staff said, "We have got a good supervisor, we can call her

and she will talk it through with us." A third member of staff told us, "I 100% feel supported. I feel valued. It's brilliant. Really happy."

The service worked closely with other agencies. The service liaised with other organisations such as the local authority in order to provide effective care. The registered manager had worked in partnership with the GP and social worker to ensure that one person received the care that they required in order to meet their care needs.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events including significant incidents and safeguarding concerns.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people's consent to treatment was sought in line with legislation and guidance.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that safe care and treatment was always provided.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there was robust and comprehensive oversight of the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that robust recruitment was taking place before staff started work.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff were

appropriately trained and supervised for their role.