J McKenna Ltd

Homestead Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Homestead Care is a domiciliary care agency that was providing personal care to 14 older adults living in their own homes at the time of our inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Systems and processes to protect people from preventable harm were not always operating effectively. Safeguarding concerns had not always been shared with external organisations which meant risks to people did not always have the right level of oversight.

The service had not made statutory notifications to CQC as required. A notification is the action that a provider is legally bound to take to tell CQC about any changes to their regulated services or incidents that have taken place in them.

People were supported by a staff team who understood how to recognise and report safeguarding concerns. Risks to people were assessed, monitored and regularly reviewed and staff understood actions needed to minimise risk of harm. Staff recruitment included employment references and a criminal record check to ensure applicants were suitable to work with older people. People received their medicines safely. Infection, prevention and control practices were in line with government guidance.

Staff spoke positively about their roles, felt their opinions mattered and were supported by the management team. Quality assurance processes captured the voice of people using the service and enabled improvements. Partnerships with other health and social care agencies supported best practice and positive outcomes for people.

The registered manager told us challenges during the pandemic had led to difficulties recruiting staff and a reduction in the number of people they supported with care. This had meant the financial viability of the service was under review and they were making difficult decisions about the future of the business.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 18 December 2019).

Why we inspected
We received concerns in relation to the management of medicines, safeguarding and governance. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key

questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Homestead Care on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding people and not meeting regulatory reporting requirements. Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service. The provider told us they had informed people, staff and the local authority of plans to close the service due in part to staffing issues arising out of the COVID-19 pandemic. We will continue to liaise with the service and the local authority around the issues raised and the potential closure of the service.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Homestead Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection-
We spoke with five people who used the service and four relatives about their experience of the care

provided. We spoke with eight members of staff including the provider/registered manager, deputy manager, office manager, senior care workers and care workers.

We reviewed a range of records. This included five people's care records and medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We met with the provider to follow up on some concerns and ask them to respond to our questions. We looked at safeguarding and accident and incident records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

We inspected this service in part because we had concerns about how safeguarding concerns were managed. We found improvements were required.

- Systems and processes in place to safeguard people had not always been followed. Some incidents were not investigated or reported. This meant risks to people did not always have the right level of oversight.
- Safeguarding concerns had not always been shared with external safeguarding teams in line with safeguarding policies and procedures.
- Legal requirements to notify the Care Quality Commission of safeguarding incidents had not always been met.
- Safeguarding concerns and incidents had not always been recorded. The registered manager told us actions they had taken but records had not been completed detailing findings, outcomes or learning.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People received care from staff who had been trained to recognise and report safeguarding concerns. Records showed us that care staff were confident and competent in reporting any concerns they had about people they were supporting.

Assessing risk, safety monitoring and management

- Risks to people had been assessed, were monitored and regularly reviewed with people, ensuring people's choices and freedoms were respected.
- Staff knew people well and understood the actions needed to minimise the risk of avoidable harm. This included risks associated with skin damage, falls and eating and drinking. A relative told us, "They (care staff) are well trained to minimise any risks".
- When people needed equipment such as specialist air mattresses or a hoist to aid moving and transferring care staff ensured it was safe. A care worker told us, "We check the service is in date, that there's been a PAT (portable appliance test), and visually check they are in good condition".
- Environmental risks had been assessed, including risks to staff. This included access and lighting to people's homes.

Staffing and recruitment

● Staff had been recruited safely. Records showed us this included references, employment history and criminal record checks to ensure candidates were suitable to work with older people.
● Staffing levels were able to meet the assessed needs of people. A care worker told us, "There are enough staff to cover calls. If an emergency, we would have to prioritise; if somebody had a live-in carer then they're safer than somebody with a high priority such as a diabetic or living alone".
● People and their families told us there had been a high turnover of care staff but that they generally had regular care staff, they were responsive to change and flexible. One person told us, "They (care staff) can be with me longer than my time when I'm unwell or feeling grotty".

Using medicines safely
● People had their medicines administered safely by staff that had undertaken medicine administration training and had their competencies regularly checked.
● Some medicines were prescribed for as and when required. Medicine records included instructions on when these medicines should be administered. One person told us, "If I need further pain relief, they (care staff), will give me liquid paracetamol. They record all they have given me".
● When people had been prescribed topical creams body maps were in place that clearly identified where they needed to be supplied.
● Risk assessments had been completed to ensure safe storage of medicines.

Preventing and controlling infection
● People were cared for by care staff that had completed infection, prevention and control training and understood the actions needed to keep people safe from avoidable infections.
● People described staff practice as safe. One person told us, "They (care staff) wear masks, aprons and gloves. They wash their hands first thing and ensure all surfaces are clean and hygienic before leaving me".
● Personal Protective Equipment, (PPE), such as gloves, masks and aprons, was in good supply and easily accessible to staff. One care worker told us, "There's loads of PPE. I have a skin allergy and they cater well for me with gloves".

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
● The registered manager failed to ensure that safeguarding systems and processes in place to protect people from abuse were operating effectively.
●The registered manager failed to take action in line with safeguarding procedures when alerted to alleged abuse. They told us they agreed safeguarding policies and procedures had not been followed.
●Records had not always been maintained about incidents or risks to people or shared with relevant bodies such as local safeguarding teams or CQC.

This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notifications of incidents had not been sent to us in line with regulatory requirements.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

● The registered manager was also the provider of the service. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.
● The registered manager/provider was on extended absence at the time of our inspection with senior staff overseeing the day to day management of the service. We spoke with the registered manager/provider on a video call. They told us challenges during the pandemic had led to difficulties recruiting staff and a reduction in the number of people they supported with care. This had meant the financial viability of the service was under review and they were making difficult decisions about the future of the business.

Continuous learning and improving care
● Auditing systems and processes had improved since our last inspection. Audits were detailed and completed monthly. They included reviewing people's care plans and risk assessments and checking people received their medicines correctly.
● Quality reviews took place with people to gather feedback on the standard of care, timekeeping, respect and safety.
● Information gathered from audits and quality reviews had been used to create action plans, which were shared with the care team and led to improved outcomes for people. Examples included changes to the

time a person had their visit or the routines during a visit.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff spoke positively about their work and felt supported by the senior team. A care worker told us, "Feels like a family, we all chip in. I'd recommend it to everybody I know".

● Staff felt they had a voice and could make a difference to people. A care worker told us, "Our opinions matter. All our ideas are listened to and acted upon. (Registered manager) is a good leader". Another explained how they had shared their experience which led to a change in the recording of a medicine.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●Staff understood the requirements of the duty of candour. This is their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm. Records showed us they fulfilled these obligations, where necessary, through contact with families and people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People, their families and staff had opportunities to be involved in the service in a variety of ways including quality reviews, group and individual supervisions. People, families and staff spoke positively about the accessibility of the service, information sharing and feeling included. One relative told us, "I do know the (registered manager). He is approachable and listens".

● The service had developed links with other agencies in developing best practice guidance. This included Public Health England and Skills for Care.

● Good relationships had been established with community health and social care professionals such as GP's, district nurse teams and social workers ensuring positive health and well-being outcomes for people.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes to protect people from preventable harm were not being operated effectively.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance arrangements failed to ensure that systems in place to protect people from abuse were operating effectively.