

Audley Homecare Limited

Audley Homecare

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?

Requires Improvement 

Summary of findings

Overall summary

This announced comprehensive inspection took place on the 20, 21 and 22 September 2017.

Audley Homecare is registered to provide personal care to people living in their own homes. This included providing live-in-care support. At the time of our inspection, the service was providing care and support to 50 people.

At our last inspection in February 2016, we rated this service as Good. At this inspection, we found that some improvements were required. There was currently no manager registered with the Care Quality Commission (CQC). Since our last inspection a new manager had been appointed. The recently appointed manager told us they were in the process of submitting their application to register with CQC. 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.

Quality assurance systems had not always been effective in recognising and rectifying issues. The registered provider had not carried out regular quality assurance audits to ensure the service was providing good quality care. Where people's views about the service had been obtained, there had been no analysis of the feedback into plans to make improvements to the service.

Systems in place for the recruitment and selection of staff were ineffective. This was because the risks to people using the service of inappropriate staff being recruited had not always been considered. Recruitment checks had not routinely been carried out before staff started their employment to ensure they were suitable to work with people using the service.

The care needs of people had been assessed prior to their using the service. However, not everyone had an up to date care plan, which guided staff as to their current care and support needs. Not all risks to people's health and wellbeing had been clearly identified with actions in place to minimise these. However, work had begun to rectify this as the registered provider was implementing a new system to provide more comprehensive information. People told us they had been involved in the initial planning of their care.

Systems were in place to ensure that people received their prescribed medicines. Medicines were administered by staff who were trained to do this safely. However, we recommend that the registered provider ensure that medicines audits included a check of stock against medication administration records. This would ensure checks were robust enough to monitor that people received their medicines as prescribed and where medicines errors were identified appropriate action was taken to prevent them happening again.

People's safety had been considered and they were at a reduced risk of harm, as staff understood their roles

and responsibilities in relation to action they should take to safeguard people from the risk of abuse. Staff had access to guidance and training, which gave them the information, and knowledge they needed to respond to incidents where they suspected people were at risk of harm, including reporting such incidents to the appropriate authorities.

People were generally satisfied with the service apart from occasional shortages of staff, which prevented them from receiving their planned care. There had been a recent high turnover of staff with insufficient numbers of qualified, skilled and experienced staff available to meet people's needs. This had resulted in people's care calls being cancelled and people advised to find another agency at short notice.

Staff received comprehensive induction and training to provide them with the knowledge and skills they needed to meet the needs of people using the service. Training included supporting staff to understand their roles and responsibilities with regards to the Mental Capacity Act 2005. Staff understood the legal requirements to seek consent and provide care and treatment in a manner, which protected and upheld people's human rights.

There were systems in place to carry out spot checks on staff performance. However, the impact of staff shortages meant these had not been carried out at the regularity required.

Staff were not always provided with opportunities to contribute to the development of the service. This was because they were not provided with regular planned supervision, access to annual appraisals and regular staff meetings. This meant that staff were not provided with regular opportunities to discuss their work performance, plan their training and development needs and discuss face to face any concerns they might have.

Some people who used the service were supported by staff with meal preparation and where possible people's independence was promoted in this area. Records and people confirmed that they were given choice and were able to make independent decisions about what they had to eat and drink.

People were knowledgeable about the registered provider's system for receiving and responding to complaints. Complaints and concerns were taken seriously and investigated. However, the overall governance of the service was in need of improvement.

During this inspection, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

The service was not consistently safe.

Whilst staff had been trained to administer medicines safely, care plans did not always set out the medicines prescribed to people and any specific requirements, which staff need to be aware of when administering people's medicines.

The registered provider had systems in place to reduce the risk of people experiencing abuse and poor care. The training staff received ensured they understood how to recognise abuse or potential abuse and how to respond and report these issues of concern.

There were not always enough staff employed to keep people safe and meet their needs.

The risk of employing inappropriate staff had not always been considered because there were ineffective systems in place for the recruitment and selection of staff.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

Whilst staff received comprehensive induction training, staff were not always provided with regular appraisal, supervision support and team meetings. This meant they were not always provided with the opportunity to discuss their work performance, air their views and identify their training and development needs.

Staff had been trained to understand their roles and responsibilities in relation to the Mental Capacity Act 2005 and related Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain good health and had access to appropriate services, which ensured they received on-going healthcare support.

Requires Improvement ●

Is the service caring?

Good ●

The service was caring.

People were generally positive about the care they received. Staff supported people in a manner that was kind and supportive of their privacy and dignity.

People had been consulted and staff guided in how best to support people in promoting their dignity and independence.

Is the service responsive?

The service was not consistently responsive.

People's choices, wishes and preferences in relation to the planning for their end of life care had not always been considered and recorded in their plan of care.

Care plans did not always provide staff with sufficient detail to ensure people's needs would be met and that they would receive consistent and safe care. A new system was being implemented with work in progress to rectify this.

There were systems in place to ascertain people's views and to address concerns and complaints.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led, as there was a further need for development of the service.

The overall governance of the service was in need of improvement. Quality assurance systems had not been fully developed to regularly monitor the service and assess the care provided to people. People's views had not been analysed or taken into account in planning to make improvements to the service.

Staff and people who used the service did not always have opportunities to be involved in sharing ideas for improving the service.

Requires Improvement ●

Audley Homecare

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 announced inspection took place on the 20, 21 and 22 September 2017.

This inspection was carried out by two inspectors.

In advance of our inspection, we reviewed the information we held on the service, in particular notifications about incidents and safeguarding information. A notification is information about important events, which the service is required to send us by law. We looked at safeguarding concerns reported to us. We also contacted the local authority quality monitoring team. Prior to our inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to our inspection, we sent questionnaires to all of the people using the service and people involved in their care. We received completed questionnaires from 15 people who used the service, three relatives and one community health professional. During our inspection, we spoke with three people on the telephone who were able to verbally express their views about the quality of the service they received and two people's relatives. We also visited four people in their own home.

As part of our inspection, we spoke with stakeholders including the local safeguarding authority and one health professional. We spoke with the registered provider, manager, an independent consultant and nine staff including senior staff.

We reviewed records in relation to seven people's care. We also looked at records relating to the management of medicines, four staff recruitment files, staff training, complaints and systems for monitoring the quality and safety of the service.

Is the service safe?

Our findings

The risk to people who used the service was not always considered because there were ineffective systems in place for the recruitment and selection of staff. A review of staff recruitment files found Disclosure and Barring (DBS) checks had not always been carried out prior to staff being employed. The DBS checks people's criminal record history and their suitability to work with people in this type of setting. We also found references had not always been obtained from the most recent employer. The provider's employment application form required potential applicants to list at least 10 year's employment history when a full employment history was required.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found care plans did not always set out the medicines prescribed to people and any specific requirements, which staff needed to be aware of when administering their medicines. For example, medicines which needed to be administered before meals. Risks such, as those surrounding people's capacity and safe storage of medicines were not always identified and staff had not been given guidance on how to minimise the risks to individuals. We recommend that the registered provider access the most recent National Institute for Clinical Excellence (NICE) guidance for managing medicines within a domiciliary care setting and take action to improve their practice accordingly.

Prior to our inspection the local safeguarding authority told us that there had been a recent safeguarding investigation where it was found that a live in carer had not recorded the administration of a person's medicines for six days. This meant we could not be assured that people received their medicines as prescribed and this highlighted our findings at this inspection of ineffective monitoring in place to identify shortfalls including medicines errors. The registered provider had failed to notify us of this safeguarding concern as they are required by law to do so.

Medicines were administered by staff who had been trained to do this safely. Some medicines management audits had been undertaken but not always on a monthly basis in accordance with the provider's policy. We looked at a sample of these audits as part of our inspection. These audits were primarily assessing staff record keeping rather than any checks on the quantity of medicines stock and cross referencing them with the records. We were unable to carry out any audit of medicines stock against medication administration records (MAR) as the amount of stock received had not been recorded. We recommend that the registered provider's medicines audits include a check of stock against people's medication administration records. This would provide more effective monitoring to check that people had received their medicines as prescribed.

Prior to our inspection 100% of the people who responded to our satisfaction survey told us, 'I feel safe from abuse' and 'or harm from my care and support workers'.

We noted from discussions with staff and a review of policies available to staff that the registered provider

had procedures in place which guided staff on how to whistleblow and respond to allegations of suspected abuse. These provided steps for staff to take to protect people from the risk of harm. Staff told us they had received up to date training in recognising the signs of abuse and demonstrated their understanding of the provider's whistleblowing policy and what action they would be required to take. They were clear about how to make referrals directly to the local safeguarding authority if they had concerns about people's safety.

One member of staff who had received training as part of their induction told us, "The training I received equipped me to know what to do if I was worried about anyone. We know how to look for signs of abuse. We are told to speak to the manager if we have any concerns." The manager demonstrated their knowledge in reporting concerns to the local safeguarding authority for investigation if required.

Staff told us that they were provided with information about risks and there were clear about the arrangements in place regarding key codes and access to people's homes. However, we noted that not all care plans contained fully completed assessments of risk relating to the environment, including fire safety, the use of electrical and gas appliances, and pressure relieving equipment.

Staff told us that that they had undertaken comprehensive training in moving and handling and they were able to tell us the actions they had taken following accidents to ensure people's safety. We saw that these actions were recorded in people records.

People's experiences varied and we received mixed responses. Whilst some people told us they were happy with the care provided, others expressed concerns about the punctuality of their visit and the fact that carers were "rushed." Some people told us that that they did not mind their call being later than scheduled but almost everyone told us that they were not told beforehand if staff were running late. One person told us, "The agency has lost a lot of staff and has a habit of, swapping carers around but they don't always tell you. You don't always know who is coming." People told us they did not always receive a weekly schedule which would provide them with information as to the timing of their calls including the names of staff who would be providing their care. This would be common good practice within domiciliary care services.

Prior to our inspection, we received information of concern from people who told us their care packages had been cancelled without or with little notice to enable them to find another agency. We found from discussions with staff, the manager, the registered provider and people who used the service that there had been a recent high turnover of staff with some staff leaving the service without notice. This had left the service short of staff and unable to cover all the care calls required and meet people's needs. The manager along with other office staff told us they were spending significant amounts of time out of the office providing hands on care to people. Whilst the manager had begun to identify where improvements were required they told us they had little time available to make the improvements necessary. We discussed this with the registered provider who confirmed this. They told us the agency had been through a difficult time but said that things were improving as they were in the process of recruiting more care and office staff.

We reviewed staff work schedules and found that staff were not always provided with sufficient travel time in between visits. We also found some visits scheduled where staff were expected to be in two places at the same time. Staff told us that recently there had been consistent mistakes made in the scheduling of care visits, which they found frustrating and believed this to be as a result of staff shortages. They also told us that if they telephoned the office to point out these errors office staff would respond by reallocating the call to put this right.

There were arrangements in place to support staff and people out of office hours. An on call duty system was in place, where out of hours contact was managed by senior staff on a rota basis. People who used the

service and staff confirmed they could contact the service at any time and someone was always available to respond. One person told us, "There is always someone available at the end of the phone day or night." A member of staff told us, "I have contacted the on call before. They always respond, sometimes take a little time to answer but they have always been helpful and supportive."

Is the service effective?

Our findings

Staff supervision and support was not consistent. Staff did not always receive regular supervision or appraisal. Staff told us, "I have had only one supervision in six months, they sound very pressured in the office and don't always have time but I can phone if I need to." Another told us, "Spot checks have happened in the past but not for a while."

We asked the manager how they ensured staff were competent in areas such as administering medicines and safe moving and handling. We could see that staff had completed training but competency assessments and spot checks on staff performance had not always taken place on a regular basis. The manager told us that the constraints caused by a recent high staff turnover and shortages of staff had meant it had not always been possible to supervise staff but that this would be resolved with the current recruitment of new senior staff.

Newly appointed staff told us they had benefitted from a comprehensive induction programme, which took place over five days. This included induction training in safeguarding people from the risk of abuse, emergency first aid, safe food handling and safety procedures for moving and handling people. Staff told us they also worked alongside other staff shadowing them to get to know people and become familiar with their care and support needs before they started working alone. One member of staff told us, "The length of shadowing was enough for me, about 30 hours I think. I was supported until I felt confident to work alone. There is always someone to help and support you if you are unsure of anything."

Discussions with staff and training records showed us that staff had received training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and related Deprivation of Liberty Safeguards. This meant that staff had the required knowledge to identify when a person without capacity needed specialist support to ensure that their best interests were protected and their human rights upheld.

We observed and people told us they were asked their consent before they received care. Care staff demonstrated how they asked permission before doing anything for or with a person when they provided care. Staff told us how they supported people to make decisions about their everyday lives and gave examples of supporting people to maintain their independence. For example, people told us, "They try to accommodate the timing of my calls to suit me, not always possible but they try." People told us that the service provided was flexible if routines changed to accommodate trips out or hospital appointments. Staff also gave examples of how they supported people living with dementia citing examples of best practice where people may become distressed and anxious.

Some people were supported by staff with meal preparation and where possible people's independence was promoted in this area. Records and people confirmed that they were given choice and were able to make independent decisions about what they had to eat and drink.

Some care records contained evidence of staff working closely with a range of community professionals to

maintain and promote people's health. These included GP's, district nurses and social workers. Some people were able to manage their healthcare independently or with support from their relatives. Staff recorded the support that they provided at each visit and other relevant observations about the person's health and wellbeing. This showed us that staff were knowledgeable regarding what action they should take to ensure people's health care needs were met. However, further work was needed to ensure that care plans were updated to reflect people's changing health care needs including information describing known allergies.

Is the service caring?

Our findings

In response to questionnaires we sent to people prior to our inspection, they told us, "I am concerned about the use of mobile phones by the live-in carers whilst they are working", and "The care workers are all efficient, kind and pleasant. I looked forward to their visits."

People were generally complimentary about staff and told us that they were treated with kindness and consideration. They had good relationships with their allocated care staff and told us that their only complaints were regarding the scheduling and timeliness of their visits and not the carers who supported them. They told us, "They always ask, do you want anything else done", "They are always respectful in my home", "The staff are very nice, I have the same carer, she always asks, 'What shall we do today?' I am very happy with how it works" and "They are all so friendly, kind and helpful."

Staff were observed to be kind, caring and considerate of people during our visits. People were seen to be comfortable in the presence of the staff.

People told us that they were assisted to retain their skills and maintain their independence. An example given was with areas such as personal care and being encouraged to do as much as they were able for themselves. One person said, "They respect my wish to keep going and do as much as possible for myself." Another said, "If I want anything one they do it, sometimes I think they do too much, they are very good."

People told us that they were treated with respect and staff listened to them. One person told us, "The staff are sensitive to my need for privacy. They don't just barge in and start doing things for me without checking with me what I need and how I want it done." Another said, "They always knock before they come into a room. They are sensitive to my needs and I never feel uncomfortable with them washing me."

Staff told us although care plans had not always been reviewed and reflective of people's current needs, they had a good knowledge about their preferences, daily routines and their likes and dislikes. Some staff said that they supported the same people and knew them well. One member of staff said, "I love my job, I love the people and what I am doing."

In response to questionnaires, we sent to stakeholders prior to our inspection, one healthcare professional told us, "As part of a hospital discharge team I have dealt with Audley Homecare over the phone and in person on the ward. They have always been courteous, polite and supportive. Staff are always prepared to go the extra mile when feasible. They communicate often with the ward when in the process of taking on a client. They come on to the ward to introduce themselves to the client and to discuss their needs before discharge home. All patients and their families I have met who are clients of Audley Homecare have always been full of praise for the carers and the service given."

Is the service responsive?

Our findings

Care plans did not always provide staff with sufficient detail to ensure people's needs would be met and that they would receive consistent and safe care. We looked at a sample of care plans and found that they varied in the level of detail provided to guide staff. Some people had comprehensive information whilst others only contained an assessment of need but no plan of care, which would guide staff as to what they were expected to do when providing care and support. This had the potential to place people at risk of receiving inadequate and unsafe care.

People told us that their preferences for support with areas such as the management of their medicines, their personal care needs and provision of meals was respected by the agency but this information was not always within their care plan.

Staff told us there were occasions when the update of care plans to reflect people's current care needs was delayed. One staff member told us, "The care plans are not what the person needs anymore. For instance, one person, no longer drinks alcohol but the care plan tells us they like a drink of whiskey with their meal. Another one gives us the wrong information about a person's breakfast. We tell the office when care plans need changing and they do their best to get them updated but they have been short of staff and falling behind."

Further work was required to ensure the service took account of people's religious, social and cultural diversity and how these may influence their wishes and decisions about their end of life care. We noted from the people we reviewed, people's end of life care needs had not always been assessed. People told us their views, wishes and preferences had not been considered at their initial assessment and ongoing reviews of their care in relation to how they would like to be cared for if they required end of life care. This included assessing their views in relation to implementing, 'Do Not Attempt Resuscitation' (DNAR). This meant that people were at risk of not having their end of life care needs, wishes and preferences met.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When the registered provider was asked in their Provider Information Return (PIR) 'What improvements do you plan to introduce in the next 12 months that will make your service more responsive, and how will these be introduced?' They told us, "We are aware that we should be reviewing the service provided to clients more regularly. We have recently taken on a new staff member who is going to take responsibility for making sure that all the appropriate activities are correctly entered onto our system, so that members of the management team are reminded electronically, in good time, of client-related activities they need to undertake and by when. We are also aware that our clients' needs must be more outcome-focused as well as person-centred. We have updated our Care Planning Questionnaire to highlight the need to include details of what the care being provided is actually trying to achieve."

The manager told us work had begun to review people's care and update care plans. They showed us the

new system they were introducing for assessment and care planning which they hoped would provide more comprehensive information to guide staff in meeting people's needs.

The registered provider operated an accessible system for receiving, handling and responding to complaints. Information, which guided people as to this process, was provided to people at the commencement of the service. The complaints procedure guided people in how to raise any concerns or complaints they might have with timescales they could expect for a response. We saw that four complaints had been received within the last year but these had not all been responded to in a timely manner in accordance with the provider's policy. However, there was a clear audit trail, which described the investigation and the response to the complainant.

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager. Since our last inspection, a new manager had been appointed who had been previously employed as the training manager. The new manager told us they were in the process of applying to become the registered manager with the Care Quality Commission (CQC).

When the registered provider was asked in their PIR, 'What improvements do you plan to introduce in the next 12 months that will make your service better led, and how will these be introduced?' They told us, 'We are in a period of transition in terms of the senior management team and are aware of the need to 'steady the ship'. The aim of the senior management group was and remains to take the business forward at a strategic level, at the same time as overseeing and monitoring the service at an operational level.'

We found examples where the registered provider's current quality assurance systems had not been effective in recognising and rectifying issues, including those we identified at this inspection. This identified a lack of consistent overall governance of the service. Quality and safety audits had not been completed by the registered provider on a regular basis to promptly identify shortfalls and ensure the service was providing quality and safe care. There had been only two quality monitoring audits carried out in the last year by independent consultants. The last audit in May 2017 was described as a mock inspection. This audit focused on the inspection of the office environment and office based records but did not include any assessment of people's views as to the quality of the service they received or staff and relative's views assessed. The audit had highlighted some areas for improvement but did not include any action plan with timescales for these improvements to be completed.

We found some irregular, sporadic spot checks which had been carried out by senior staff in relation to; staff performance, staff medication competency assessments, and quality recording in care records. We also found some auditing of care plans and complaints. However, we found no audits had been carried out with any analysis of incidents and no audit of staff recruitment files which would have identified the shortfalls we found at this inspection.

The one annual satisfaction survey available had been carried out in the last year with a response from 15 people. Whilst the majority of people commented positively as to the conduct of staff, other responses received were less positive. For example, 'The serving of food is not always heated properly', 'I am not always notified of late calls', 'I have requested a schedule of visits to be emailed to me but this is not always provided unless I ask' and 'carers do not always want to give me a shower. I think this is because they lack confidence.' We discussed these responses with the registered provider who confirmed no formal evaluation of people's views had been carried out following this survey and no action plan produced. This meant that there was no plan in place, which would describe how the registered provider used people's views to plan for continuous improvement of the service.

This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

When we asked staff about the culture and management of the service and if they were valued and invited to be involved in planning for improvement of the service, we received mixed responses. Staff told us the service had been through a challenging time with the change from one manager to another and said the recent high turnover of staff had impacted on their morale. Most of the staff were positive about the current management and their approach whilst others described what they termed as a 'blame culture'. The majority of the staff we spoke with said they would appreciate more planned opportunities to receive supervision, appraisal and team meetings with opportunities to be involved in sharing ideas for improving the service.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not regularly reviewed and updated to identify and plan for people's needs and preferences.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have effective systems or processes in place to assess, monitor and improve the quality and safety of the service provided.
Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment safety checks had not routinely been carried out before staff started their employment.