First Choice Homecare & Employment Services Limited

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Inspection report

1st Floor
6 Lanark Square
London
E14 9RE

Tel: 02075380867
Website: www.firstchoiceforhomecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

This focussed inspection was conducted on 13 September 2017 and was announced. We gave 24 hours' notice because the location provides a domiciliary care service and we needed to ensure that someone would be in. At the previous inspection on 23 and 27 February and 1 March 2017, one breach of legal requirement was found. The provider had not done all that was practicable to mitigate risks to people's safety, and had not ensured that care and treatment was provided in a safe way in regards to operating effective systems for the proper and safe management of medicines. We also made a recommendation that the provider sought advice and guidance from a reputable source in relation to the Mental Capacity Act 2005 (MCA), in order to ensure people's rights were protected. The provider sent in an action plan to tell us what they were going to do to make improvements.

First Choice Home Care and Employment Services Limited is a domiciliary care agency which provides personal care and support to people living in their own homes. At the time of this inspection 182 people residing in the London Boroughs of Newham and Waltham Forest were receiving a service. We were informed by the branch manager that most people using the service were funded for their care package by their local authority.

We carried out this inspection to check that the provider had adhered to their action plan and to establish if they now met the legal requirement and the recommendation. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for First Choice Homecare and Employment Services Limited on our website at www.cqc.org.uk.

There was no registered manager in post at the service. 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. The service was being managed by a branch manager who was present during the inspection.

Comments from people who use the service and relatives were predominantly positive. The remarks we received from people indicated that they felt their needs were being met in a safe way and they felt their care workers provided person centred care that respected their choices and wishes. One person told us, "They are very supportive, please put it on record that I am very grateful. The carers are excellent and bring me cheer when I feel at a low ebb" and another person said "I am very happy, they are very nice and never do nothing wrong." One relative told us, "The care workers work hard, they (office staff) keep us informed, I couldn't fault them" and another relative said, "[My family member is happy, they don't treat [him/her] roughly, there is no rudeness and [care worker] is fantastic, always friendly. Some care workers are really good. We have asked for a change of one care worker and they (office staff) are sorting things out."

We found that some improvements had been achieved with the quality of documentation for supporting people with their medicines, and the use of risk assessments to identify and mitigate risks to people's safety

and welfare. However, there were still some inconsistencies in this documentation. The branch manager told us he thought the service had made progress with staff training and supervision, with a particular focus on how to keep people safe.

Actions were being undertaken to make sure that people were asked for their consent to their care. We noted that people's care plans were being updated to ensure that people signed their consent to care forms wherever possible or a relative with appropriate legal authority signed instead.

The branch manager informed us that the provider had decided to deregister the service. We noted that a formal application for deregistration had been submitted by the provider to CQC on the day before the inspection visit, after we gave notice of our intention to conduct an inspection. At the time of the inspection the provider stated that they had not informed employees about its plans but had set up staff meetings that week to engage in discussions about the closure. We were informed by the branch manager that plans were being developed with the two local authorities to ensure that people's care packages were transferred to a different provider in a safe and seamless way, to ensure no disruption for people using the service and their care workers. The completion of this process was due by the end of October 2017 for people who use the service and live in Newham, and the end of November or early part of December 2017 for Waltham Forest residents. The commissioning representatives for both local authorities confirmed that arrangements were in place to make sure that people who use the service experience a smooth transition of their care to other organisations.

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

We found that some action had been taken to improve the safety of the service.

Medicine administration records were audited every month to promote people's safety. However, there were still some inconsistencies in this documentation.

Risk assessments had been reviewed and some changes had been made in order to address people's needs. However, there were still some inconsistencies in this documentation.

Records for staff training, individual supervision and team meetings showed that staff had been supported to improve their knowledge of how to promote people's safety.

While some improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of improved practice and we did not cover all aspects of the key question.

We would ordinarily review our rating for safe at our next comprehensive inspection. However, the provider is in the process of de-registering the service.

Is the service effective?

Requires Improvement

We found that some action had been taken to improve the effectiveness of the service.

The provider had taken action to support people to sign their agreement for their care and support. Where it was necessary to ask a person's chosen representative to sign instead, the provider had commenced actions to check that the representative had the correct legal authority to do so, in line with the Mental Capacity Act 2005.

While some improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of improved practice and we did not cover all aspects of the key question.

We would ordinarily review our rating for effective at our next comprehensive inspection. However, the provider is in the process of de-registering the service.

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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, and to check that improvements to meet the legal requirements planned by the provider after our inspection on 23 and 27 February and 1 March 2017 had been made.

We inspected the service against two out of five questions we ask about services: Is the service safe and is the service effective? The inspection team consisted of two adult social care inspectors. Prior to the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report. We also reviewed the provider's action plans that had been sent to CQC since the last inspection.

During the inspection we spoke with the branch manager, a care coordinator and the finance manager. We checked a range of documents including 10 care plans with accompanying risk assessments, medicine administration records, staff training and supervision records, minutes for staff meetings, the complaints log and quality monitoring audits. Due to the planned closure of the service and the need for the provider to discuss this with employees, we did not contact care workers.

Following the inspection we spoke by telephone with three people who received a service and the relatives of three other people who used the service. We also spoke with commissioning representatives from the two local authorities that use the service.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we had found issues of concern in regards to how people were supported to take their prescribed medicines, and how people were protected from identified risks to their safety and wellbeing through the provision of accurate and up to date written guidance for staff to follow.

We had noted that there was a system in place to carry out monthly medicine audits, which was used to check if care workers had correctly completed medicine administration records (MARs) if they prompted or assisted people with their medicines. Although we saw some positive examples of how these audits had been conducted, we also found that some people who use the service had been placed at risk of harm as errors in their MAR charts had not been identified by the provider's auditing system. We had found that staff had received refresher training in assessing risk and writing care planning documents and some care plans demonstrated a better quality of risk assessments. However, we had noted that further work was needed to improve the quality of other risk assessments.

The above issues in relation to the provider's failure to ensure that they did all that was practicable to mitigate risks to people's safety, and ensure that safe care and treatment was provided to people by operating effective systems for the proper and safe management of medicines, resulted in us issuing a Warning Notice to the provider. All required improvements were due to be completed by 31 July 2017.

At this inspection people using the service, and relatives where applicable, told us that care staff provided care that maintained their safety at home. There were no concerns expressed about how staff prompted people to take their prescribed medicines and/or mobilise safely at home.

We noted that although some improvement had been achieved, several of the care plans we looked at required clearer information to clarify that people's needs were being safely met. For example, the risk assessment for moving and handling for one person was scored as eight, which indicated that there were potential risks. However, there was no further information recorded about how staff should provide care to safely meet people's needs. In a second care plan we noted that the medicine risk assessment recorded that a person needed to be prompted to take their medicines but it also stated that the person administered their own medicines. The daily records were not available for viewing in order to establish how the person's medicine needs were supported and we therefore asked the branch manager to look into this matter.

We noted that individual medicine risk assessments were not written in a consistent manner. For example, we found that 'prompt', 'assist' and 'administer' were used interchangeably, which could lead to confusion for care staff, people using the service and their relatives. Records showed that the provider was carrying out monthly audits to check that the documentation within people's care plans about their medicine needs was up to date and accurate, and checks were in place to make sure that MAR charts were properly completed. The branch manager told us that the provider had focused on supporting staff to understand their responsibilities in regards to assisting people to receive care, through training, supervision and discussions at staff meetings.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection we had found areas for improvement in regards to how the provider followed requirements of the Mental Capacity Act 2005 (MCA). 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. We had found in some instances that where relatives had signed to consent to the care and support of their family members, the provider was not always able to demonstrate that the relative had the legal authority to do so.

At this inspection we found that the provider now demonstrated some improvement in terms of how to ensure that consent forms and other care planning documents were signed by people who use the service if they had the capacity to do so or were signed by relatives who held the legal authority to make decisions on behalf of their family members. Some of the care plans we looked at had been signed by people who use the service and information within the care plan clearly showed that people had the capacity to make decisions about their care and support. One person who uses the service told us, "They (office staff) bring papers to my home every year to sign. I have been using the service for over four years and they ask me my views." The branch manager and care coordinator told us that mental capacity issues were being looked at when people's care plans were being reviewed and families had been asked to provide documentation if they stated that they held power of attorney for health and welfare and/or financial affairs. We were informed that if there were any concerns about people's mental capacity, senior staff at the office discussed their findings with the branch manager and this information was passed on to social care professionals at people's local authority.